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Walden University

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Walden University

College of Health Sciences

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Tiffany Schweitzer

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Walden University
2017

Abstract

U.S. Marine Corps Veterans' Perceptions of Screening for Posttraumatic Stress Disorder

by

Tiffany Lawing Schweitzer

MA, Walden University, 2013

BS, Pfeiffer University, 2006

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Services

Walden University

July 2017

Abstract

Posttraumatic stress disorder (PTSD) is a serious issue for post-deployment United States Marine Corps (USMC) veterans, especially because PTSD can increase the risk of suicide. Marines are screened post-deployment, yet little is known about Marine veterans' perceptions of the PTSD screening process. The purpose of this phenomenological study was to explore USMC male veterans' perceptions of the Post-Deployment Health Reassessment (PDHRA). The social cognitive theory constructs of a triadic relationship among person, environment, and behavior were the framework for understanding this population's perceptions of the PDHRA and potential stigma. Two research questions focused on how people, culture, and behavior affect Marines perception of the PDHRA and PTSD attached stigma. Interviews were conducted with 10 Marine veterans' participants and transcribed interview responses were input into NVivo 11 software to retain a reliable database and Colaizzi's strategy to identify emerging themes. Key findings revealed potential positive social change to military chaplains and veterans' health service providers. This knowledge might inform about the perceptions of Marines through informed understanding and may help develop an updated evaluation tool. Future researchers might focus on the forthcoming answers and treatment of PTSD and the attached stigma among Marines by alleviating repercussions for Marines' answers on the PDHRA. An understanding of the study's findings may elicit strategies for health care administrators to expound on the PDHRA and provide educational programs to assist in future screening environments and processes through Marines perspectives.

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Dedication

I dedicate this study to the men and women of the United States armed forces. Their sacrifice allows freedom for you and me. In addition, I dedicate this dissertation to my two daughters, Sierra and Alexandria. Without their love and support, this project would not have been possible. Lastly, I dedicate this study to my mother, father, and brother, Jeff. Their support for me to keep pushing forward and achieve my educational goals provided inspiration and comfort throughout the dissertation process.

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Chapter 1: Introduction to the Study

Introduction

Posttraumatic stress disorder (PTSD) among USMC veterans (hereafter referred to as Marines) has increased over the years due to overseas deployment and combat (Wisco, Marx, & Keene, 2012). The Department of Defense's (DOD) Post-Deployment Health Reassessment (PDHRA) (Appendix D) is a screening tool devised to promote an overall healthier outcome of PTSD among Marines. Researchers have linked PTSD to veteran suicide attempts due to the guilt of combat (Veterans Affairs [VA], 2015). This guilt is primarily due to actions during wartime. There is an alarming increase of PTSD diagnoses among Marines over the past decade, and the number continues to increase (VA, 2015). United States Marine Corps (USMC) veterans may encourage health professionals to campaign for an improved PDHRA. PTSD screening process is important to mental health issues within the USMC that encompass 183,787 active personnel and 38,213 reserve personnel (Graphiq, 2016). Apparently, there is a need to study this important research.

Exploration of Marines' perspectives on PTSD screening process might assist in a revised PDHRA. The DOD (2015) noted the increase in PTSD diagnoses continues to rise over the past several years. The uncertainty of the DOD (2015) diagnosis tools such as the PDHRA emphasizes for awareness. Researchers have not investigated if this updated 2012 form can be a unique tool to diagnose symptoms of PTSD among Marines (DOD, 2015). References that the screening tools administered to Marines after deployment (Aralis et al., 2014) can underestimate brain injury and can be limited in a

predictive state to diagnose PTSD. The PDHRA is a screening method used by the DOD to assess PTSD symptoms of Marines 90 to 100 day's post-combat deployment (DOD, 2015). Literature review conducted to date yield-limited research on the perspectives of Marines and the PDHRA screening process. A proposed study designed to aid this research gap and provide understanding about the concerns of this screening process through the perspectives of Marines. Exploration of Marines' perspectives in this area may assist health professionals to promote additional screening measures and a deeper understanding into the lives of Marines who may have PTSD, but are unwilling to expose the truth.

The perspectives of former Marines may bring insights that can contribute to a more effective screening tool that ultimately might help Marines with PTSD and even preserve lives. These perspectives may lead to a clearer understanding for health professionals to stimulate faster treatment and might allow the Marine to be honest about their health and feelings with no repercussions due to the stigma from the USMC. The understanding of the perspectives from the experiences of former Marines may interject a heightened awareness of the issue surrounding the PDHRA. In addition, the Marines perspectives may yield an increased appreciation for this research arena.

This chapter included the background of the study, problem statement, purpose, research questions, framework, nature of the study, and definitions. It will follow with assumptions, scope and delimitation, limitations, a significance of the study, and social change. The chapter will end with a summary of the study of chapter 1 and will transition into the introduction of Chapter 2 and the extensive literature review of PTSD.

Background

I executed an exhaustive research of the literature on PTSD. Originally, PTSD claimed to be a disorder caused by traumatic neurosis or brain concussions according to Birmes, Hatton, Brunet, and Schmidt (2003). Particularly, during 2014 and 2015, Marines have displayed increased symptoms of PTSD after experiencing combat deployments (VA, 2015). The increased number of PTSD symptoms and diagnoses (Macera, Aralis, Rauh, & MacGregor, 2013) attributed to the size and duration of Operations Iraqi Freedom (OIF) and Operation of Enduring Freedom (OEF). Combat Warfare exposure and engagement place Marines at increased risk for developing signs and symptoms of PTSD and ultimately, the stigma that attaches to this disorder (Aralis et al, 2014). There are different factors that now cause PTSD and mental illness.

Although mental illness can be linked back to the American Civil War, the screening processes are dissimilar than the types used today. The screening processes for the mental illness and PTSD have been revised to suit present day combat experiences, but the research on Marines perspectives of the PDHRA and the stigma attached have not been fully examined (VA, 2015). Additional research may lead to an understanding of an effective screening tool to gauge PTSD among Marines.

Traditionally, Marines uphold standards that honor self-worth. Researchers provided research on self-efficacy and the meaning of life with PTSD and depression severity among veterans. Kirsch et al., (2014) provided details on how understanding self-efficacy can help overcome stressful situations resulting from PTSD. Self-efficacy has played a role in present day symptoms and has (Bush, Ouellette, & Kinn, 2014)

helped with understanding the different ways of tracking and treatment related to combat PTSD. Likewise, Mulvaney et al., (2014) supported the combatting of PTSD and symptom exposure and relief that could ultimately assist in alleviating the stigma placed on Marines with PTSD.

