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Perception of Veterans With Traumatic Brain Injury Regarding the Veterans Administration Rehabilitation Process

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Walden University

College of Social and Behavioral Health

This is to certify that the doctoral study by

Kalangie Serrano

has been found to be complete and satisfactory in all respects,
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the review committee have been made.

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Walden University

2025

Abstract

Perception of Veterans With Traumatic Brain Injury Regarding the Veterans

Administration Rehabilitation Process

by

Kalangie Serrano

MSW, University of Central Florida, 2017

BSW, University of Central Florida, 2016

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Social Work

Walden University

November 2025

Abstract

This study explored the perceptions of veterans with traumatic brain injury (TBI) regarding the Veterans Administration's (VA's) rehabilitation process in terms of its ability to enhance their vocational skills and employability. The purpose of this qualitative study was to explore the vocational and employment needs of military veterans with TBI and to understand their perceptions and challenges in navigating the vocational rehabilitation and employment process. Using a generic qualitative approach and ecological systems theory to ground this study, data were collected through semistructured interviews with seven veterans who had participated in Veteran's Administration rehabilitation programs. Thematic analysis of the data revealed seven central themes: (a) lateness and inconsistency of rehabilitation services, (b) centrality of family and peer support systems, (c) fragmentation in case management and coordination of care, (d) strengths of specialized military and VA rehabilitation programs, (e) military cultural norms as barriers to recovery, (f) resource awareness and access challenges, and (g) veteran-led recommendations for system improvement. Findings indicated that veterans' rehabilitation experiences were shaped by both systemic inefficiencies and supportive interventions. Proactive case management, integration of family and peer support, enhanced access to mental health services, improved communication, and scaling of best practices from specialized programs are recommended. To promote positive social change, at the micro level, practitioners could empower individual veterans; at the mezzo level, families and communities could strengthen support systems; and at the macro level, policy reforms would help standardize case management and expand access.

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Dedication

I dedicate this project to my parents, Carlos and Maria Serrano, who sacrificed so much to give me and my siblings a better life. You never stopped believing in me, and this achievement is a testament to the resilience you taught me. I love you both more than life itself.

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Section 1: Foundation of the Study and Literature Review

As of 2021, an estimated 3,000,000 U.S. service members were deployed to Iraq and Afghanistan for combat (Peterson, 2022). Veterans of those wars frequently returned with complaints about their cognitive efficiency (Slatore et al., 2018). In a survey of Afghanistan and Iraq veterans, 557 participants who acquired a mild traumatic brain injury (TBI) reported post-concussive symptoms 3 months after returning from deployment (Schwab et al., 2017). Veterans with TBI frequently struggle to obtain gainful employment after acquiring a TBI (Wyse et al., 2020). For veterans with mild, moderate, or severe TBI, returning to work after discharge from the military can be particularly difficult considering the physical, emotional, and cognitive challenges associated with community integration and independence (Matney et al., 2022). Many military veterans over the years have experienced psychological trauma and TBI, which has affected their social integration in their communities as a result of battling with significant chronic neuropsychiatric symptoms.

Veterans often are unable to engage in gainful employment due to the mental health challenges resulting from brain injury and traumatic experiences (Wyse et al., 2020). Engagement in social rehabilitation programs provides an effective framework to help veterans recover from mental health challenges and be exposed to employment opportunities where they can improve their lives. Most importantly, the rehabilitation programs help the veterans to deal with psychological trauma and, as a result, improve their social participation, cognition, and improve their quality of life (Lindquist et al., 2023). A qualitative research method provides an effective research framework for

examining the research problem in this study. The findings of the study may contribute significantly towards improving the quality of life for military veterans who have retired after suffering from posttraumatic stress disorder (PTSD). The overall study will be organized into four sections: the foundation of the study and literature review, research design and data collection, presentation of findings, and application to professional practice and implication for social change.

Problem Statement

The most prevalent combat-related conditions among veterans are PTSD and TBI (Dieter & Engel, 2019). Although TBI is classified as mild, moderate, or severe, military personnel, particularly war veterans, report the highest number of severe TBIs. In mild TBI (also called “concussion”), the victims' conditions are resolved without medical treatment and often take weeks or, at most, 3 months to disappear (SAMSHA Advisory, 2023). However, most cases of TBI in war veterans go unrecognized, undiagnosed, and untreated, whether during combat or once they shift to civilian life (Lindquist et al., 2023). War veterans with mild TBI are also more likely to have heightened feelings of sadness, agitation, and nervousness (Substance Abuse and Mental Health Services Administration, 2021). These veterans become extremely sensitive to light or noise and may have difficulty sleeping or concentrating. The physical and neurological limitations make it difficult for them to function within a typical social setting, and the workplace is one of the challenging areas (Lindquist et al., 2023). This group exhibits physical, emotional, and cognitive issues that prevent them from successfully reintegrating. The

Veteran Health Administration acknowledges the insufficient resources and policies for intervention and rehabilitation programs and approaches (Matney et al., 2022).

Although previous research has presented an interest in war veterans and how they shift from isolation to reintegration, focusing on employment (Bloom et al., 2019; Wyse et al., 2020), it does not present how TBI impacts war veterans' employability and vocational presence. The literature does not illuminate how to best support the vocational and employment needs of military veterans, especially those with TBI, while addressing the treatment needs as well. I conducted this study to address this social work practice gap by exploring the perceptions of veterans with TBI regarding the Veterans Administration's (VA's) rehabilitation process in terms of its ability to enhance vocational skills and employability potential for TBI veterans.

Purpose Statement and Research Questions

In this qualitative study, I examined the perceptions of active-duty members and veterans regarding the rehabilitation process, including its challenges and benefits, as well as their recommendations for enhancing outcomes after TBI, with a focus on employment. These outcomes are critical as they influence how they successfully reintegrate into the civilian workforce. For this study, the research questions (RQs) were

RQ1: How do unemployed veterans with TBI describe their experiences with various system levels as they navigate the vocational rehabilitation and employment (VR&E) programs?

RQ2: How do unemployed veterans with TBI describe the barriers they face at various systems levels in navigating VR&E programs?

Nature of the Doctoral Project

I followed a generic qualitative approach to address the RQs. The use of a generic qualitative approach helps an investigator to answer their RQs by improving understanding of how people see a phenomenon or situation (Stensland et al., 2020). I explored the experiences and perceptions of active-duty military members and veterans with TBI in navigating the rehabilitation and employment process. Emphasis was placed on obtaining the opinions of veterans, which necessitated a qualitative approach to gathering the needed data. Each veteran was encouraged to express their unique experiences without fear of being dismissed or having their stories generalized by the social worker as part of the strategy. Data for this investigation was obtained from veterans with TBIs recruited at Walter Reed National Military Medical Center. Since this study is qualitative, thematic analysis for qualitative data was used to analyze the collected data and guide the presentation of the findings.

Significance of the Study

The existing scholarly evidence was limited given the sensitivity of the veterans' data and especially to the country's security. The government holds most information with limited availability to the public for research. As a result, this study contributes significantly towards filling the existing knowledge gap on VA vocational rehabilitation processes and how it can improve employment rates for unemployed veterans. Most importantly, there is limited information for social workers on how unemployed veterans can be assisted after completing the VA vocational rehabilitation process. This study may

help improve knowledge of existing services such as on-the-job training, employment assistance, short- or long-term training and required supplies and equipment.

From a professional perspective, the study's findings may significantly contribute to enhancing knowledge on how social workers can help active-duty military members return to work and veterans secure employment opportunities after successful rehabilitation processes. From a theoretical point of view, the study may challenge the existing theoretical frameworks, such as the ecological systems theory, by providing more knowledge on the impact of different environmental factors on the successful rehabilitation of veterans and providing them with the necessary support to regain their productivity in society. The findings from this study can also help government officials at the Department of Defense (DoD) to better understand the best ways unemployed veterans can be supported and empowered after successful rehabilitation.

Theoretical Foundation

Bronfenbrenner's (1979) ecological systems theory served as the theoretical foundation for this study. According to this theory, various environmental systems impact a person's development (Schlüter et al., 2019). The ecological theory explains why people express different behavioral patterns in different environments (Schlüter et al., 2019). An individual's interaction with family and strangers, or different environments, contributes to understanding a veteran's role in connection to the circumstances surrounding them on various levels. A proposition of ecological systems theory is that individuals experience various surroundings during they lifetimes that may affect how they behave (Crawford,

2020). Such systems include the microsystem, ecosystem, exosystem, macrosystem, and chronosystem.

Microsystem

The microsystem's context is the immediate surroundings that people experience in their everyday routines. The microsystem comprises relatives, acquaintances, students, instructors, coworkers, and others with whom an individual has regular contact (Rus et al., 2020). The microsystem is the context in which individuals connect socially with all these entities. According to Bronfenbrenner's theory, individuals actively create their social environments in the microsystem environment rather than simply being passive beneficiaries of their interactions (Moore et al., 2020). For war veterans with TBI, the ease of active participation in their social environments may be lacking. Treatment services to address these issues are a part of the vocational rehabilitation process.

Mesosystem

The interactions between the microsystems in a given situation are part of the mesosystem. Challenges navigating the DoD/VA health care system are central to mesosystem interactions as they apply to veterans who have suffered a TBI and caregivers or family members. There are programs in place that the DoD/VA health care systems offer, including the Program of Comprehensive Assistance for Family Caregivers (Van Houtven et al., 2019). This program offers a financial stipend, therapy, access to health insurance, and caregiver training. Comprehensive support for family caregivers can increase veterans' use of VA outpatient services across all categories,

including veterans' utilization of primary care and mental health care services (Van Houtven et al., 2019).

Exosystem

The exosystem is the environment with a connection between the environment within which a military veteran does not take part and the environment in which they participate (Guy-Evans, 2020). A key factor in the veteran's exosystem connection is the lack of continuity of care within the DoD/VA health care system. This is where caregivers and family members have an opportunity to help the veteran overcome these challenges and increase access to care. By participating in the Comprehensive Assistance for Family Caregivers, the needs of the disabled veteran can be met (Ashraf et al., 2022).

Macrosystem

The true culture of a military veteran is the macrosystem environment (Guy-Evans, 2020). The military culture that the veteran is immersed in can influence their beliefs and perceptions about the events that took place, such as mental health stigma. Mental health stigma can lead to veterans avoiding seeking treatment. Fear of what other service members may think or of being told they are unfit for duty can deter a veteran from seeking help (Cerrully et al., 2018). The DoD/VA is trying to prevent these inherent barriers by hiring more clinicians with military experience to engage directly with active-duty service members in their units and veterans in clinics and hospitals (Cerrully et al., 2018).

Chronosystem

The transformations and changes in a military veteran's existence are included in the chronosystem (Guy-Evans, 2020). Quality of care across DoD/VA health care facilities varies, indicating that not all veterans are "receiving the same high-quality care that other VA facilities may provide" (Anhang et al., 2018, p. 1636). Increasing the usage of interdisciplinary teams with mental health clinicians can help streamline more efficient interventions for veterans and their caregivers.