There are overlooked symptoms of PTSD among Marines. PTSD symptoms assessed Escolas and Escolas (2015) showed an understanding of symptoms military personnel might present. Marines battling PTSD carry anxiety and nervousness (Hart, 2015) that are debilitating in nature to daily living. The perspectives of Marines may provide insights on the PDHRA and better ways of how to address the symptoms in order to save the lives of Marines. According to Stop Soldier, which is a non-profit organization preventing active-duty suicides (Hart, 2015) expressed that 22 American veterans commit suicide every day due to a combat-related exposure. Offered models. (Steele et al., 2014) that aligned with the possible methodologies were used in this study. A focus on Marines' perspectives may help in recognizing PTSD symptoms.

The culture of the USMC upholds standards of honor and fortitude. Bartlett, Phillips, and Galarneau, (2015) suggested that Marines need to be mentality and physically prepared at all times in order to perform Marine level tasks. As a Marine, there is difficulty in securing these capabilities all the time and can cause levels of stress and unwanted anxiety (Hart, 2015). A standard is not to show weakness at any time for the USMC. The USMC expects the Marine to be strong mentally and physically. If a Marine does not meet the USMC standard then, the possibility of termination or no promotion for career advancement may occur.

Attached stigma to a Marine may alter the safety and security that was once possessed. If a Marine had stigma placed on them because they held a diagnosis of PTSD and were seeking help, this stigma can place obstacles in the Marines' future career (Mittal et al., 2013). Marines labeled as crazy, violent, and dangerous can be life altering. Therefore, many Marines do not seek treatment for symptoms related to PTSD or mental illness associated with PTSD (Mittal et al., 2013). The stereotypes cause Marines not to engage in further PTSD treatment even if they are encountering the symptoms of PTSD. Hence, Marines' responses may skew the results of the PDHRA fearing the ramifications of being forthcoming with accurate answers.

There are various reasons to use PTSD screening. Researchers (Wisco et al., 2012) provided understanding on the diagnosis, treatment, screening, and the prevention of PTSD. The need to explore the perspectives of Marines and their experience with the PTSD screening process and possible stigma placed on them after diagnosis with PTSD as studied by Riggs and Sermanaian (2012), engaged in the understanding of the PDHRA. This purpose of this qualitative phenomenological study was to explore the research gap of the Marines' perspectives on the PTSD screening process and possible attached stigma. This might provide insights that could contribute to an effective screening process and mental health treatment for Marines diagnosed with this disorder.

Problem Statement

PTSD is a serious issue for post-deployment Marines. Wisco et al. (2012) demonstrated that the screening process for PTSD is of concern. There is specific concern with PTSD screening among Marines and factors that might affect the overall PDHRA

screening process (Aralis et al., 2014). The Department of Veterans Affairs (2015) revealed many veterans report guilt and disconcerting thoughts due to actions taken during war times that result in suicides. Researchers have linked PTSD to veteran suicide attempts due to guilt of combat (VA, 2015). The Quarterly Suicide Report provided by the DOD (2015) showed nine Marine suicides in 2014's cumulative second quarter compared to the increase in the 2015's cumulative second quarter of 12 Marine suicides.

The research as mentioned above elucidates important findings regarding PTSD screening. Based on my literature review to date, a research gap was apparent in Marines' perspectives about the PTSD screening process. An area for future study, as Hall (2015) suggested exploring methods that would be effective in defeating negative stigma surrounding mental health treatment in the U.S. Military. Therefore, little was known about Marines' perceptions of the PTSD screening process and potential stigma.

Purpose of Study

The purpose of this qualitative, phenomenological study is to explore the perceptions about PTSD screening and potential stigma among Marines located in a community in the southern United States. The community in the southern United States location was ideal due to the close proximity of respondents. This approach allowed me to devour into the intense perspectives of Marines as it related to post-deployment PTSD health screening process and the possibility of attached stigma. The study attempted to conclude that areas of the PDHRA might not fully identify the symptoms of PTSD among Marines. Additionally, this study will search to determine factors that may prevent Marines from accurately reporting their symptoms of PTSD. Furthermore, this study will

try to determine if these factors were due to the stigma that surrounds mental health disorders among Marines.

Research Questions

I derived the following two qualitative phenomenological research questions from the problem statement and a review of the literature on PTSD screening process for Marines. To explore the perspectives of Marines the use of these phenomenological research questions assisted in providing an effective screening.

RQ1: What are the perceptions of Marines about the PTSD screening process?

RQ2: How does the potential stigma surrounding PTSD hinder the decision of Marines to report PTSD symptoms while completing the PDHRA?

The questions were discussed in detail and analyzed in future chapters to support the study's interview questions related to a specific theory along with a detailed examination of the nature of the study.

Theoretical Foundation

In this qualitative phenomenological study, I integrated theoretical perspectives with qualitative assumptions. These assumptions can build an image of the issues and studied individuals along with the needed changes. The use of Bandura's (1986) social cognitive theory (SCT) will be relevant to this study's research problem of the PTSD screening and potential stigma among Marines. The SCT captures a triadic relationship among person, environment, and behavior (Oppong, 2014).

Essentially, the recursive relationships indicate connections that people create the environment that shapes the individual and, in turn, both the person and the structures

affected the behavior (Oppong, 2014). The SCT centers on interpersonal characteristics and immediate context. The author of the theory suggested that cognitive events determine environmental events and how they acted on, interpreted, and organized. Additionally, the theory implies that positive or negative feedback from behavior influences people's cognitions and the way they act and change the environment (Oppong, 2014).

The use of phenomenological research strategy allowed for an understanding of Marines' lived experiences of PTSD screening and potential stigma. Likewise, lived experiences are denoted as a philosophy and a method (Blackburn & Owens, 2015). This strategy contributed to the development of patterns and meanings of PTSD screening and potential stigma among Marines. The theory provided me with a conceptualization of the little known research problem about Marines' perceptions of the PTSD screening process and potential stigma to promote the concerns of behaviors, health, and incongruences. A more detailed explanation of theoretical propositions presented themselves in chapter 2.

Nature of the Study

The qualitative, phenomenological research method guided my study of the perceptions of PTSD screening process and potential stigma among Marines. Data collection resulted from face-to-face interviews of Marines on their lived experiences with the PTSD screening process and potential stigma. This qualitative design rifled with purposeful strategies instead of statistical formulas (Marshall, Cardon, Poddar, & Fontenot, 2013). The use of this methodology motivated my need to have a clearer understanding of this phenomenon delivered by Marines perceptions.

This qualitative research design also incorporated open-ended interview questions to gain responses that would answer this study's research questions. The open-ended interviews allow for in-depth communication that relayed pertinent information from the Marines. Initiating my own questions assisted me in fully knowing about the study and prevented bias as the interviews were administered (Silva et al., 2013). Face-to-face interviews allowed for the experience of participants voice, intonation, and body language. These social cues (Opdenakker, 2006) provided additional information that combined with the verbal answer of the participant. The combined advantage provided a comprehensive description of the lived experiences of Marines as it related to the PDHRA and attached stigma.