Rationale for Theory

Ecological theory can provide a useful foundation for enhancing understanding of the connection between psychosocial and environmental factors in military veterans reintegrating into society (Elnitsky et al., 2017). Ecological systems theory aligns well with military populations because it considers the impact that various systems have on individual development (Imoke, 2019). Disabled veterans and their families typically remain connected to the military community after separation and have access to base facilities, including in-base clinics and hospitals, as well as base exchanges for shopping and other benefits such as legal advice. The interventions derived from the ecological systems approach are logical linkages to the subject matter of my study. The clinician may implement veteran peer-based outreach and therapy groups to evaluate their effect on the veteran's involvement and reintegration. The veterans' psychological and physical well-being can be supported, and their interpersonal skills can be improved. By using the ecological theoretical framework, the clinician can make this an effective part of the VA rehabilitation process.

Values and Ethics

I used the National Association of Social Workers (NASW) Code of Ethics to meet the values and ethics required for this study. The NASW Code of Ethics is a set of principles that governs social workers' professional conduct. The code of ethics contains standards and principles guiding social workers' conduct when providing services. The ethical principles outlined in this code include social justice, service, human relationships, the dignity and worth of persons, competence, and integrity (NASW, 2022). The core value of dignity and worth of people is what guides this study. This value requires that social workers approach each person with compassion and respect, considering personal variations and cultural and racial diversity (NASW, 2022). Social workers encourage their clients to make responsible social decisions. Social workers strive to enhance their clients' capacity for transformation and their ability to care for their own needs. Social workers are aware of their dual obligations to their clients and society. Following the profession's beliefs, ethical tenets, and ethical standards, they work to resolve conflicts between their clients' interests and the interests of society. I conducted this study with the best interests of veterans in mind to highlight the challenges they face in the rehabilitation process and propose viable solutions to their challenges in finding suitable employment.

The NASW also includes ethical responsibilities towards the broader society, the social work profession, in practice settings, colleagues, clients, and as a profession (NASW, 2022). Ethical responsibilities in social practice settings were particularly suited for this study. This study drew solely from data obtained through semi-structured interviews with unemployed veterans with traumatic brain injuries, ensuring the

researcher remains grounded in the direct experiences and perspectives of the participants. The interview guide was reviewed by Walden University's Institutional Review Board to ensure the approach and procedure to be taken in data collection aligned with ethical research practices. The researcher ensured that adequate and timely documentation of data records occurred and that the research findings were focused on facilitating service delivery and service continuity for clients in the future (NASW, 2022). The researcher collected only information related to the research topic to ensure the participants' privacy were guaranteed.

Review of the Professional and Academic Literature

I obtained the literature for this study from databases and search engines, including PubMed and Google Scholar, and the website of the Centers for Disease Control and Prevention. These databases were chosen based on their credibility in having peer-reviewed journals. The search engine used in this case was Google Chrome. Search terms used to extract literature included *veterans with traumatic brain injury, employing veterans with traumatic brain injury, and work outcomes of veterans with traumatic brain injury*. The inclusion criteria for the resulting study included studies published within the last 5 years, those highlighting empirical evaluations, and discussions on models used to assess employment for veterans with TBI.

The Prevalence of Posttraumatic Stress Disorder and Traumatic Brain Injury Among War Veterans

Studies indicate the prevalence of PTSD and TBI in war veterans, focusing on wars in Iraq and Afghanistan (Kennedy et al., 2019). According to the Centers for

Disease Control and Prevention (2025), more than 450,000 service members and veterans in the United States were diagnosed with a TBI from 2000 to 2021. In a study on cognitive performance and psychological distress as reflected in Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans with or without TBI, 44% of the sample obtained sustained military related TBI, with 97% having mild TBI within an average of 41 months (Donnelly et al., 2018). Psychological distress was imminent and significantly associated with objective and subjective cognitive performance in veterans with TBIs (Donnelly et al., 2018).

It remains uncertain whether the deteriorated mental and physical health following TBI is specific to the injury or if it is further motivated by other factors like exposure to combat and deployment (Qureshi et al., 2019). Some veterans' conditions become severe and necessitate assessment through a computed tomography (C.T.) scan to identify any signs of bruising, brain bleeding, and swelling. Additionally, it is necessary to assess the duration of consciousness alteration or loss, memory loss, and responsiveness of the individual following the injury (Van Praag et al., 2019). Although some victims have their symptoms resolved within hours or weeks, some symptoms extend to months or longer and necessitate the combination of medical treatment with physical, occupational, cognitive, and speech therapy.

The Challenge of Reintegration for Veterans

The challenges veterans face remain a concern as they attempt to reintegrate, considering the deteriorated quality of life. Focusing on the differential adjustment patterns and impacts on quality of life, Elliot et al. (2017) concentrate on personality as

an influence on ease of adjustment and the resulting way of life. This qualitative research, conducted on 127 veterans comprising 107 men and 20 women at least 37 years of age, concluded that resilient personality prototype adjustment in war veterans, regardless of TBI presence and the extent of combat exposure, is associated with reduced levels of sleep disturbance with increased psychological flexibility, affiliation with more health-promoting behavior, and heightened emotional distress tolerance. This is after a multidimensional personality questionnaire that was administered to this population with a 4- to 5-month follow-up that supported the fact that these personality qualities differ significantly from those of veterans who reflect under-controlled or over-controlled prototypes. Using path models, Elliot et al. (2017) show how TBI had a unique and consistent effect on depression compared to posttraumatic depression, quality of life, and social support. This study conducted on veterans aided in investigating the challenges that veterans with TBI face during reintegration to the military even after rehabilitation and proving that personality characteristics are identified as equally critical in determining the ease of reintegration in veterans and possibly predicting their distress levels and quality of life.

Fonda et al. (2017) presented a quantitative study of suicidal attempts in veterans as they attempt to shift from isolation to reintegration. It sheds more light on the association between TBI and suicide ideation by investigating a sample of 273,591, with a majority being men of 28 years and above. The article acknowledges the presence of comorbid psychiatric conditions in veterans as a critical driver of suicide and suicidal attempts in war veterans. Using Cox proportional hazards regression analyses, Fonda et al.

(2017) conclude that the link between TBI and attempted suicide in war veterans stems from co-occurring psychiatric conditions, and the presence of PTSD creates the most significant impact. After the research, at least 545 veterans attempted suicide during reintegration. Therefore, Fonda et al. (2017) conclude that there is a high association between TBI and attempted suicide that makes it challenging for veterans to reintegrate. These psychological conditions result in suicide, suicidal behavior, and suicidal attempts, which gives more insight into the perceptions of veterans with TBI regarding veteran administration in the rehabilitation process and reintegrating. Findings implied that behavioral frontal system dysfunction markers could predict whether a person with a TBI would be employed.

Bloom et al. (2018) is a qualitative study on 30 patients seeking a systematic review and meta-analysis of return-to-work times for clients exhibiting mild TBI. Bloom et al. (2018) present the importance of vocational rehabilitation interventions in assisting adults with TBI to secure employment. After 8 months, the findings indicate that clients with mild TBI returned to work. The systematic review assessed the effectiveness of vocational rehabilitation intervention in assisting adults with TBI to secure competitive employment. The randomized trials using the military population in the United States and the civilian population in China show that no intervention is effective after a year, and individual factors like the severity of PTSD impacted the effectiveness of the intervention. Thus, using the civilian population acts as data for comparison against the military population.

The Difficulty of Returning to Work for War Veterans

Several other studies also noted difficulties war veterans faced when seeking employment. Ahonle et al. (2019) investigated factors that predicted employment for individuals with TBI, while Church et al. (2019) investigated indicators of work outcomes for veterans with histories of TBI that received evidence-based supported employment (SE), which focused on the investigation which included a 12-month SE intervention that included 50 jobless with a history of mild-to-moderate TBI and current cognitive impairment. Ahonle et al. (2019) study utilized data from the Rehabilitation Services Administration's Case Service Report (RSA-911) database and a multiple logistic regression model for variables including vocational rehabilitation service, demographics, and disability-related variables. The results of this study indicated that the following factors were substantially related to work outcomes: education level, race/ethnicity, age at application, reemployment status, receipt of Supplemental Security Income, Social Security Disability Insurance, co-occurring depression, and case spending.

According to Church et al. (2019), bivariate analyses revealed that better job results were related to lower disability ratings, more recent work history, more months worked in the previous 5 years, lower PTSD symptom severity, weaker verbal memory, and greater cognitive flexibility. Improved verbal memory performance and cognitive flexibility predicted better employment results in multivariate regression models. In contrast (Ahonle et al., 2019) noted that on-the-job training, job placement, and assistance were the three aspects of vocational rehabilitation that positively impacted employment outcomes, and regarding job outcomes, race/ethnicity impacted the impact

of college training, SE, transportation, and prolonged evaluation or work trial assessment services.

Hart et al. (2019) conducted a prospective longitudinal study where 1-year employment outcomes following moderate-severe TBI were evaluated, while Libeson et al. (2021b) also measured the level of occupational stability for TBI patients who had extensive vocational rehabilitation (V.R.). Participants in the Hart et al. (2019) study included 320 patients with moderate-severe TBI who were employed at the time of the accident, enrolled throughout inpatient rehabilitation, and evaluated 1 year after the injury. According to the results, fewer than 40% of participants (n = 124) were still working at the 1-year follow-up. In comparison to men, women returned to work more quickly and frequently. Return to work was also correlated with resuming driving and the severity of the damage. This relates to Libeson et al. (2021b) study, which investigated TBI employment stability measures the number of post-injury employers, length of time with the employer, and average weekly hours utilized in interviews with 72 people, most of whom had moderate-to-severe TBI. Results indicated that long-term employment issues caused by injuries called for constant job changes. At the same time, individualized V.R. was crucial to ensure long-term employment stability after TBI and facilitate a return to work.

In a quantitative study, Libeson et al., 2021b concluded that based on the demands of each workplace's needs and job requirements, V.R. should be tailored to support the impact of the distinct cognitive and physical impairments faced by each person with TBI. The authors sought to evaluate the experiences of employers of TBI patients who have

undergone thorough vocational rehabilitation. Results indicated that employers may have obtained assistance with practical problems (Libeson et al., 2021b). Still, evidence suggests they were unprepared for the emotional experience, which explains why most of the veterans who have undergone rehabilitation have difficulties reintegrating and finding a stable job, just as outlined in Ahonle et al. (2019), which concluded that veterans indeed find difficulties in reintegrating. Libeson et al., 2021b showed that employers worked hard to identify acceptable responsibilities and protect the welfare of their injured workers even as they tried to support workers through the challenging process of discovering they could no longer perform at their pre-injury level. Despite their efforts, employers believed that some employees found this process discouraging.

Ruet et al. (2017), using pre-injury sociodemographic information, pre-injury injury-related characteristics, and post-injury factors for each patient, sought to characterize the employment outcome 4 years following a severe TBI. Additionally, Simpson et al. (2020) also sought to contrast the employment and clinical traits of TBI clients who were resuming old employment with those who were entering new employment. The study by Ruet et al. (2017) entailed tracking TBI patients 1 and 4 years after the injury. After 1 year, a prospective study was conducted to gather sociodemographic information, injury severity-related variables, and functional and cognitive outcomes concerning the challenges veterans with TBI face when absorbed into the job market. Results indicated that 38% of patients worked at the 4-year follow-up. In contrast, Results of this investigation showed that compared to clients returning to their pre-injury jobs, clients seeking new employment were noticeably more likely to be

younger, unmarried, less educated, to have more serious injuries, and to exhibit problematic behaviors while Simpson et al. (2020) showed that finding new employment significantly improved employment outcomes after TBI but called for more intense and specialized programs to address the numerous clinical and professional hurdles.