I used Colaizzi's (1978) phenomenological strategy and methodological approach to analyze the collected data obtained from the face-to-face interviews. Colaizzi's approach sought to discover and understand a phenomenon, perspectives and worldviews of individuals involved in a process. This approach permitted the theoretical position to be explicit through the SCT. The approach provided rigor details through the lens of Marines and identified behaviors and environmental factors (Oppong, 2014). This approach provided a way to sufficiently obtain data and describe the distinguished collection in a qualitative nature.

Overall, the obtained data collection was through the transcripts of the interviews. These transcripts delivered the lived experiences of this phenomenon (Rosenthal & Erickson, 2013). This method generated findings free from bias and preconceptions that influence the study according to researchers (Walker, McDonald, & Frank, 2014). The

method integrated interpretive phenomenological research and show how individuals interpret and understand a similar life experience. I used NVivo a qualitative software program to manage the data. This software program provided easy access to handle the material in large amounts (Bergin, 2011). The program permitted a single location for storage. Additionally, it granted audio and video materials to provide for a deeper analysis.

Definitions

Below are concise definitions of the key concepts within this research that are not common terms.

Active-duty: A military member who is employed full-time in a branch of the United States military (Britt, Jennings, Cheung, Pury, & Zinzow, 2015).

Combat Stressors: The experiences that individuals encounter during combat that activates and heightens stress, tension, and anxiety (Hart, 2015).

Combat Marine: A Marine, who is involved in deployment and engage in wartime combat or battle experiences (Hobfoll et al., 2016).

Hyper-arousal: Is a heightened sense of tension that is common with PTSD in combat Marines and may include anger, agitation, irritability, and insomnia (Boden et al., 2016).

Marine Perspectives: The way in which Marines perceived lived experiences with the specific situations or environments (Veterans Affairs, 2015).

Nostalgia: A desire to return to a former thought or an experience that is wished to be experienced one more time (Friedman, 2015).

Post-Deployment Health Assessment (PDHA): A post-deployment health assessment that is required. This assessment is one of two brief questionnaires that Marines complete. The Marine completes this questionnaire 30 days following their return from deployment (Macera et al., 2014).

Post-Deployment Health Reassessment (PDHRA): A post-deployment health reassessment that is one of two required brief questionnaires and administered to Marines 90 to 180 day's post-combat deployment (McCarthy, Thompson, & Knox, 2012).

Posttraumatic Checklist- Military (PCL-M): A PTSD Checklist-Military is a 17-item self-report measure for PTSD screening tool used by the Marines to identify symptoms and assist in conjunction with the PDHA and the PDHRA (Phillips et al., 2010).

Posttraumatic Stress Disorder (PTSD): A disorder defined as a psychiatric condition that is a result of witnessing a traumatic event or exposure to a traumatic event that could cause a life- threatening event or serious injury to an individual or others (APA, 2013).

Self-identity: Recognition of one's characteristics as a particular individual and is essentially who and why you are the way you are in life (Stephens, 2014).

Self-stigma: A burden placed on one's self is prevalent among mental illness and is destructive because of the negative messages of weakness and distorted self-image it sends to an individual's brain (Britt et al., 2015).

Shell shock: An expression given to combat military personnel that described symptoms as "shell shock" due to individual's reactions that were associated with explosion of artillery shells (Friedman, 2015).

Soldier's heart: An expression referenced from the civil war that military personnel would experience also known as "Irritable Heart". This was termed when military personnel would come off the battlefield and have symptoms of rapid pulse, anxiety, and trouble breathing (Jones, 2013).

Stigma: Feeling judged by other individuals because of some personal quality or trait (VA, 2015).

Veteran: Individual who served in the United States military and defined as no longer in active-duty status (VA, 2015).

Assumptions

Assumptions are important to researchers due to providing clarification, help with the planning, and design of the research questions. There are descriptive and conferred assumptions when completing face-to-face interviews within this qualitative study. Strategies helped with legal and discriminatory concerns of interviewing (Parent, Weiser, & McCourt, 2015).Within this study, it assumes that the participants would be honest with their disclosures. The study assumed that Marines who are involved in the DOD mandated PDHA, and PDHRA were forthcoming with their answers while being interviewed so that it created an unbiased study. The next assumption was that the Marine participants did not withhold any information during the face-to-face interviews so to promote the true perspectives about the PDHRA and PTSD attached stigma. Another

assumption within this study was that Marine veterans might isolate certain experiences and ask to move to a different question due to the Marine's unpleasant experience associated with that particular question. Other participants may stand on the cautious side when answering to protect emotional and behavioral reflexes.

Marine veteran participants are capable of coping with certain traumatic experiences and associated PTSD. The interview questions were be open-ended and allowed the participant to expand in detail. Follow-up questions provided an environment where the participants could express their experiences in detail. The assumptions are necessary for this study in order to have a better understanding and disseminate the proper relationship with the Marines to ensure they are comfortable in answering the interview questions and the voice they portray did not allow ramifications.

Scope and Delimitations

The scope of this study was the Marines' perspectives on the PDHRA and attached stigma associated with PTSD. This study might influence an effective screening tool to gauge PTSD and expunge stigma for Marines diagnosed with PTSD. Gaining the insights from the Marines was essential in relaying the understanding of the types of stigma that placed on Marines diagnosed with PTSD. This qualitative phenomenological study cultivated a disclosure that encompassed the topic of the study during participant recruitment.

The study delimited by the recruitment of 10 male veteran Marines who resided in a community in the southern United States. Convenience-based used sampling due to their close proximity to MCRD. There was no restriction on race or age. Active-duty or

Reserve Marines were not included in this study. The delimitation was suitable due to the number of participants that fall within the range of 6-10 and were no more than 10. This delimitation can improve the validity of this study according to the guidelines of research methodologists (Marshall et al., 2013).

Limitations

Limitations of this qualitative phenomenological study are important to research because it may include providing information about PTSD and the attached stigma of Marines The limitations are comprised of time, sample size, gender specific, funding, along with guilt and shame. First, time constraints were relevant due to the Marines busy schedule and availability. Second, having a small study with convenience-based sample limited the perspectives of the PTSD screening process due to this narrowed defined group. A potential limitation of the study may include utilizing an all-male participant pool. For example, utilizing an all-male participant panel can limit the perception of an inefficient screening process because males predominantly suppress emotion and feelings according to Boden (Boden et al., 2016). Likewise, the findings may not be generalizable to female perspectives. Third, the funding for this study was limited due to its size in nature. Trauma-related guilt and shame may differ from each Marine due to their experience and may affect this study's results. The limitations for this study was not a representation of the entire DOD (Owens & Anderson, 2015).

Significance

This qualitative phenomenological research study was unique because study findings may provide insights of Marines' experiences with the PDHRA and potential

stigma. PTSD among Marines was largely misunderstood (Kok, Haan, Meer, Najavits, & Jong, 2015). Dissemination of study findings may contribute to positive social change for health services by increased understanding of Marines' experiences with the PTSD screening processes and potential stigma. Dissemination of study findings to stakeholders such as military chaplains and veterans' health service providers may contribute to informing understanding about the PDHRA through the lens of Marines.