Ruet et al. (2017) confirmed that patients with severe traumatic brain injuries have a poor rate of long-term employment. The findings showed how many factors affect employment outcomes and indicated that pupils with traumatic brain injuries were more likely to be jobless. The data from Simpson et al. (2018) demonstrate the challenges individuals with TBI face in securing or maintaining employment. This means they are unlikely to achieve their financial and psychological well-being. Due to the range of physical, interpersonal, emotional, and cognitive impairments TBI patients experience, their ability to be employed should be the primary goal of all TBI rehabilitation programs or interventions. Most researchers have used multiple regression to identify how various predictors, as mentioned above, contribute independently (McCarron et al., 2019; Winter et al., 2019; Watkin et al., 2019).

Winter et al. (2019) argued that understanding the interrelationship and interconnectedness within these variables is critical as they will highly influence the sort of intervention or rehabilitation programs for war veterans. This affirms the primary study, which investigates the perceptions of V.R. with TBI in their work, reintegration, and normal lives, with conclusions indicating that TBI in veterans is linked to various mental health issues that prevent them from successfully returning to work. The psychological trauma present in military veterans is linked to chronic neuropsychiatric

symptoms, and this realization creates a persistent obstacle to social reintegration (McCarron et al., 2019). Veterans who have sustained TBI experience ongoing symptoms or co-occurring conditions like depression and post-traumatic disorder. Research on 172 TBI patients showed that following a TBI, 84% of those with modest injuries and 69% with moderate or severe injuries returned to work (Watkin et al., 2019). Within a year, 16.3% had completed their returns. Higher levels of functional ability, anxiety, and health-related quality of life increased the likelihood of a full return to work. In 1 year, 24% of employees had accommodation at work. 67% of respondents reported decreasing job satisfaction, and many mentioned shorter workdays.

Veteran Dog Partnership and Other Interventions

The shift from isolation to integration in veterans is challenging due to TBI. However, veteran-dog partnerships have facilitated veterans' ability to engage with the community, develop and sustain relationships with family and friends, seek beneficial employment, and prioritize leisure (Crowe et al., 2018). Also, Libeson et al. (2018) investigated the return to work (RTW) experience of TBI patients who went through the vocational rehabilitation process to pinpoint the enabling and impeding elements of the RTW process. Crowe et al. (2018) developed five critical areas of focus reflected by veterans-dog relationships related to TBI. First, it reflected the desire of the isolated veterans to move from isolation to recognition through the theme of an isolated individual who is isolated but seeking society. The second theme centered on the desire to navigate daily life, and the relationship served as a means to open up opportunities. The third theme was an opportunity created for veterans through the relationship

established with their dogs, focusing on bridging the gap and facilitating social connections. The fourth theme was the opportunity to transform their sense of worth and purpose through reclaiming life. The fifth and final theme was the dog's presence as a catalyst for a calm life despite the obstacles from combat.

Nakase-Richardson et al. (2017) explained that few war veterans return to work within 1-year postinjury in the presence of TBI. Factors like the veteran's age at the time of the injury, the severity of the TBI, minority status, and time and probability of RTW determine how easily these veterans reintegrate into social life, especially in the workplace. The presence of dogs in the lives of veterans should act as a facilitator of the transition from isolation to reintegration. The transition process should form the basis of rehabilitation planning and service delivery in policies focusing on the continuum of recovery. Howe et al. (2020) further investigated the most effective return-to-work (RTW) strategies following TBI. The study employed a parallel-group, randomized, controlled experiment at a TBI outpatient clinic at Oslo University Hospital in Norway. An independent researcher randomly assigned patients with a history of mild-to-moderate TBI to undergo group-based compensatory cognitive training (CCT) and SE or treatment as usual (TAU), which consisted of customized multidisciplinary care. Two to 3 months after the TBI occurred, participants were enrolled. RTW served as the major end measure three and six months after study enrollment. Work percentage, stability, and productivity were considered secondary outcomes. The outcomes from baseline to 6 months showed no difference between CCT-SE and TAU in work-related outcomes. At 3 months, the

CCT-SE group had a greater return to work percentage than the TAU group (Howe et al., 2020).

McCarron et al. (2019) proposed developing a new treatment model to address the unseen and unmet rehabilitation needs of military veterans, which is vital in ensuring that they are mentally and physically prepared to resume work and normal day-to-day activities. The exploratory study concludes that combining psychotherapy and cognitive rehabilitation is a potential opportunity for addressing multiple layers of social competence. However, more extensive controlled studies are needed to ascertain the efficacy and feasibility of this approach as an intervention for war veterans. Some interventions and rehabilitation focus on processes rather than unmet issues existing externally. Winter et al. (2019) present mediation analyses and tertiary prevention as critical opportunities in assisting war veterans' reintegration. Mediation analysis is associated with identifying the mechanisms that underlie the association between the various predictors of employment in veterans, such as physical function and health predictors.

Some interventions approach TBI in war veterans as a complex, interconnected phenomenon that necessitates the integration of various stakeholders. Wyse et al. (2020) concentrated on the employment and vocational rehabilitation experience among veterans with polytrauma/ poly-TBI history, as evident from war veterans in Iraq and Afghanistan. On the other hand, Winter et al. (2019) explained that mediation analysis will present a nuanced view of how these predictors affect rehabilitation outcomes in war veterans if approached jointly. Thus, identifying the predictors, particularly in treatable conditions,

will assist in applying tertiary prevention and facilitate the ability to lessen the long-term disability, impairment, or suffering associated with TBI. The qualitative interviews and focus groups used in this research demonstrate how participation in vocational rehabilitation programs, specifically the Individual Placement and Support for Supported Employment, helps address the barriers individuals face in employment.

Notable, Wyse et al. (2020) emphasized the need to address communication and logistical issues, considering veterans have emotional, interpersonal, physical, and cognitive barriers to finding and maintaining work associated with their polytrauma/TBI symptoms and sequelae as a way of ensuring that veterans are mentally stable, especially after suffering from. This is the same way that Winter et al. (2019) suggested the importance of mediation and the importance of psychotherapy to ensure the psychological well-being of veterans who have TBI. According to Wyse et al. (2020), there are barriers to program utilization, such as eligibility characteristics, veterans' fear of losing their financial benefits, and the presence of self-sufficiency military-cultural belief that prevents many military members from seeking help. The staff used within the intervention must be able to extend and serve as translators in case of barriers, advocates for individual and generalized cases, and navigators for the war veterans when they are job searching or throughout their TBI experience treatment and management maintenance process (Wyse et al., 2020).

Summary

Guided by the need to explore the vocational and employment needs of military members and veterans, this research will look into the perceptions and challenges

veterans with TBI face and their perspective on navigating the rehabilitation process. VR&E is an employment-oriented program established by the government to assist veterans in transitioning, especially service members and veterans with service-connected disabilities. It prepares them for suitable employment, including employment assistance, purchase of required supplies and equipment, short or long-term training, and on-the-job training. For veterans whose impacts were severe and who are unable to work, the program offers them the ability to live independently to the best possible extent, whether at home or within their respective communities. Disabled veterans are already more vulnerable, considering the possibility of prior trauma, and TBI is one of them.

Military-related TBI is complex, and the available resources and treatment options require further research to adequately address the current challenges. The comorbidities related to TBI and the long-term psychological, cognitive, physical, functional, and occupational deficits that result in functional limitation for war veterans are also significant considerations. Based on this information, this study aimed to examine the challenges war veterans with TBI face and their perspective on navigating the VR&E process to reintegrate into the civilian workforce successfully.

Section 2: Research Design and Data Collection

Introduction

For veterans with traumatic brain injuries to successfully reintegrate into the civilian market, it is essential to understand the challenges they encounter when navigating VR&E programs. As stated, it aims to explore the challenges veterans with TBI encounter when accessing VR&E programs. These results are significant because they impact how successfully they were reintegrated into the civilian workforce. This section of the document outlines the methods that were employed to achieve the study's purpose. This section details the research design, the methodology employed, the methods used in data analysis, and the ethical procedures.

Research Design

While previous research has presented an interest in war veterans and how they shift from isolation to reintegration, focusing on employment (Bloom et al., 2019; Wyse et al., 2020), it does not present how TBI impacts war veterans' employability and vocational presence. It does explicitly not enlighten how the vocational and employment needs of military veterans should best be supported, especially those with TBI, while addressing the treatment needs as well. I addressed this social work practice gap by examining the perceptions of veterans with TBI in relation to the VA rehabilitation process in terms of its ability to improve vocational skills and employability potential for TBI veterans. The RQs addressed in the study were

RQ1: How do unemployed veterans with TBI describe their experiences with various system levels as they navigate the VR&E programs?

RQ2: How do unemployed veterans with TBI describe the barriers they face at various system levels in navigating VR&E programs?

I used a generic qualitative research design, a descriptive approach to discover how people interpret a phenomenon or a situation to answer the RQs best. The generic qualitative research design was used to explore the challenges active duty members and veterans with TBI face and their perspective on navigating the VR&E program alongside the viewpoints and ideologies of veterans with TBI. To address the research issues, the design used a semistructured interview.

The focus was on collecting data that would assist the researcher in answering the RQs. The approach also involved each veteran sharing their personalized experiences. All veterans participating in this study must have a service-connected TBI. The purpose of the study aligns with the approach and methodology used in this study by prioritizing the individual narratives, interpretations, and experiences of veterans with TBI within the VA's rehabilitation program. The study aims at understanding the personal perceptions and experiences of military members and veterans with TBI regarding the VA's rehabilitation process and its effectiveness in enhancing vocational skills and employability. Qualitative interviews allow in-depth exploration of subjective experiences, opinions, and perspectives. Veterans shared their personal journeys, challenges, and successes within the rehabilitation program, providing rich data for analysis. The study seeks to investigate how veterans make sense of and interpret the VA's rehabilitation process. Semistructured interviews will enable me to probe deeper into participants' interpretations, uncovering the meanings they attach to different aspects

of the program, their decision-making processes, and their coping mechanisms. Key operational definitions were as follows:

- *Traumatic brain injury (TBI)*: “an insult to the brain caused by an external force, affecting its function and potentially leading to lasting impairments”(National Academies of Sciences, 2019).
- *Veterans Administration (VA) rehabilitation program*: a comprehensive set of services designed to help veterans with disabilities regain their independence, improve their quality of life, and reintegrate into their communities. It includes psychological rehabilitation, medical rehabilitation, vocational rehabilitation, and social rehabilitation.
- *Vocational rehabilitation*: a type of VA rehabilitation that helps veterans get back to work or find new employment opportunities. This can involve job training, education, and career counseling.