Significance to Practice

This study attempted to provide the current body of literature an increased awareness of the PTSD screening process and the possible stigma placed on Marines. Potential contributions included the awareness of perspectives of Marines regarding stigma of PTSD and the effectiveness of screening process. This can assist a veterans' health care provider and military chaplain to be well versed in the understanding of a Marines thought process on the effectiveness of the PDHRA. Additional supportive capabilities and awareness given to providers about the Marines authentic thoughts of the PDHRA and stigma might assist with an encouraging outcome after returning from combat deployment and experiencing PTSD.

Significance of Theory

This study intends to aid the Marine Corps with the PDHRA and attached stigma associated with PTSD. The current screening process through understanding can help evaluate different mental health concerns after the Marines have returned from a combat deployment (Hourani, Bender, Weimer, & Larson, 2012). Having a comprehensive

understanding that the USMC was distinct in honor and toughness and knowing that Marines uphold traditions might assist the providers in recognizing early signs of PTSD even though the Marines may not be forthcoming on the PDHRA due to fear of attached stigma and consequences for not upholding this rectitude.

Significance to Social Change

Within this qualitative phenomenological study, there are potential contributions to policies, practices, and progressed knowledge. The contributions can lead to a positive social change in health services and provide awareness of the PDHRA and the stigma that might be placed on a Marine being diagnosed with PTSD. Although combat tours continue and Marines return from deployments, it might be helpful to understand the perspectives of the veteran Marines about the screening process. These particular individuals have no straight stakes or consequences in voicing their thoughts about the PDHRA and attached stigma. Therefore, gaining advanced knowledge from Marines provided a deeper meaning to the effectiveness of the PDHRA.

Summary

This chapter introduced the importance of the screening tools for PTSD within the USMC specifically the PDHRA and attached stigma resulting from Marines diagnosed with PTSD during their time on active-duty service. The problem was addressed, elucidated, and was supported by the research purpose. Next, the introduction of the research questions and reinforce my theoretical framework. After that, my theory (SCT) explained and disseminated the reasoning for this phenomenological study. Finally, I provided the assumptions, scope, delimitations, limitations, and significance of this study.

The awareness of PTSD within the USMC has increased over the years. Historically, there has been an increase in PTSD among Marines underdiagnosed and resulted in lives being lost (Bryan, 2015). A Marine's life can be stressful and with added psychological emotions, the burden may be too hard for this once tough individual to conquer without the proper health care provided. This study's findings were intended to inform military health care professions on ways to expedite treatment and recognize the truth behind Marines thought process about placed stigma if they relay honest feedback on the PDHRA. The DOD has provided the foundation for effective screening tool and through the perspectives of Marines, there are continued gaps in the research on PTSD screening tools and attached stigma.

Chapter 2 was a review of the current literature on PTSD screening tools and attached stigma resulting from PTSD diagnoses among Marines. This chapter provides an indication for new research in accurate PTSD screening tools and modes to assist in the stop of stigma placed on Marines who are diagnose with PTSD while on active duty.

Chapter 2: Literature Review

Introduction

Traumatic life events are exceedingly widespread within the United States. There are millions of Americans diagnosed with PTSD on a yearly basis (Russo, Katon, & Zatzick, 2012). More importantly, there has been an increase in PTSD among Marines underdiagnosed and resulted in lives being lost (Bryan, 2015). Recent studies (Hourani, et al, 2012) illuminated that PTSD among Marines was associated with combat deployments. Individuals and health professionals may not completely comprehend PTSD and the stigma attached with this disorder among Marines. PTSD is a serious issue for Marines. The purpose of this study was to understand better and to explore the perceptions of PTSD screening and the potential stigma among Marines using a phenomenological approach.

Marines' perspectives point towards worrisome thoughts regarding the PDHRA. Wisco, et al., 2012 demonstrated that the screening process for PTSD was of concern. There was a specific concern with PTSD screening among Marines and factors that might affect the overall PDHRA screening process (Aralis et al., 2014). Many veterans report guilt and disconcerting thoughts according to the Department of Veterans Affairs (2015), due to actions taken during war times that result in suicides. Researchers have linked PTSD to veteran suicide attempts due to guilt of combat (Veterans Affairs, 2015). The Quarterly Suicide Report provided by the Department of Defense (2015) showed nine Marine suicides in 2014's cumulative second quarter compared to the increase in the 2015's cumulative second quarter of 12 Marine suicides.

Based on my literature review to date, a research gap was apparent in Marines' perceptions about the PTSD screening process. An area for future study, as Hall (2015) suggested that exploring methods that would be effective in defeating negative stigma surrounding mental health treatment in the U.S. Military was. Therefore, the problem exists that little was known about Marines' perceptions of the PTSD screening process and potential stigma.

This literature review institutes a need for continual research on the PTSD screening process and possible stigma among Marines. The understanding and perspectives of health professionals regarding the post-deployment health reassessment (PDHRA) may have contributed to shutting down and not being present during the diagnosis system (Kolk & Najavits, 2015). Subsequently, Kolk and Najavits (2015) advocated the lack of understanding might have affected the welfare of Marines. In chapter 2, a provided literature explicit to the problem revealed. Initially, the described literature strategies demonstrate and follow this study's theoretical framework. Thenceforth, important research concepts provided coupled with an ended chapter summary.

Literature Strategies

There were numerous key terms used as search criteria throughout this literature review that included *Marines, veterans, PTSD, PDHRA, stigma, screening, diagnosis, treatment, perceptions, health effects, quality, death, and awareness.* The literature review included journal articles and dissertations extending from 2012 to 2016. All sources acquired through Walden's utilizing CINHAL, Google Scholar, MEDLINE,

ProQuest Central, PubMed, and Science related databases. In addition, I used websites that included the Department of Defense and Veterans Affairs.

Several studies conducted on the PTSD screening for Marines and military services. I have found little research on the perspectives of veterans on the PDHRA and attached stigma. Henceforth, obtained study's findings may assist in addressing this literature gap and deliver a way for dissemination among the stakeholders such as military chaplains and veterans' health service providers that may contribute to informing understanding about the PDHRA through a Marines' perspective. Additionally, assisting health care administrators, other health service providers, and organizations to reduce cost and diagnosis time in order to enhance the lives and well-being of Marines.

Theoretical Foundation

In this qualitative study, theoretical perspectives integrated philosophical assumptions. These assumptions built an image of the issues and individuals studied along with the needed changes. The use of Bandura's (1986) social-cognitive theory (SCT) provided the foundation that related to this study's research problem of the PTSD screening and potential stigma among Marines. Theoretical frameworks are generalized theory or theories within a specific research (Wu & Volker, 2009). Thus, in this chapter a provided overview of the SCT incorporated descriptive theory elements and an explored illustration of the concept.

This theory offered pivotal context from scientific discoveries and examinations among agency, structure, and behavior. The theoretical framework incorporated persons, environment, coupled with outcomes for social understanding and learning inside the

health services arena (Oppong, 2014). Listed in Table 1 consists of the theory related to the structure of this study. Table 1 illuminates the theory's origin and relationship to the research questions and constructs.