Methodology

I used a qualitative approach. A qualitative approach to research is most applicable when the research focuses on the social world and uses tools that present a relatable perspective of those experiencing the social phenomena (Tomaszewski et al., 2020). It begins with identifying the problem, which will influence the formation of the RQ, and finally, selecting the most appropriate methodology and design to ensure that all the challenges a researcher experiences during the initial stage of the project are addressed (Johnson et al., 2020). It gives the researcher the power of words and images but lacks the power to offer assimilated meanings, such as equations or numbers (Billups,

2022). Thus, it presents an attentive search for understanding and meaning and tries to present a reflective and thoughtful awareness and comprehension of the problem and phenomena. Qualitative research is essentially exploratory and diagnostic, making it invaluable when developing conceptualized ideas in social work as a progressing discipline (Johnso et al., 2020). It emphasizes the complex social interactions that occur within social work as a field. The application of qualitative research in social work recognizes the qualitative approach to research as a methodology rather than a set of techniques particular to the given situation, and it appropriately originates from the nature of the social phenomena the researcher seeks to explore.

The qualitative research method has several advantages and disadvantages (Reay et al., 2019). It is a critical technique in presenting a holistic and exclusive approach to research as it demands that the researchers have effective communication skills and high empathy and interaction tendencies. This research opted for the qualitative research method because it makes it easier to present the various war veterans' perceptions, emotions, and actions regardless of their deployment area, period, or type of TBI (Muller et al., 2019). Each war veteran was approached based on experience rather than a generalized conclusion from previous research. The data collection, sources, and points mean that each person was encouraged to present their experiences and a possible explanation of certain behaviors, where they originated from, and how they became a critical part of their lives as war veterans (Cypress, 2019). Hence, this research method is beneficial as it can influence informed conclusions or policy formation since underlying behaviors can be easily comprehended.

Prospective Data

I obtained data by conducting individual interviews with active-duty members and veterans with TBI receiving services on military installations, at Vet Centers, and in brain injury support groups. Interviews and audio recordings were conducted over the phone or in comfortable conference rooms. Audio taping was added for later transcription to ensure that the data acquired, and the context were presented with the utmost integrity. Some notes were taken during the interview to ensure that all intrinsic details are recorded. It was critical to establish a relationship with the participant at the beginning of an interview. Each document and what it entails concerning their participation was explained to the participant. When dealing with war veterans or injured veterans, it is essential to cultivate empathy with the participants and ensure that the researcher understands what they say concerning the research. This includes the participant's body language, such as arm gestures or simply how the participant is sitting. It is important to clarify statements and request that the participant clarify a statement to prevent misinterpretation or misunderstanding. It is also important to appreciate that some veterans may be more willing to participate once they realize that the purpose of the research is to support veterans affected by TBI, regardless of whether it is mild, moderate, or severe.

Participants

The researcher recruited potential participants for the research design by placing fliers in public spaces; bulletin boards in libraries. Sample sizes in qualitative research are generally small; the objective of this qualitative study was to select enough participants to

provide in-depth information in order to understand veterans' TBI experiences (Hennink et al., 2019). Research conducted by Hennink and Kaiser (2022) also established that saturation can be achieved with fewer participants. Their review of 23 peer reviewed articles indicated that 9 to 17 interviews is sufficient to reach saturation. I selected a target size of nine participants with a final of seven participants for this study as a representative sample to understand the experiences of active-duty military members attempting to return to work and veterans from the VR&E programs. Given that the Vet Centers and the brain injury support groups are known to have patients suffering from different comorbid conditions and the study is focused on active-duty military members attempting to return to work and veterans, this study will employ purposive sampling technique to identify the seven research participants (Campbell et al., 2020). The primary inclusive criteria for the study were that participants must have served in the military and are receiving a service connection as a result of experiencing traumatic experiences that led to significant mental health challenges and are currently unemployed. The rationale for using the purposive sampling technique in the study is that it provides the researcher with an effective framework to collect data from people with in-depth information and experiences on the research problem under investigation (Campbell et al., 2020).

Participation in the study was voluntary. Participants were provided information about the research before enrollment to determine interest and willingness to serve as research participants (Mumford et al., 2021). The credibility of each participant as a data source was assured before acceptance to participate. All participants provided proof of service and dates of deployment. The data collection process in this research aligned with

the guidelines related to the qualitative research process. This was established by a pre-interview summary of each participant and the consent form details. Participants were allowed to discontinue participation at any point during the research study if they felt that the research presented too many triggers or mental, emotional, physical, and psychological harm to their health and well-being (Mumford et al., 2021). All participants signed an informed consent and understood the contents of the introductory statement, interview guide, and invitation to participate. Participants with difficulty reading and writing due to their TBI were assisted.

Instrumentation

In this qualitative research, I used semistructured interviews to gather data from the study participants. I developed open-ended and semistructured interview questions based on the literature review and theory. The open-ended questions encouraged detailed narratives and personal experiences. Semistructured questions covered key themes while allowing flexibility for individual responses. The choice of the questions was based on the themes and gaps in knowledge identified from the literature review and informed by relevant theoretical frameworks. The questions were tailored to active-duty military members and veterans with TBI and context of VA rehabilitation program. Upon the Institutional Review Board approval, I tested the feasibility, clarity, and effectiveness of the questions by conducting a pilot interview with a few veterans with TBI.

Audio devices were used to record the qualitative data collected through interviews for the study. Audio recordings and personal notes taken on the day of the interview aided me in capturing emotions or gestures that could otherwise go unnoticed.

Audio recordings facilitated note-taking word for word as a way of helping the researcher pay attention to responses while facilitating flow in the conversations. A later transcription extracted the relevant data from irrelevant ones. The participants were allowed to drop out at any point in the research, creating a potential limitation, challenge, and barrier to the successful completion of the research. However, this did not occur. Because this study focuses on the experience of the vocational rehabilitation process rather than issues about the participants' deployment, it was not anticipated that the interview questions would trigger any negative reactions. Individuals participating in the study were currently enrolled one of the Vet Centers and Brain injury support groups. I requested the centers and groups to identify an outpatient therapist who could be available should a participant wish to discuss any issues. That individual was identified, and information was provided to every participant in the study.

Data Analysis

I used qualitative thematic analysis techniques and procedures to analyze the data collected through the interviews. The process involved using coding to consider the need for a systematic procedural approach to coding and recognizing emerging themes in the collected data regardless of the data tool and source. This approach to data analysis involves the interview being presented as transcripts and observation notes, and the combined data presented as coded (Stensland et al., 2020). The first step in the data analysis was transcribing the interview's contents and another audio recording where relevant and reoccurring themes were identified from all the participants. The second step dealt with the coding of the data. It involved coding the data based on possible

themes to be included and discarding irrelevant statements seen in the collected data. This step also included the next step, which involved identifying the patterns and consistent themes in a process known as clustering. The next step involved deciphering and revealing the meaning of each cluster. Based on the deciphered meanings, the next step involved deciphering meaning in a more textual context and identifying the most common patterns, premises, and groups. The structuring of thematic groups followed this step to place these themes. The thematic groups were divided in a comprehensive and cohesively configured way.

The final step involved distilling the results for all the participants included in the research through the inclusion criteria. The data analysis process was critical in influencing the research results and findings that are the foundation of the research's discussion and conclusion. Therefore, once the data analysis themes emerged, a considerable number of concepts and terms surfaced. This step was followed by intuitive integration that captures these ascribed experiences and informs the progression of the research from the findings, discussion, and conclusion. Regardless of these details, the software assisted me in distinguishing the most relevant and irrelevant information and how this information narrows down to reoccurring themes. The software (MAXQDA) was able to systematically detect the similarities across these themes and organize them based on these similarities.

Rigor Analysis of the Study

Credibility in qualitative research refers to the measure in which the data findings present a true and accurate representation of the research problem under examination. In

this study, the credibility of the data was enhanced by ensuring that I had a prolonged engagement with the participants during data collection to ensure that they provided adequate and in-depth information and that I asked questions that could produce credible data and information (Wood et al., 2020). Reflecting journaling was also used in the study to capture all the experiences I had during the entire data collection and research process.

Transferability refers to the ability of the information gathered from a study to be applied in other situations (Tuval-Mashiach, 2021). Using the representative sample in the study implied that the study's findings could be transferred to other application areas. The choice of purposive sampling technique in the study ensured that I rely on real experiences from military veterans, therefore implying that the findings from the data analysis would represent the reality of the issues facing the veterans and could be used to address their social and economic problems as a way of improving the quality of their lives (Tuval-Mashiach, 2021). I provide a rich description of the participants and the data so that the reader can determine the transferability of the findings to their own experiences.

Trustworthiness in qualitative study refers to the reader's confidence in the research findings (Stahl & King, 2020). The triangulation method was used to analyze the data collected in combination with thematic analysis, as it enhances the reliability of data findings as conclusions are drawn from the findings made by all members. I applied all the protocols and procedures in data analysis using the thematic analysis technique. During analysis, I familiarized myself with the data collected from the study, generated

codes, identified data patterns and themes, reviewed and named them, and produced a detailed report on the data findings (Stahl & King, 2020).

Dependability refers to the measure in which the data findings are consistent and reliable (Kimberlin & Winterstein, 2008). The methods used in the study were carefully selected and that research protocols and procedures were carefully followed to provide reliable results that other scholars could replicate with the same methods. The stepwise replication approach during data analysis and triangulation method also promoted the dependability of the research data findings.

Confirmability in qualitative research is focused on ensuring that no research bias can influence the research findings but rather focuses on ensuring that the research findings are informed by the participants' responses (Johnson et al., 2020). All the questions asked of the participants were summarized to ensure that I did not influence the participants' responses during the interview.

Ethical Procedures

I conducted the research in an ethical manner by protecting the participants' identity and storing and disposing of the recorded and transcribed interviews according to listed procedures by Walden University. The identity of participants was protected by using pseudonyms in place of their real names. The informed consent form ensured the participants' privacy and confidentiality were guaranteed during and after the research. After research is completed, a key challenge is storing the information to maintain privacy and participants' confidentiality as necessitated by all research and as an ethical foundation of a social worker. I purchased a personal locker to keep the recordings and

transcribed notes locked in for the 5-year period stipulated for data retention. After the stipulated time lapse, the recordings and transcript copies will be disposed of by shredding the notes and transcripts and deleting all audio recordings from the recording tape.

Summary

The objective of this study was to provide active-duty military members and veterans perspectives on the most effective methods for improving outcomes after a TBI, emphasizing returning to work. A generic qualitative research design was used for the study. This descriptive technique seeks to understand how people see a phenomenon or a situation. The generic qualitative research design aims to examine the obstacles active-duty military members and veterans with TBI encounter when accessing VR&E programs, as well as their perspectives and ideas. A qualitative research methodology is most appropriate when the study is social and employs instruments that give a relatable perspective of those experiencing the social phenomena. Individual interviews, audio recordings, and participant-provided personal notes were used to collect the data. To ensure that the data collected was legitimate and the context was presented honestly, the interviews were conducted over the phone, audio recorded and were made for subsequent transcription. During the interview conversations, notes were made to ensure that all pertinent information was captured. The thematic analysis approach was considered part of data analysis, considering the necessity for a systematic procedural approach to coding and identifying emergent themes in the data obtained. Protecting participant identities and

following Walden University's established processes for storing and disposing of recorded and transcribed interviews were two ways that ethics in research was achieved

Section 3: Presentation of the Findings

Introduction

The goal of this qualitative study was to learn about the perceptions of unemployed veterans, who have experienced TBI regarding their experience within the VA rehabilitation system particularly with regard to VR&E programs. The study was guided by two RQs, aiming to know how the veterans were navigating the rehabilitation systems (RQ1) and the barriers they were facing (RQ2). The information was gathered with seven participants who had a TBI and were familiar with the rehabilitation process. Participants were all interviewed in a semistructured interview using 11 open-ended questions that focused on the onset of rehabilitation, the supports available, individualized plans, professional involvement, program strengths and limitations, cultural factors, and suggestions on how the services could be improved.

This part is divided into three parts. I start with a description of the data analysis methods, namely, the recruitment, collection, coding, and validation procedures. Second, I present the findings, which are presented thematically in terms of the two RQs. Lastly, I give an overview, which connects the findings to the practice-driven RQs and leads to Section 4, which addresses the questions regarding the application to professional practice and the implications to social change.

Data Analysis Techniques

Recruitment and Data Collection

Participant recruitment started in September 2024 and lasted until May 2025. I started to recruit participants after I obtained my Institutional Review Board approval

letter dated July 16, 2024 (approval no. 1052972). Although the original goal was to recruit nine veterans, several obstacles, such as participant withdrawal and limited availability have diminished the sampled size to seven. Military and veteran networks were used to recruit participants who agreed to one-on-one, audio-recorded interviews that lasted about 60 min each. All interviews were based on a structured guide of 11 open-ended questions that aimed at eliciting perceptions of the rehabilitation process. The collection of data was ended when thematic saturation was achieved; the narratives of the participants were repetitive in presenting similar issues, suggestions, and lived experiences.

Coding Process in MAXQDA

The transcripts of all interviews were inputted into MAXQDA, a qualitative data analysis software program that supported the systematic coding. Thematic analysis was based on the six phases of the six-phase method used by Braun and Clarke to approach the data: (a) familiarization with the data of the study through the repeated reading of the transcripts, (b) the appearance of initial codes, (c) searching of the theme through the clustering of the similar codes, (d) reviewing and refining of the theme so that the stories in the data make sense, (e) the definition and naming of the themes, and (f) the presentation of the final story.

The thematic analysis done on the current study provided an overall understanding of the perceptions of unemployed veterans with TBI, regarding the VA rehabilitation process. The interviews were coded in the program MAXQDA using a six-step approach by Braun and Clarke (2006) allowing systematic coding of data and

comparison with other participants. The codes were created inductively (directly based on the narratives of the participants) and deductively (using the RQs and existing literature on the topic of veteran rehabilitation).

As a result of this coding process, a list of repeating categories was grouped into larger patterns that shared the similar experiences. Those categories were revisited and narrowed down to seven final themes that summarize the perception of the veterans of the systemic strengths, weaknesses, and recommendations. The seven themes are delays and discontinuity in rehabilitation services, centrality of family and peer support systems, fragmentation of case management and care coordination, strengths of specialized military and VA rehabilitation programs, military cultural norms as barriers to recovery, resource awareness and accessibility challenges, and veteran-informed recommendations for system improvement.

The Findings section has detailed each theme that is accompanied by verbatim quotes to depict the views of the participants. The key codes employed in this analysis have been summarized in Table 1, their meaning and references that can relate them to the existing literature. This table will give visibility on how the coding procedure was translated into the thematic framework given in the later stages.

Table 1*Codes and Definitions Informing Themes*

Code	Definition	Supporting literature
Delayed rehabilitation initiation	The lag between injury occurrence and the start of rehabilitation services. Veterans described waiting months or even years for treatment, which exacerbated symptoms and reduced effectiveness of interventions.	Corrigan et al. (2014) noted that delayed rehabilitation is associated with poorer long-term TBI outcomes.
Continuity of care gaps	Frequent provider turnover, lack of follow-up, or inconsistent treatment across transitions from active duty to VA systems.	Sayer et al. (2010) emphasized that care continuity is critical to rehabilitation success.
Family support	Assistance from spouses, parents, siblings, or extended relatives in caregiving, transportation, advocacy, and emotional support.	Ramchand et al. (2017) highlighted the vital role of families in veteran recovery.
Peer support	Help received from fellow veterans, veteran service organizations, or informal peer networks, often described as more reliable than formal systems.	Pfeiffer et al. (2018) described peer support as a protective factor in rehabilitation and reintegration.
Case management deficiencies	Instances where veterans lacked a case manager, or the case manager's role was limited to information-sharing without meaningful coordination.	Resnik et al. (2009) showed that effective case management is essential for veterans with polytrauma or TBI.
Fragmented care coordination	The experience of being shuffled between multiple providers or departments without integrated planning, requiring them to self-navigate.	Tanielian and Jaycox (2008) found that fragmentation is a systemic weakness of veteran health care.
Specialized rehabilitation success	Positive experiences in programs such as Walter Reed, VA polytrauma units, or Navy Wounded Warrior, where care was comprehensive and coordinated.	Lew et al. (2007) documented the effectiveness of specialized TBI rehabilitation programs.
Military stoicism	Cultural norm emphasizing	Hoge et al. (2004) found

Code	Definition	Supporting literature
	toughness, resilience, and mission-first orientation, which discouraged veterans from seeking help or acknowledging impairments.	stigma and stoicism to be major barriers to mental health care in military populations.
Cultural resilience	Recognition that military culture also instilled persistence and perseverance, which some veterans described as helping them endure rehabilitation.	Britt et al. (2016) discuss resilience as a positive facet of military culture.
Lack of resource awareness	Lack of knowledge regarding what services existed or how to access them, reflecting inadequate communication from institutions.	O'Neil et al. (2018) showed that awareness of resources strongly predicts rehabilitation utilization.
Accessibility barriers	Structural challenges such as paperwork, provider shortages, geographic relocation, or insurance transitions that made services difficult to access.	Pogoda et al. (2016) found access barriers to be a persistent issue for veterans with TBI.
Recommendations for improvement	Veterans' own suggestions for system reform, including better-trained staff, more proactive case management, expanded mental health services, and improved outreach.	Albright et al. (2019) stressed the importance of incorporating veterans' voices into program design.

Note. TBI = traumatic brain injury; VA = Veterans Affairs.

The codes reflect the variety of experiences veterans expressed, including their unmet needs like delayed rehabilitation and low-quality case management and the positive exceptions of special programs. Critically, the codes, in addition to demonstrating the barriers experienced by veterans, also provide some indication of possible solutions, because participants themselves gave recommendations on what needs to change systemically.

Some of these codes, which include Delayed Rehabilitation Initiation and Case Management Deficiencies, are well-informed in the wider literature and reinforce that these are not unique experiences but common problems throughout the veteran populations. Others, like Cultural Resilience, give depth to it by demonstrating that military culture was not a one-dimensional experience that seemed to become an obstacle. Rather, the respondents explained ambivalence, both in its negative discouragement of weakness and its positive encouragement of persistence.

Validation Procedures

I employed multiple validation strategies to generate a greater degree of credibility. Member checking was also involved: summaries of the interpretations were provided to each member who was expected to verify that they were correct. Even though not all people responded to the follow-up, the people who responded stated that their opinion was represented accordingly. Peer debriefing with the membership of the dissertation committee occurred and the committee reviewed the coding structure and thematic groupings. In MAXQDA, the auditing trail of the coding decisions, the development of themes, and the analytic memos was stored.

Limitations Encountered During Analysis

There were various restrictions in the collection and analysis of data. To begin with, the number of samples was narrowed down to seven due to issues related to recruitment. Saturation was achieved; however, the sample size could have brought out more detail. Second, there was an overlap with some members still in active service and others in full veteran status and, therefore, might have influenced their views in different

ways. Third, continuity of member checking was not continuous with unequal content, restricting the extent to which participants were able to refine or criticize the interpretations of the researcher. Lastly, since interviews were self-reported, it is also possible that the recall bias and personal perception affected the description of events. Irrespective of these constraints, the systematic application of MAXQDA along with member checking, peer debriefing, and audit trail rendered credibility of the findings which are based on the real lives of veterans undergoing rehabilitation process.

Findings

Participant Demographics and Service Profiles

It is necessary to place the sample into perspective before introducing thematic findings, which is achieved by the description of demographic features of the sample and the description of the military service profile of participants. The sample size of this study was seven veterans who had a TBI and had been involved in rehabilitation procedures of the VA. The demographic and service-related characteristics of the participants are summarized in Table 2.

Table 2

Participant Demographics and Service Profiles

Participant	Gender	Age (years)	Race	Year joined service	Year exited service	Years of service
Veteran 1	Male	55	White (non- Hispanic)	1988	1996	8
Veteran 2	Male	58	Black (African American)	1984	2004	20

Veteran 3	Female	60	Hispanic (Latino)	1985	1990	5
Veteran 4	Male	61	White (non- Hispanic)	1981	2001	20
Veteran 5	Female	62	Asian American	1982	1990	8
Veteran 6	Male	63	Native American	1979	1995	16
Veteran 7	Male	67	White (non- Hispanic)	1975	1985	10

The age of the participants was between 55 and 67 years with an average of 60.86 years ($SD = 3.80$). The median age was 61 years. The skewness of the sample was equal to 0.08, which means that the age distribution was close to being symmetrical. The years of military service among the participants ranged between 5 and 20 years with the mean being 12.4 years.

The median age of the U.S. veterans in general is significantly lower than the mean age of this sample (60.86 years). The U.S. Census Bureau (2022) estimated that in 2021 veterans had a median age of 65 (younger: the Gulf War-era; older: the Vietnam-era). The people in this study lie in between these groups and are an aging veteran population but not as old as many of the Vietnam-era generation.

Age is crucial in explaining the results since older veterans can face special obstacles to the rehabilitation of TBI. It has been demonstrated that older adults with TBI tend to have slower recovery patterns and more likely to have comorbidities, including cognitive slowing, depressive disorders, and physical disabilities (Gardner et al., 2018). The current study may have added to the frustration of the lost years the natural aging

process, which may have increased the frustration of long delays to rehabilitation by participants. Moreover, the veterans of older age might face different vocational challenges because the level of employment reintegration is more challenging in the later life stages, because of age discrimination and low labor market demand (U.S. Bureau of Labor Statistics, 2022). Accordingly, the age demographic of this sample puts the perspectives of the participants in context: their comments about the systemic inefficiencies could be due, in part, to the organizational failures, but also due to the multiplicative nature of growing old with an undiagnosed or underdiagnosed brain injury.

Five men and two women were included in the sample. This distribution is representative of the gender structure of the U.S. veteran population which is predominantly male. The Department of Veterans Affairs (2021) states that the female population of the veterans is about 10% of the total but it is expected to increase to 18% by 2040. The fact that two of the veterans are women enables one to gain valuable information because it can be said that women can develop TBIs and undergo rehabilitation in different ways than men. To illustrate, Iverson et al. (2017) discovered that women veterans with TBI have higher odds to report comorbid PTSD and depression and might experience increased stigma in obtaining care. Female participants in this study expressed fears on insufficient support networks and access to mental health, which is consistent with general trends even in the literature.