Table 1

Purpose of Theoretical Foundations of the Study

Theoretical Foundation	Origin	Research Question(s)	Construct
SCT	Bandura (1986)	RQ1	Marines
SCT	Bandura (1986)	RQ2	Marines

The theoretical foundation listed in Table 1 to demonstrate the correlation to the framework of this qualitative phenomenological study. The affiliation of the SCT helped to support the research questions. Moreover, the theory provided a conceptualization of the research problem where little was known about Marines' perceptions of the PTSD screening process and potential stigma to promote the concerns of behaviors, health, and incongruences.

Social-Cognitive Theory

With the SCT, Bandura (1986) recognized that person variables or human agency and environmental factors like family regulates human behavior. Similarly, Wu and Volker (2009) argued that theory affects the person and the environment. The beliefs of the SCT have been useful throughout health services. Thus, casting this theory within the study's questions to view the perceptions of Marines related to the PTSD screening process are understood and to investigate if potential stigma surrounding PTSD can hinder the decision of Marines to report their symptoms accurately while completing the

PDHRA, it was safe to conclude that the above factors may be responsible (Oppong, 2014).

The SCT captures a triadic relationship among person, environment, and behavior. Mostly, these recursive relationships indicate relationships that people create the environment that shapes the individual and, in turn, both the individual and the structures affected the behavior (Oppong, 2014). The SCT centers on interpersonal characteristics and immediate context. The theory suggested that cognitive events determine environmental events and how they acted on, interpreted, and organized. In addition, the theory implied that positive or negative feedback from behavior influences people's cognitions and the way they work and change the environment (Oppong, 2014).

The SCT has been applied in several studies to push for understanding with PTSD in Marines and assist with reducing Marine deaths (Veterans Affairs, 2015), depression (Hobfoll et al., 2015), substance abuse (Possemato et al., 2015), guilt (Popiel, 2014), and violent behavior (Hart, 2015). This triadic determinism paralleled with improvements in diagnosing PTSD, the associated symptoms, and treatment (Skopp et al., 2012). The SCT demonstrated that structures and environment influenced Marines' behavior (Oppong, 2014).

In Figure 1, the social-cognitive theory depicts associated concepts. This figure represents alignment with RQ1 and RQ2 to Marines' perspectives and their involvement in the PDHRA and stigma. An illustration of SCT within a triangular symbol supports the direction that all angles with Marines' deployment environment and outcomes of PTSD are covered.

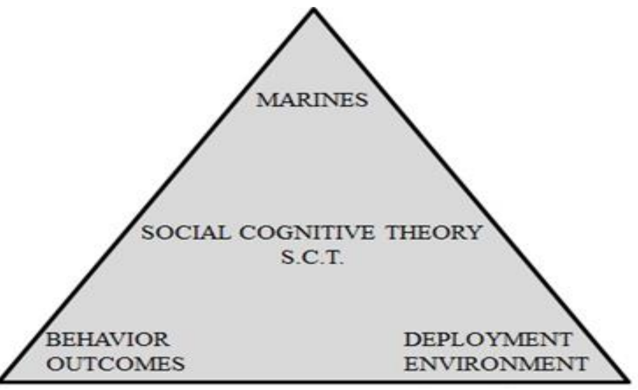

Figure 1. Purpose of the SCT to this study

Subsequently, the SCT offered validation for the sample selection of Marine veterans to study for advanced screening processes understanding of Marines' perspectives of PTSD, PDHRA, and stigma. Granted, the abovementioned studies utilized SCT to investigate Marines' and PTSD, there was no subsequent study found on the perspectives of Marine veterans with the PTSD screening process and possible stigma. Therefore, the construct of the SCT theory utilized within this study can address this research gap and support the understanding of Marines perspectives as it relates to the PTSD screening process. Throughout this study, SCT used the perspectives in relations to Marines, deployment environment, and behavior outcomes to investigate.

In Figure 2, an illustration of the principle points of the SCT as it relates to my research questions presented. The alignment of these questions within the roles of Marines and the PDHRA depicts the two main points of this research study. Supplementary, the illustration placed within a brains' thinking pattern to demonstrate the SCT theory and the cognitive areas of concern.

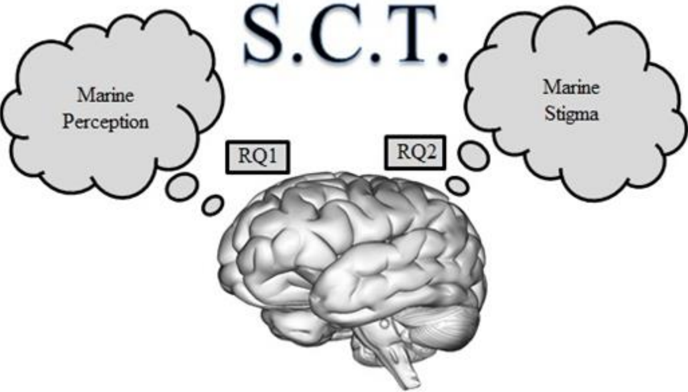

Figure 2. Purpose of the SLT to the study

As a result, for incorporating the SCT throughout this study, the SCT pointed towards the intent that provided a rationalization of selecting specific Marines for sampling in order to investigate their perceptions and thought processes of stigma placed on them when considered to have or diagnosed with PTSD. This theory brought forth both the effects of the human and the environment and displayed that personal, environment, and behavior interact as factors to influence one another (Oppong, 2014). The SCT exhibits how the recursive relationships among persons, environment, and behavior shape each other. Marines as the person and structure (environment) can influence their behavior and this was expected.

Posttraumatic Stress Disorder

PTSD was a psychiatric condition experienced by individuals after exposed to a life altering or traumatic event according to Gates et al., (2012). It affects 7-8 % of the U.S. population over the course of a lifetime. Two groups have an increased prevalence for PTSD. These groups include active duty military personnel and veterans. The

diagnosis of PTSD according to the Statistical Manual of Mental Disorders (DSM), held great opposition as late as 1982 (Kolk & Najavits, 2013). PTSD was first included as a diagnosis in the late 1970s and inspired by Kardiner's book, *The Traumatic Neuroses of War, and this book referenced* World War one veterans and focused on physiological and biological systems that were muddled (Kolk & Najavits, 2013). Additionally, PTSD is a diagnosis familiar to many U.S. Marines.

The stress of war and traumatic experiences were discerning factors of PTSD amongst Marines. The chief complaints encompass anger, sleep deprivation, flashbacks, rage, depression, and not enjoying the pleasure of the surroundings (Kolk & Najavits, 2013). There are many combat stressors linked to the development of PTSD (Hart, 2015). These may include seeing deceased individuals, shot, or being familiar with someone killed. A recent study (Hart, 2015) confirmed that nearly 20% of the 2.3 million American veterans who served in Afghanistan and Iraq had experienced PTSD. Of these individuals, approximately 60% to 70% have not received treatment for PTSD (Hobfoll et al., 2016). The discerning factors play a role in PTSD diagnosis among Marines.