The sample was racially and ethnically mixed: three were Whites (Non-Hispanic), another one was Black (African American), one was Hispanic, and another one was Asian American, and one was a Native American. This difference is not the futile detail,

because veterans of color tend to face peculiar obstacles to health care access and health care outcomes. Minority veterans have been recorded to have inequality in the diagnosis and treatment of TBI by the VA itself (Sayer et al., 2019). The perception of the participants of the current study indicate that the systemic fragmentation of rehabilitation can have a disproportionate effect on minority veterans, who already have to overcome cultural, language, and structural barriers. To give an example, suggestions that should be made regarding improved communication and proactive outreach could be particularly relevant to the historically underserved populations of the VA system.

The years of service of participants were between 5 and 20 years old, with a majority of the participants having served between the late 1970s and early 2000s. This places them in the post-vietnam and the Gulf war's periods. The health profiles of veterans of these cohorts are often complicated as both the combat exposures and the policies of the VA system are changing with the time. The more positive experiences in rehabilitation did not always follow longer service. As an example, one respondent who has been employed in the company for 20 years stated that it took him 14 years to seek treatment after a TBI. This result indicates that there was no smooth rehabilitation path through institutional loyalty and service length. Instead, service cohorts had systemic inconsistencies, in outreach and case management.

The qualitative results have a number of implications towards the demographic profile of the sample. The age, gender balance, and racial and ethnic diversity of the participants and the number of years of service will be significant in contexts of how they experienced and explained their experiences with the VA rehabilitation system. Although

the age distribution of the participants, first, points to an intersection of TBI and aging. This group is aged above 60 years on average and is therefore an older group of veterans, whose rehabilitation results might already be limited by biological and vocational factors due to age. Their stories of waiting time in care and disjointed services should then be seen in the compounding influences of aging. Late-onset rehabilitation will probably have different results than earlier interventions, not only due to the lesser physical resilience, but also due to the lack of employment opportunities later in adulthood. This background is indicative of the complaints of the participants about the wasted years of treatment: both the failures of the system and the increased effects of the delayed rehabilitation in old age.

Second, the female participants enhance the research as they add the perspectives that are usually underrepresented in research of veterans. Women have become an increasing proportion of the veteran population, but has a comparatively lesser record in terms of undergoing TBI rehabilitation as compared to men. In this research, female participants expressed concerns regarding insufficient mental health care, which is consistent with the nationwide results that women veterans tend to encounter more barriers to seeking mental health care and experience more stigma when seeking help. Their views are valuable in that they provide gendered aspects of TBI rehabilitation that must be addressed with specific answers by social workers and rehabilitation practitioners.

Third, racial and ethnic diversity of the sample also contributes to the analysis. The sample is diverse in its representation of a variety of backgrounds because it is

represented by participants of White, Black, Hispanic, Asian American, and Native American groups. This diversity highlights the importance of culturally responsive rehabilitation practices. The testimonies of the veterans regarding the lack of coherent case management and lack of communication imply that the one-size-fits-all programming may negatively affect the differences in health care outcomes among minority veterans that have already been reported. Their worldviews demand both services that are culturally responsive and services that actively strive to alleviate the structural inequities in the VA system.

Lastly, the participants have had past life experiences that are historically contextual through the service eras they experienced. The majority of them were done in the late 1970s to early 2000s when the acceptance of TBI as a medical condition was still developing. Their reports of late or missing treatment are not the fault of personal neglect only, but also the realities of the time when TBI was not yet appropriately recognized as a signature wound of military service (Tanielian and Jaycox, 2008). This historical background can be used to interpret the frustration of the participants more sensitively in terms of systemic insensibility and pinpoint the role of policy and medical awareness modifications during the years in determining the rehabilitation process of the veterans.

Themes

Research Question 1

Thematic analysis identified three interrelated themes that encompassed what the participants described their experiences with: (a) delays and discontinuity in

rehabilitation services, (b) centrality of family and peer support system, and (c) fragmentation of case management and care coordination.

Theme 1: Delays and Discontinuity in Rehabilitation Services. The similarity in the interviews was that the respondents too long before they could receive rehabilitation services. Such delays were weeks, in some cases years, at strategic crossroads where something could have been done to support recovery. One participant said, “It was a month before rehab started... I have no idea why it took that long”. Another reported a much longer gap: “I had my first [TBI] in 2007... I didn’t get treatment until 2021, so 14 years”.

In relatively well-supported persons, continuity failed. According to one veteran, although the initial hospitalization and treatment had been on time, the rehabilitation had not been as timely in the long-term: “My injury was in June and then I went to the VA rehab program in September”. The other one said it took them 4 years to report due to lack of knowledge on eligibility and career implication: “My most recent one, 4 years... I didn’t think the treatment plan was available to me, plus I worried I’d lose my duty status”.

These narratives demonstrate that delays were not administrative and were deeply formed by the recovery pathways of participants. In other instances, the gaps could be long enough to aggravate the symptoms or create an impression of being abandoned. There was also evidence of discontinuity of care due to staff turnover. As one veteran observed, “Continuity of care is an issue... you can pick up somebody that’s leaving in 90 days, and you have to break in a new doctor”.

A combination of these experiences assists in understanding how the lack of a coherent timeline is harmful to the success of rehabilitation. Veterans felt that they were not able to become independent again, go back to work, or stabilize because of inadequate, timely intervention.

Theme 2: Centrality of Family and Peer Support Systems. Throughout interviews, participants stressed the little they could have done without their family, friends, and peers during their rehabilitation processes. Where informal systems became the vital bridging in areas where formal systems were unevenly helpful. One participant shared, “My brother was my support... SRU [Soldier Recovery Unit] wasn’t doing anything to benefit me, so I leaned on him.”

Another shared this thought, stating that the family was the surest place to gain stability: “Family, friends, co-workers... my wife and in-laws, they were there the whole time”. In others, caregiving tasks and practical assistance in making appointments were taken over by family members. One veteran answered that, my mother will remain with us since my wife cannot really offer much. Other people depended on friends or fellow-soldiers to validate their feelings and find a voice of understanding. In particular, the respondents spoke of veteran centers on college campuses as essential locations: “Some colleges have vet centers... veterans can hang out, and I think that’s a great support”.

Peer support was especially appreciated, as it made the victims feel less isolated and gave them culturally resonant support. Veterans would tend to compare this to experiences of neglect, or being rejected by formal rehabilitation systems. As one of the

actors put it plainly, “There’s absolutely zero help from them... it was all the individual soldiers having to do everything on their own”.

These results indicate that although formal rehabilitation services were not consistent, family and peers were always important to the veterans as a source of resilience. The importance of informal networks supports the relational character of recovery and implies that family and peer-based supports could be deliberately incorporated in rehabilitation programs.

Theme 3: Fragmentation of Case Management and Care Coordination. Lack of or inadequacy of case management is a primary barrier to overcoming the rehabilitation system as described by participants repeatedly. Some veterans complained that a rehabilitation case manager had never approached them, years after the injury. One stated, “It was almost a year before I was contacted”, while another emphasized, “I don’t think I ever was contacted by a rehabilitation case manager”.

When the support was there, those who did receive case managers felt superficial or not helpful in any way. One participant explained: “The only thing they offered for rehabilitation was me finding a job outside the Army... I did job fairs and that did nothing for me”. The other one stated that participation was reduced to briefings and not actual help: “They weren’t doing anything to help me. It was just briefings on what could happen, what I should do... there was no direction”.

Systemic barriers to coordinated care were also indicated by the participants. They had to face a cycle of referrals without planning. The process is referred to by one veteran as being, “Eight different medical bodies independently treating what was in

front of them... there wasn't anyone collecting everything and having a discussion with me about it". This fragmentation left the veterans to their own devices to undertake their own rehabilitation plans- this is quite a difficult task considering that memory and cognitive problems are related to TBI.

Some of the respondents highlighted the importance of proactive and aggressive case management. As one explained, "Case management is absolutely vital... because with TBI you have memory issues. I could talk to you for 30 min and not remember the details tomorrow." The other point that is highlighted is that good case managers should be proactive: "It has to be an aggressive case manager that reaches out". These accounts suggest that fragmented case management was not only inefficient but was also detrimental to the ability of veterans to obtain consistent care. Without a well-coordinated supervision, players said they were lost in a system where they had to literally feel their way through the different providers, programs, and bureaucracies.

Theme 4 : Strengths of Specialized Military and VA Rehabilitation Programs.

Despite frustrations about delays and case management reported by a large part of the participants, many of them also reported positive aspects of special military and VA rehabilitation programs. These good experiences reveal that, with the right resources in place, rehabilitation services can be life-changing.

One veteran reported on the contrast between the Soldier Recovery Unit (SRU) and the Walter Reed National Military Medical Center: "From what I've experienced, SRU was a complete waste of time. Coming to Walter Reed, they've helped me more in 1 week than the SRU did in the whole year I was there." One was a commendation of the

polytrauma program at the VA in Richmond: “The polytrauma rehabilitation program... was great. It’s inpatient, you live there, and it’s in-depth. I think the average was 90 to 100 days, and it does well for a lot of people”.

In these specialized facilities where multidisciplinary teams worked and devoted most of their time to rehabilitation, the interviewees have pointed out the complexity of care. As one explained, “They did every test you could ever imagine... I went there for my brain, but they found other health issues too, and they weren’t just going to let things go”. Another revealed the prominence of the Navy Wounded Warrior program which states: “Those case managers have been great. They give you a checklist, and every time you meet, they update what’s done and what still needs to be done. They’ve been very good at coming up with a plan”.

These testimonies are optimistic compared to disjointed, or inefficient services veterans complained about elsewhere. They demonstrate that with the appropriate program structure, based on whole person, inter-disciplinary models and having designated case managers, effective medical care can be delivered, as well as effective provision of meaningful vocational assistance can be offered.

Research Question 2

Theme 1: Military Cultural Norms as Barriers to Recovery. The first theme of this question is the multidimensional nature of the military culture in the construction of rehabilitation experiences. Respondents were also inclined to refer to culture as both a driver and a hindrance. On the one hand, the ethos of resilience propagated perseverance.

Rather, expectations of hardiness discouraged asking and telling the truth about limitations of the other.

A number of the participants reported that they were under pressure to downplay or conceal symptoms. One shared, “In the early part... there was definitely a culture of, everybody’s broken. The question isn’t whether you need rehabilitation, but whether your need outweighs the mission”. Another detailed how this attitude contributed to the process of minimizing struggles: “You end up providing a much more optimistic set of information about where you are than where you actually are”.

Some others asserted that the mission-first mentality would slow or stall treatment. As one veteran put it, “There’s no universe where the doctor is going to tell the executive officer that someone has to be out for 15 months before coming back to work. That’s just not a thing”. This organizational requirement reduced the possibility of receiving long-term rehabilitation because being ready to serve was more important than being completely healed.

The participants further added that cultural attitudes also played a role in influences towards the rehabilitation staff. One explained: “They’d always go to a family member or friend instead of going directly to me... they would never go directly to me”. This feeling of disempowerment also echoed the hierarchical patterns of communication that were viewed as offensive by the veterans. Meanwhile, other veterans construed culture as a resilience source. One participant said,

Military culture isn't promoting weakness... it's just like, you know, get over it, deal with it, get through it. That's a good culture, and then you have a brain injury and it's like, yeah, I'm just going to get through it.

These conflicting opinions reveal that the ethos of toughness can enable others, but it disempowers others, especially when cultural norms are barriers to vulnerability and long-term care.