Combat Marines not only experience PTSD but are also at risk for increased psychological distress and suicide (Hobfoll et al., 2016). Marines may encounter moral and ethical challenges associated with combat that could similarly lead to PTSD (Currier, McCormick, & Drescher, 2015). The moral and ethical challenges have led to guilt among Marines exposed to a prolonged traumatic experience.

The DSM-5 studies showed that exposure therapy with individuals who have PTSD exhibit signs of anger and guilt. Other issues may include substance abuse,

disengagement, marital problems, and coping adaptability (Held, Owens, & Anderson, 2015; Passemato et al., 2015). This has led to parental and spiritual struggles mainly in non-developed Marines not prepared for the intricacy of war (Sherman, Harris, & Erbes, 2015). The psychological stress among Marines needs more observing in detail for an appropriate PTSD diagnosis.

PTSD has affected society and the economic sector due to the cost related to this disorder. Likewise, this disorder was a potentially disabling mental disorder that is widespread among Marines and veteran population. An estimated 6.2 billion dollars (Gates et al., 2012) was spent on military personnel that has returned from war. PTSD affects society as a whole and can directly relate to individual or other terms. Further, Lasiuk and Hegadoren (2006) demonstrated that individuals tend to manifest unfulfilled potential in their employment, education, relationships, and day-to-day functions.

Not only does PTSD affect the individual with this disorder, but also their family and friends. Combat exposure has increased the risk of PTSD and personality factors (Hahn, Tirabassi, Simons, & Simons, 2015). A negative urgency to have impulsive behavior and act rash with family members and friends can be a hardship on all involved. These negative urgencies are also considered (Hahn et al., 2015) an independent risk factor for PTSD.

These factors have played a fundamental part in Marines holding down jobs, relationships, and even daily activities. Marines tend to isolate themselves from others or act out due to fighting the traumatic experience or events of a war deployment and combat exposure (Frankfurt et al., 2015). Marines with this disorder can have issues with

substance abuse, violence, or even death (Skopp et al., 2012). PTSD may influence individuals related or connected to a Marine.

PTSD Related to U.S. Wars

Throughout American wars, Marines and other military personnel have displayed signs and symptoms of PTSD. Authors including Homer, Dickens, and Shakespeare recorded accounts of traumatic experiences and the reactions that followed these events way before the creation of the term PTSD (Friedman, 2013). These authors displayed the symptoms related to accounts of surviving trauma together with psychological responses. Research about veterans returning home from combat was a contributor in the formulation of this disorder. Hence, the history of combat war as what we know today is referenced PTSD (Friedman, 2015).

Before the U.S. military designed efforts to diagnose PTSD, there was an Austrian physician named Josef Leopold who wrote about the nostalgia among military personnel that had encountered the military trauma and other related issues like missing home, sleep deprivation, and anxiety (Friedman, 2015). These symptoms exhibited correlated with what we now know as PTSD. As a U.S. doctor, Mendez Da Costa expressed after studying individuals who were in the civil war that military personnel would experience known as “Soldier’s Heart” or “Irritable Heart” (Jones, 2013). These terms used when individuals came off the battlefield and have symptoms of rapid pulse, anxiety, and trouble breathing. In most cases, military personnel had an option to be use drugs to regulate and treat the symptoms and eventually returned to the battlefield.

The U.S. military during the 1800s observed military fatigue and exhaustion due to the war-torn environment in which they inhabited. Later, the military physicians would diagnose this as a psychological breakdown due to the initial years of the 1861 American Civil War (Friedman, 2015). In the early 1900's and at the end of World War I there were signs and symptoms of what we now know as PTSD. At this time in the world (Jones, 2013) described these symptoms as "shell shock" due to individual's reactions that were associated with the explosion of artillery shells.

By the late 1950s, the DSM moved more towards a diagnosis for these symptoms as an adjustment to adult life and contained only three symptoms to address. Symptoms were linked to suicidal thoughts, unwanted pregnancy, and fear of military combat (Jones, 2013). The symptoms diagnosed led the American Psychiatric Association (APA) in 1980 to add PTSD to the DSM-III as a diagnosis. In addition, prompted continual research on clarification of PTSD (APA, 2013). The clarification of PTSD led to recent data that presented that 4% of American men and 10% of American women diagnosed with PTSD at some point in their life (Friedman, 2015).

PTSD Today

The criteria change in the DSM-5 does not consider PTSD as an anxiety disorder. Most recently, PTSD was associated with depression, anger, irresponsible behavior, unlike the previous years when it was associated with anxiety. A new category linked PTSD to a trauma and stressors related disorder. The symptoms of PTSD now include experiencing a traumatic event, avoiding conditions that remind them of this traumatic event, adverse changes in feelings and beliefs, and hyper-arousal or overreacting to

situations (Friedman, 2015, pp. 2). This new category has led to PTSD not being diagnosed unless the individual display signs of these four symptoms and has occurred over a month time span or affects day to day functionality of the individual (Friedman, 2015).

Today, Marines (Frankfurt, 2015) experience PTSD that was associated with deployment. These deployment experiences include posttraumatic dissociation and survival and safety concerns. The concern that lies with Marines are aspects of guilt and problems that occur due to PTSD. The concern brings my current study to a point of interest where Marines returning home from deployment may not admit to having PTSD because of perception and stigma. It was important to note that the Marine Corps has a unique culture and to Marines returning from combat a diagnosis of PTSD may not be acceptable to continue for promotion, maintain firearms control, or being seen as mentally ill.

Culture of the Marine Corps

The USMC culture and resulting qualities are unique. These range from self-identity to being the larger than life hero in the military spectrum. The U.S. Marine Corps' culture derived directly from history that required a physical force (Bartlett, Phillips, & Galarneau, 2015). To every Marine the understanding of taking this history and making it a part of themselves was the essence of each Marine. A Marine essentially follows the beliefs of understanding that they must uphold the strong stature and hero-like attitude with the upmost confidence. This informed understanding helps supply the primary source that informs the Marine's self-identity (Stephens, 2014). The overall

embodiment of this understanding was the U.S. Marine Corps stance and upheld to the utmost respect for its predecessors.

The Marines carry responsibility for those who have gone before them. Hence, the Marines follow the historical military figures and exemplify certain characteristics of these particular individuals (Stephens, 2014). Embodied characteristics leads Marines to develop and maintain self-identity promoted by the organization. Fundamentally, the Marines operate on the influence of these historical figures and base this on who they should be and how they should behave. The U.S. Marine Corp (Terriff, 2006) carries a complex tradition and mirrored by symbols, rituals, practices, and cultural characteristics.

Marines were thinkers, innovators, improvisers, penny pinchers, brothers, and fighters suggested by Krulak (1984). The cultural attributes were a focal part of the Marine Corps culture. Trained to be warriors and fighters, Marines display confidence in all aspects of Marine Corps life. Marines are prepared to move into combat at any given moment, and they constantly withhold healthy physique, as well as, a healthy mind. Being weak in stature or weak in mind function was unacceptable to the Marine Corps culture, and it was necessary to establish a physically fit body to perform fundamental military tasks (Bartlett et al., 2015). The Marines pride themselves in continuation of strength and stamina to endure the physically demanding combat tours throughout the world (Bartlett et al., 2015).

Overall, the Marines endure the most demanding and longest basic training amongst the military branches. The introductory training starts with 12 weeks of recruit training and ends with four weeks of combat training. The average costs for each Marine

for the duration of basic training cost was between $9,400 and $13,500 to the department of defense (Reis, Trone, Macera, & Rauh, 2015). Nonetheless, the U.S. Marine Corps is the smallest U.S military branch but has the largest infantry in modern history (Kozloski, 2013). This self-contained military force has continued to decline due to costly military personnel and reduced purchasing power (Kozloski, 2013). Over time, a reduction may lead this thrifty organization to a decline in military capabilities that needed to protect the U.S. nation (Kozloski, 2013).

When an individual becomes a Marine, they principally take on the title of the U.S. Marine for a lifetime. The Marine adheres to the standards and duties bestowed upon them. Failure was not a route for Marines. The Marines must abide by its high-ranking reputation and transform into a new way of life. Their integrity was to meet specifications and requirements for a proven military success (Bartlett, Phillips, & Galaneau, 2015). Not upholding this standard was unequivocal and not tolerated in the Marine culture or environment.

Identifying PTSD in Marines

PTSD was not a simple task to identify within the Marine Corps. Over 2 million U.S. service members have deployed to foreign countries (Harmon, Hoyt, Jones, Etherage, & Okiishi, 2012). These deployments had an increase in the number of mental health and PTSD symptoms due to their exposure to combat. It was apparent that the physical and mental effects on Marines after deployment has increased, and the need for immediate identification was suggested (Harmon et al., 2012). As of 2005, the DOD has conducted official screening for Marines returning from deployment during two distinct

time points (Hourani et al., 2012). The first screening time point occurs immediately following the return of deployment. The post-deployment health assessment (PDHA) was the initial screening. The second screening time point takes place 90 to 180 days later and referred to as the PDHRA (McCarthy et al., 2012). Thereafter, military health providers may continue screening at their discretion.

Another operating screening tool used for Marines was the PTSD Checklist-Military (PCL-M). The Marines use this 17-item self-report measure for PTSD screening tool to identify symptoms and assist in conjunction with the PDHA and the PDHRA (Phillips et al., 2010). Although the PCL-M has remained unstudied in specific military sections it was still incorporated throughout the Marines screening routine (Gore, et al., 2013). Historically, the PCL-M in recent studies has concluded to be limited in general quality for diagnosing PTSD (McDonald, Whitney, Benesek, & Calhoun, 2015).

PTSD Screening for Symptoms

PTSD screening was mandatory for Marines returning home post-deployment, and the mental screening became mandatory in 1997. Shortly after there were additional, tools formulated to address concerns of PTSD (Harmon et al., 2012). Presently, there are instruments used by the U.S. Marine Corps to assist in screening for symptoms of PTSD (Steele, Benassi, Chesney, Nicholson, and Australian Army Psychology Corps., 2014). It was an inherent aspect of combat Marines to experience a traumatic psychological event (Walker et al., 2014). The instruments provide possible detection for Marines exposed with PTSD.

Researchers (Riggs & Sermanian, 2012) suggested that therapeutic advances and efforts to prevent PTSD might be a deficient in the screening process. Essentially, this was why the psychological screening tools for PTSD among Marines was essential immediately following post-combat deployment. Several screening instruments used by the Marine Corps are inexpensive and preferred by the mental health division. These instruments include the PCL-M, PDHA, and the PDHRA.

Granted, PTSD remained a unified and cohesive construct expressed by the DSM-5, but was presently more comprehensive (Graham et al., 2016). PTSD symptoms relate to trauma associated with wartime experiences. Notably, the Marines (Graham et al., 2016) encountered elevated rates of PTSD attributed to the cruel nature of combat. Marines and veterans experienced a higher vulnerability and severity of PTSD compared to criminal victimization. This Eludes to view PTSD not only through characteristics of developing this disorder, but also the differences in symptom patterns exhibited (Graham et al., 2016). Recognition of PTSD presented by symptoms uniquely occur.

Consequently, PTSD symptoms presented as experienced hyper-arousal PTSD might re-occur in the future. The increased emotional state (Boden et al., 2016) contributed to the avoidance of emotion and stimuli. In addition, it unveiled depleted cognitive emotions and responsiveness over time. Henceforth, Marines avoided strategies to control emotion, and there was a lower cognitive review for their feelings (Boden et al., 2016).

Posttraumatic Stress Disorder Checklist-Military

The DOD and Department of Veterans Affairs employ the Posttraumatic stress disorder checklist-military version (PCL-M) for diagnosing PTSD among Marines (Chappelle et al., 2014). This screening tool was a 17-item self-report screening instrument and has a high degree of reliability and validity (Walker et al., 2014). The Diagnostic and Statistical of Mental Disorders-4th Edition (DSM-IV) for PTSD criteria was the base for the PCL-M (Chappelle et al., 2014, pp.66). In addition, the PCL-M geared towards military personnel had a range of cutoff scores that mandated specific clinical settings (Walker et al., 2014). The cutoff scores for the PCL-M may differ due to the environment and the way of administration.

The PCL-M helped military clinicians assess symptoms of PTSD that Marines may be experiencing. Current reviews indicated the diagnostic accuracy for PTSD frequently measured by the PCL (Conybeare, Behar, Solomon, Newman, & Borkovec, 2012). The overall makeup of the PCL-M, which was the military version, asks questions that measure the severity level of PTSD (Holliday, Smith, North, & Suris, 2015). In contrast, the Clinician Administered PTSD Scale (CAPS) to differentiate between the intensity and frequency characteristics of PTSD. The use of the desired feature of the PCL-M (Holliday et al., 2015) suggested that the desired feature would be to add the intensity and frequency of symptoms as separate components.

Recently, (Bovin et al., 2015) revealed the updated PTSD checklist or otherwise referred to as the PCL-5 mirrored the criteria of the *Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition* (DSM-5). There are no prior studies validated alongside

CAPS-5 in turn; this resulted in not having a cut-off score for the PCL-5 that could assist in evaluating PTSD in veterans or Marine victims (Bovin et al., 2015 pp.2). Utilizing a cut-off score was vital (Spoont et al., 2015) suggested for veterans because it was widely used by the Veterans Affair (VA) Medical Centers. Without the cut-off score, the compromised reliability for the VA to diagnose PTSD and enduring symptoms may not be identified (Arbisi et al., 2012).