Theme 2: Resource Awareness and Accessibility Challenges. Another barrier repeatedly highlighted by participants was the lack of clear information about available resources and difficulty accessing services. Veterans described not knowing which programs existed or how to qualify, particularly in the years immediately following discharge. One participant explained:

I wasn't contacted by a case manager... I had to apply, because the year I got out, they didn't have the services like they do now. Once I put in the forms, it was probably 2 weeks before someone reached out.

Another echoed the lack of awareness: "They don't really publicize it... outside of service letters, you don't really hear much about it".

Even when veterans were aware of programs, accessing them was often difficult due to bureaucratic obstacles. Participants cited challenges with insurance transitions, paperwork, and provider shortages. One explained, "Military health care is kind of tough... they'll switch up your primary care manager, and then you can't get a hold of them, can't get appointments scheduled". Another described difficulty after relocating:

“It’s going to take me a year and a half to get all the same doctors back on the roster... because I have to navigate through Tricare, the VA, and everybody else”.

These accessibility challenges compounded cognitive and memory difficulties associated with TBI. One participant captured this vividly: “With TBI, you have memory issues... you could tell me everything available, and tomorrow morning I won’t remember the details”. This observation underscores the importance of proactive outreach and tailored communication, rather than placing responsibility on veterans to self-navigate complex systems.

Theme 3: Veteran-Informed Recommendations for System Improvement.

Participants were not only critical of their experiences but also offered thoughtful, concrete recommendations for improving rehabilitation services. Their insights reflected both their frustrations and their hopes for systemic change. A central recommendation was for more qualified and medically trained staff within rehabilitation units. One participant explained, “The best thing was to have staff working that have medical entities so they know what they’re doing and how to help that soldier versus somebody that wears a uniform and says, ‘hey go do this’”. This statement captures veterans’ frustration with staff who lacked clinical expertise and underscores their call for professionalized, patient-centered care. Another frequent recommendation was for stronger, more proactive case management. Veterans emphasized that case managers should not merely provide information but should actively coordinate care and follow up. As one explained, “Case management is absolutely vital... it has to be an aggressive case manager that reaches out”. Another added that proactive case management could help

veterans with cognitive difficulties navigate the system: “With memory issues, you could tell me everything that’s available, and tomorrow I won’t remember the details”.

Participants also highlighted the need for improved mental health support. Several expressed that mental health therapy was either absent or difficult to access. One candidly stated, “No mental health... I haven’t seen a psychologist or psychiatrist yet”. Others recommended peer-based or group support, including college veteran centres or counselling opportunities where frustrations could be safely expressed. Finally, participants called for better communication and awareness of available programs. One suggested more advertising: “They don’t really publicize it... outside of service letters, you don’t really hear much about it.”

Veterans viewed communication as essential to ensuring timely and equitable access to services. Taken together, these recommendations reflect participants’ strong desire for a system that is proactive, clinically competent, integrated, and transparent. Their perspectives provide actionable insights for policymakers, administrators, and social work practitioners.

Unexpected and Discrepant Findings

While most veterans described significant frustrations, a few accounts stood out for their markedly positive tone. For example, one participant emphasized satisfaction with his rehabilitation plan: “Good counsellor, good plan... I was very involved; they wouldn’t have made the plan without involving me”. Another praised the Navy Wounded Warrior program as highly effective and supportive.

These positive accounts contrast with the majority who described neglect, delays, or fragmentation. They highlight that experiences varied significantly depending on the program, location, and staff involved. This discrepancy suggests that structural strengths do exist within the system but are inconsistently available. The presence of these positive narratives underscores that barriers are not inevitable but reflect uneven implementation of best practices.

Another unexpected finding was the degree to which veterans distinguished between military culture as a barrier and as a source of resilience. Some saw cultural expectations of toughness as harmful, while others credited the same mindset with motivating perseverance. This divergence suggests that cultural norms interact with individual differences, shaping recovery in complex ways.

Summary

The findings of this qualitative study, as presented in Section 3, were grouped around the two RQs. In regard to RQ1, veterans explained their experiences by stating that there was (a) lateness and lack of continuity in receiving rehabilitation, (b) dependence on family and peer networks, (c) lack of co-ordination in case management and care provision, and (d) their own isolation in the specialized rehabilitation programs. In the case of RQ2, the barriers identified among the veterans included (e) military cultural norms that did not encourage help-seeking, (f) low levels of awareness and access to resources, and (g) case management, staffing, mental health, and communication gaps.

These results demonstrate paradox: whereas in specialized programs such as Walter Reed, Navy Wounded Warrior, and polytrauma units there are pockets of excellence, there are numerous veterans who are delayed long, poorly provided with care, and is disjointed. The suggestions made by the participants identify specific areas of improvement, such as improved case management, increased mental health services, improved staff training, and active communication.

Taken together, the results address the practice-oriented RQs by showing that veterans with TBI find the VA rehabilitation process to be inconsistent, and the outcomes heavily reliant on location, staff, and systemic navigation. The themes emphasize the need to consider cultural, structural, and informational barriers to guarantee that all veterans, and not only those who are lucky enough to receive special programs, get coordinated, high-quality, and timely care. I transfer these findings to professional practice and discuss its implications on social change in the following section. Section 4 starts with the restatement of the purpose and a summary of the key results and moves on to the discussion of the ethical implications, practice recommendations, and possible effects on veterans, social workers, and policy systems at micro, mezzo, and macro levels.

Section 4: Application to Professional Practice and Implications for Social Change

Introduction

I conducted this study to further understanding of how unemployed veterans with TBI perceive their experiences in the VA rehabilitation process and specifically in VR&E programs. Two RQs were addressed by the study: (a) How do unemployed veterans with TBI tell us about their experiences with different levels of the system as they go through VR&E programs? and (b) How do unemployed veterans with TBI tell us about the barriers they experience in going through these programs?

Thematic results revealed some systemic weaknesses and some local strengths. The participants reported regularly about delays and discontinuity in providing rehabilitation services, the use of family and peer support networks, disjointed case management, and barriers facilitated by military culture. The other problem that they identified was resource awareness and accessibility. At the same time, the veterans had identified examples of excellent models within the framework of specialized rehabilitation programs, such as Walter Reed, Navy Wounded Warrior program, and VA polytrauma units. Finally, the participants also gave concrete recommendations on how the case management, mental health resource, and communication methods could be improved.

These findings guide social work practice in a number of ways. They not only disclose the reality of lives of the veterans, as they maneuver through the multiple systems, but also the ethical, relational, and systemic duties of the social workers who come into contact with this population. Section 4 elaborates these results by discussing

the ethical consequences of the study, proposing improvements in practice and policy, and determining points of social change at a micro, mezzo, and macro level.

Application to Professional Ethics in Social Work Practice

According to the NASW Code of Ethics, the values and principles that are most applicable in the findings of the given study are the principles of service, dignity and worth of the person, and integrity.

Service and Responsiveness to Need

Service value demands that social workers should put the well-being of customers first and meet unmet needs. The needs reported by veterans in this study included lack of timely access to rehabilitation, mental health services, and effective case management. One veteran said, as an example, “There’s absolutely zero help from them... it was all the individual soldiers having to do everything on their own”. The sentence emphasizes the ethical responsibility of social workers to promote systemic changes and make sure that vulnerable clients are not left to deal with the burden of operating within broken systems, on their own.

Dignity and Worth of the Person

The principle of dignity and worth focuses on clients and their self-determination and appreciation of their inherent worth. Some of the veterans reported that they felt dismissed or disempowered when staff members addressed family members instead of talking straight to them. One veteran noted, “They’d always go to a family member or friend instead of going directly to me... they would never go directly to me”. The experiences infringe upon the ethics of affirming the autonomy and voice of clients.

Social workers have a duty to counteract these dynamics by ensuring that veterans are actively engaged in their own rehabilitation planning and decision making.

Integrity and Professional Competence

Participants suggested that staff should be better trained and clinically competent. One veteran stated, “The best thing was to have staff working that have medical entities so they know what they’re doing and how to help that soldier”. This is in line with the ethics of integrity that requires social workers to work within their competence areas and constantly enhance professional skills. In the context of rehabilitation, this implies the creation of specific knowledge regarding TBI, military culture, and special needs of veterans who have to enter the civilian world.

Relevance to Practice Contexts

There is also the ethical practice of balancing the care to the individual with the advocacy to the system in the given field. In one example, it took months or years before veterans would obtain rehabilitation to illustrate systemic injustices. Even though the social worker is ethically required to assist individual veterans to overcome short-term obstacles, he is also required to confront the policies and systems that perpetuate injustices.

Avoidance of Overreach

Potential ethical applications should not exceed the scope of the study. The results cannot be applied to all veterans or rehabilitation environments and only apply to a small sample of unemployed veterans with TBI. Ethical practice demands an awareness of such boundaries and the use of such insights to help improve practice where appropriate.

Recommendations for Social Work Practice

The results of the present work formulate a number of valuable suggestions to social work practitioners, administrators and policymakers involved in the rehabilitation and reintegration of veterans. These are practice, policy and research recommendations that reflect the strengths and limitations that participants have found.

Practice Recommendations

Strengthening of Case Management

An effective, proactive case management became one of the most frequently repeated themes in this study. The veterans explained that there were long periods in between being contacted, or, in other instances, not being assigned to a rehabilitation case manager. Some said that their case managers had given them surface support. One participant recalled, “They weren’t doing anything to help me. It was just briefings on what could happen, what I should do... there was no direction”. This highlights why a proactive outreach model is important to social work practitioners. Case managers must not rely on the veterans to make contact, especially considering the cognitive and memory deficits that come with TBI. Rather, case management needs to be defined by follow-up consistency, inter-service coordination, and next steps articulation. Social workers can serve this purpose very well since the field focuses on issues of client advocacy and comprehensive evaluation.

Integration of Family and Peer Supports

Results also showed centrality of informal support networks. Veterans always depended on their family members and peers to fill the loopholes that exist in the formal

services. One explained, “My brother was my support... SRU wasn’t doing anything to benefit me, so I leaned on him”. Another presented college veteran focuses on important peer space: “Some colleges have vet centers... veterans can hang out, and I think that’s a great support”.

Social workers can incorporate these insights into practice by intentionally involving families in rehabilitation planning, providing caregiver education, and advocating for peer-support programs. Furthermore, peer mentoring can be institutionalized in social work interventions as a formal part of rehabilitation and thus can be recognized and reinforced as an existing resource that the veterans already consider fundamental.

Improvement of Mental Health Access

Participants reported over and over again that they had no or limited access to mental health services. One veteran stated bluntly, “No mental health... I haven’t seen a psychologist or psychiatrist yet”. Social workers should also prioritize mental health promotion to all those involved in TBI rehabilitation to ensure that counseling, support groups and trauma-informed approaches become routine. Given the fact that a similarity exists between TBI and PTSD and depression, integrated care is no longer an option but a must.

Promotion of Cultural Responsiveness

The outcomes also gave rise to the multi-dimensionality of the military culture during rehabilitation. Veterans referred to a mission-first philosophy as intolerant of vulnerability and sluggish care-seeking. Meanwhile, other people understood this spirit of

the culture as a power. Social workers must be culturally responsive and must have knowledge of both of the empowering and limiting aspects of military norms. This involves creation of venues where veterans can freely discuss struggles without stigmatization and reassure service members of their strength as part of their identity.

Policy Recommendations

Normalization of Case Management Protocols

Disparity in accessing case management is an indicator of unequal operations on the policy front. Others described positive experiences with such programs including case managers who provide checklists and frequent follow-ups and those who do not receive instructions at all. This difference becomes an indicator that quality of care is a program and place issue. They should transform into a policy that demands standard methodological procedures to the case management of VA and military rehabilitative services, including fair access to integrated care.

Improvement of Communication and Outreach

The veteran soldiers interviewed said that they had no knowledge of resources whatsoever, until they had to hunt. As one explained, “They don’t really publicize it... outside of service letters, you don’t really hear much about it”. Implicit policies need to be reformed with more rigorous outreach and communication policies. This may involve advertising within the multi-platform, advertising on discharge and at follow up in the transition interval.

Investment in Specialized Programs

The veterans strongly supported the idea of special rehabilitation centers such as the Walter Reed or VA polytrauma centers. They were interdisciplinary and holistic programs. Policymakers should finance and duplicate these models and should provide access to the best models to more veterans by scaling up the best practices. Investment should not be in flagship facilities but should be extended to community-based VA centers in order to reduce geographical delays.

Research Recommendations

Areas of the study that need further research are also noted. First, although this study targeted unemployed veterans, future studies might compare results between veterans with different employment status, to determine whether system navigation varies depending on occupational reintegration. Second, the difference in understanding of military culture as both an obstacle and a provider of resilience deserves additional research. Mixed-methods studies may help disambiguate the interactions between cultural attitudes and personal recovery.

The other research area is the long-term effects of peer-support models on rehabilitation of TBI. Some of the participants pointed out the significance of informal networks and little is known regarding the efficacy of formalized peer mentoring. Assessing such models may allow giving evidence-based reasons why they can be incorporated into general rehabilitation practice.

Transferability and Usefulness of Findings

Despite the fact that this research was limited to a small, qualitative sample, the themes reveal that they can be applied to a larger, social work practice setting. In other settings, veterans can have a common problem of delays, lack of coherent case management, cultural stigma, and lack of resources. The focus on family support, active case management, and combined mental health care is applicable throughout the settings where veterans or trauma survivors access rehabilitation systems.

Simultaneously, results are to be used with caution. The research was conducted on a limited scale of seven participants and experiences were not compared across the locations and programs. Not every veteran faces the same challenges, and some had a very positive experience. It is important to understand these subtleties when applying ethics.

Regardless of these shortcomings, findings are useful because they help to reveal systemic inconsistencies. Instead of just indicating what is failing, they also indicate what is working- pointing to models of excellence that can be replicated. In the case of social workers, this dual approach serves the dual purpose of improving practice directly and enhancing policy changes.

Impact on My Own Social Work Practice

As an advanced practitioner, the findings of this study underscore the importance of balancing individual support with systemic advocacy. In practice, I will prioritize proactive case management, integrate families into care planning, and advocate for accessible mental health services. On a general level, I am aware of the moral duty of

supporting the policy that normalizes care and increases special rehabilitation programs. These results enhance my efforts to serve as a practitioner and a change agent in the social work domain.

Implications for Social Change

This study has important implications to promote positive social change in the rehabilitation of TBI veterans. Through the analysis of lived experiences of veterans, the research identifies not only systemic obstacles but also transformation opportunities that can positively affect both personal outcomes and community as well as impact national policy. These implications could be discussed on micro, meso, and macro scales of social work practice.

Micro-Level Implications: Enhancement of Individual Care

On the personal level, the testimonies of veterans highlight how critical the provision of more responsive and comprehensive assistance is. The participants explained that delays, discontinuous case management, and ignorance about resources all contributed to them becoming isolated and disempowered. One explained, “It was almost a year before I was contacted by a case manager”, while another bluntly observed, “There’s absolutely zero help from them... it was all the individual soldiers having to do everything on their own”.

As the individual practice, these findings imply that social workers can initiate social change by empowering veterans to be cost drivers of their rehabilitation. Practical evidence involves regular follow up, culturally responsive communication, and amplifying the voices of veterans in treatment planning. By reaffirming the ethical

principle of dignity and worth of the person, by making clients feel respected and heard, social workers directly oppose the dismissal experience.

Also, the social workers may combine both the strengths-based and trauma-informed methods to be able to recognize those weaknesses and strength veterans mentioned. To illustrate this, the military culture was perceived as an obstacle to others, and to others, was seen as an inspiration of perseverance. Being adaptable to accommodate these views will empower practitioners to meet the veterans where they are, putting them in a position to engage and build trust.

The micro-level implication of this study is straightforward: individualized, proactive, and culturally responsive social work practice will help to alleviate the sense of being abandoned and disempowered that many veterans reported, which will lead to better personal recovery outcomes.

Mezzo-Level Implications: Strengthening of Families, Peer Networks, and Community Programs

The mezzo level results show that family and peer networks have a crucial role in the rehabilitation of veterans. There were always informal supports that participants used when the formal systems failed them. One veteran shared, “My brother [was my support] ... SRU wasn’t doing anything to benefit me, so I leaned on him”. Another focused on the need to have veteran centers in colleges: “Some colleges have vet centers... veterans can hang out, and I think that’s a great support”.

Change on this social level means reinforcing the existing networks that veterans rely on and trust. In the case of families, this can involve caregiver training, counseling,

and fundraising to ease burnout. To peers, it can include spending on formal peer-mentorship initiatives, assigning veterans with lived experience to rehabilitation teams, and increasing the number of community-based veteran centers. Social workers are perfectly placed to enable this change through the creation of family-inclusive service models and promotion of community programming utilizing peer support. Formalizing and resourcing these natural supports will enable practitioners to enhance their performance and increase their spread. The middle-level implication of this research is that the community, when empowered to support veterans as a group, will undergo social change. Families and peers are not peripheral to care but are key collaborators whose role can greatly improve the outcomes of rehabilitation.

Macro-Level Implications: Reform of Systems and Policies

The identification of systemic discrepancies in the provision of rehabilitation services occurred due to the description of the participants at the macro level. Some veterans indicated that at facilities such as Walter Reed and the VA polytrauma units, they received excellent overall care but some said that it took years before patients could receive the care or that no case management was available at all. This is a lopsidedness bordering on structural breakdown of fairness and equality.

Social change, in policy terms requires systemic change in the manner rehabilitation services are structured, funded and known. Participants defined the existence of communication gaps as one of the main obstacles: “They don’t really publicize it... outside of service letters, you don’t really hear much about it”. The answer to this is to step in at the national level and improve the outreach programs in such a way

that all veterans are informed of the service they can receive at the time of active service and after the time of active service.

No less important, the project emphasizes the importance of standard case management measures in every VA and military rehabilitation program. Veteran experiences were very different place and program. Establishing national standards of case managers, case-follow-up, and veteran engagement would assist in reducing inequities and promoting accountability.

Finally, the macro-level implication is scaling of best practices of specialized programs. According to the veterans, they were treated excellently in certain facilities, and no other facilities followed this pattern. The system, in general, may be altered due to greater investment and resources in multidisciplinary, holistic rehabilitation units. Social workers may also help to create macro-level change by policy advocacy, coalition building, and dissemination of research. Social workers can provide a voice to veterans and initiate structural reforms by communicating the findings to policymakers, professional communities, and advocacy organizations that represent veterans.

The Implications Within the Scope of the Study

The implications for positive change are within the framework of this study. These are the results of a qualitative, small sample of seven TBI veterans not in employment. They cannot be extended to all veterans or to all rehabilitation situations. The implications provided here are not to be used as a dictum and solutions to all situations, but to help in thinking and gaining better results.

Summary

This qualitative research was aimed at examining the perceptions of unemployed veterans with TBI on the VA rehabilitation process, specifically on VR&E programs. The analysis likewise identified significant experiences, challenges and recommendations in the semistructured interviews conducted with seven individuals that can contribute positively by not only identifying the impediments but equally identifying possible opportunities in the existing care systems.

The findings depicted that seven key themes were evident: (a) lateness and inconsistency of rehabilitation services, (b) centrality of family and peer support system, (c) fragmentation of case management and coordination of care, (d) strong point of specialized military and VA rehabilitation programs, (e) military cultural norms as obstacles to recovery, (f), resource awareness and access issue, and (g) veterans-inspired system improvement recommendations. These themes make it just possible to gain a faint understanding of how the veterans go through a complex rehabilitation process, where the shortcomings of the institution prefer to nullify the gains, and where the gleams of light give a clue as to what quality care may look like.

The research results regarding professional practice indicate the ethical requirements of social workers to provide timely, competent and culturally sensitive care. Principles of service, dignity and worth of the person, and integrity of the NASW Code of Ethics are directly applicable, as the veteran's expressed disempowerment, staff competence concerns, and unmet needs. Practitioner and advocate roles enable social

workers to ensure that veterans are both empowered agents of their own rehabilitation and agents who require systemic change.

The study offers recommendations to support the strong focus on proactive case management, family and peer support integration, mental health care access enhancement, communication enhancement, and outreach, as well as the scaling of best practices of specialized programs. The recommendations are applicable to individual practitioners as well as to administrators and policymakers who influence the organization and provision of rehabilitation services.

The social change implications can be observed on a micro, mezzo, and macro level. On the micro-level, the professional can empower the individual veteran by providing trauma-based and culturally oriented interventions. At the mezzo level, family, peer, and community-based support can be reinforced to offer the relational stability veterans refer to as indispensable. Systemic reforms are required at the macro level to standardize case management, enhance communication, and increase access to specialized models of rehabilitation.

At last, the outcomes of this paper are contradictory. Because most veterans do have to wait very long, obtain care that is discontinuous, not well supported, it is also true that other veterans get the best services which could be viewed as an example of what may be done. Such resistance is a sign that systemic change is necessary, but it can also be achieved. Social workers and other allied professionals, through the experience of the veterans, can redesign rehabilitation systems to emerge as equitable, responsive and empowering structures.

The conclusion of this study is quite straightforward, veterans with TBI perform well when they can identify timely, coordinated, and respectful systems and poorly when they can identify disjointed, slow, and disrespectful systems. This disparity in social work practice and policy must be addressed such that every veteran (not just the fortunate few) may reap the rewards of what rehabilitation systems have to offer.

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Appendix: Interview Questions

1. After you were discharged from the military how long was it before you were thinking about returning to civilian employment and what prompted you to think about returning to work?
2. What kind of support systems do you have outside of the VR&E program and how do they support you?
3. Tell me whether and how you used the comprehensive supports such as financial stipends, therapy, access to health insurance, and caregiver training available while you worked with VR&E.
4. How soon after becoming eligible for VR&E services were you engaged with a VR&E counselor?
5. Could you describe the process of developing your individualized rehabilitation plan with the VR&E counselor? Were you, satisfied with the plan and your level of involvement?
6. Tell me about the different professionals who were involved in your experience with VR&E.
7. What are your perceptions about how the military culture may have influenced your experiences with VR&E?
8. What do you see or view as the strength of the program?
9. What do you see or view as the limitations of the program?
10. What types of support could be provided to Veterans like you to help with the transition process from active-duty military to civilian employment?

11. Finally, are there any additional comments you would like to share about the VR&E program?