To date, (Wortmann et al., 2016) displayed that the DSM-5 criteria encompassed changes to warzone exposure questions and asked exposed Marines if they incurred specific stressors personally. There were revamped questions for anxiety, depression, guilt and anger symptom questions. Other items added to or edited were the sleep disturbance, alcohol use, and resilience scales. Additionally, a more stringent PCL definition was generated so that when a Marine was rated a one (a little symptomatic) was now required to rate a two (somewhat symptomatic) to meet the PTSD criteria of the DSM-5 (Wortmann et al., 2016). McDonald, Brown, Benesek, and Calhoun (2015) suggested that the PCL has room for improvements in the areas of a better description of participant’s characteristics and reference standard execution coupled with establishing representativeness.

Post-Deployment Health Assessment

The post-deployment health assessment was one of two required brief questionnaires that Marines complete. The Marine completes this questionnaire 30 days following their return from deployment (Macera et al., 2014). Here, the Marine and a trained health care provider are included in the confidential assessment process. Initially,

the Marine completes the questionnaire and then the trained health provider reviews the questionnaire and denotes any concerns in the final section of the PDHA. Lastly, there is a face-to-face interview with the Marine and trained health care provider to review and assess responses of the Marine's PDHA (Macera, Aralis, McRoy, & Rauh, 2014).

After the face-to-face interviews, the trained health professional decided if there was a need of further warranted referrals for behavioral health. The face-to-face interview stage was an important phase within the PDHA. It allows the trained health care provider to identify mental health issues and deliver follow-up consultations and treatments if needed (Harmon, Hoyt, Jones, Etherage, & Oklishi, 2012). These interviews also assisted in detecting high-risk occupational and environmental exposures that transpire during combat deployment (Luse, Slosek, & Rennix, 2016).

This screening used to identify health problems along with mental health issues linked to deployment stress (Hourani et al., 2012). This screening process assists the Department of Defense (DOD) to develop valid services and treatment for Marines who exhibit PTSD issues or symptoms. Conversely, this two-part process has resulted in errors and follows up with a subsequent screening (Harmon et al., 2012). The additional screening following the PDHA referred to as the PDHRA occurred 3 to 6 months later (Hourani, et al., 2012). The PDHA was one-step of the post-deployment assessment plan.

Post-Deployment Health Reassessment

Mandated in 2006, the PDHRA initially was introduced by the DOD in 2005 that continues to identify health concerns that surface post-deployment (Hourani et al., 2012). Administered to Marines 90 to 180 days post combat deployment, the PDHRA showed

improvement in 2008 due to the addition of traumatic brain injury (TBI) and alcohol misuse questions (McCarthy et al., 2012). It was equivalent to the PDHA in that it assesses the physical health component and symptoms of PTSD.

The screening was web-based and consisted of a 3-page self-report questionnaire that was a nearly identical screening tool to the PDHA. The PDHRA encompasses questions that relate to general health, demographic characteristics, physical symptoms, environmental exposure, as well as, mental health issues associated with the deployment. More importantly, it was a tool that was the last of a series of test that the DOD utilize to pinpoint Marines who are suffering from distress due to a combat deployment (McCarthy et al., 2012).

The PDHRA (Luse et al., 2016) continued to assist in helping to detect mental health concerns for Marines after their deployments and regardless, the previous results of the PDHA. In addition, the PDHRA continues to evaluate depression and PTSD. It acts as a follow-up exam to Marines that may remit symptoms later after deployment. Prior research (Harmon, Hoyt, Jones, Etherage, & Okilshi, 2012) indicated that military personnel might not report symptoms until 3 to 6 months following combat deployment.

An intricate process of the PDHRA was its ability to provide commanders a monthly update on the level of the Marine. Although, it does not provide information regarding the PDHRA results it does allow for support within the commanding ranks to provide efforts towards treatments (Harmon et al., 2012). The commander has developed feedback of the PDHRA to initiate unit-level interventions and assist in leadership adjustments according to the reports. In addition, the PDHRA provides an opportunity for

the Marine and a trained health care provider to discuss any potential issues and health concerns that are about PTSD (Marcera, Aralis, McRoy, & Rauh, 2014). In essence, the PDHRA can support further understanding of factors that might increase the risk of adverse outcomes such as depression and suicide following several months after deployment (McCarthy et al., 2012).

Perceived Medical Care Barriers

There are certain essential qualities of a Marine when zoning in on the Marine Corps environment that might deliver a barrier for treatment. Ultimately, negative stigma was associated with PTSD and mental health disorders. The culture for the Marine Corps was realizing the mentality to obtain physically capable force at all times and to perform tasks at a Marine level (Bartlett et al., 2015). Marines who return from combat deployment did not seek treatment for PTSD because they feared of placed stigma around their name and this might potentially cause issues with their current position and eventually judge them for future promotions (Mittal et al., 2013).

Ultimately, the negative stigma acts as a barrier for the Marine because it places a fear that their superiors will frown upon a diagnosis of PTSD and place hardships while continuing to perform in their current position. Past studies (Zinzow et al., 2013) showed that a diagnosis of PTSD could potentially harm a Marine’s career. The potential worries were the possibility of holding them back for promotion, treatment time, obtaining their weapons, and security clearance (VanSickle et al., 2016). As a Marine, it was essential to surround yourself with the ambiance of being tough and this was the norm. If a Marine

admits, to having PTSD it could display a sign of weakness and this poses a barrier for Marines to be honest when answering specific screening questions post-deployment.

Followed by the stigma of being a weak Marine, there was also a stigma that prohibits a Marine not to respond to the screening questionnaires honestly, and that was due to the fear the branding as crazy. This can also act as a barrier to care for Marines with PTSD. If the Marine was not willing to admit to the symptoms due to the anxiety of the repercussions, then it was quite challenging to health care providers to diagnose and treat them.

The medications prescribed for a PTSD diagnosis can alter the Marines ability to perform a high level. The medication can potentially affect the Marine’s mental ability to react in a timely fashion or possibly have a reverse reaction Marines might become disengaged and display anger or unruly behavior (Mittal et al., 2013). Moreover, the stigma for a Marine can act as a barrier to care and if the Marine finds it embarrassing, they will not want to seek help because they do not trust trained health care professionals (VanSickle et al., 2016). Lastly, the stigma and labeling with PTSD could cause the Marine’s unit to lose confidence in his or her ability to perform their duties, therefore; this could act as the barrier for treatment again because the Marine may not be forthcoming with the screening process (VanSickle et al., 2016).

Current Study Based on Past Research

The present qualitative study was required for the Marines to express their perceptions of the PTSD screening process and attached stigma. The Marines’ appreciated experiences was through the voice of many veteran Marines. Through the

understanding of these perceptions and beliefs of Marines can lead to a clearer thought process concerning associations of PTSD and promote changes in the way delivered healthcare ensued to these individuals (Leardmann et al., 2013). Increased awareness on how PTSD affects Marines and how they cope can yield to positive outcomes towards the stigma placed upon the Marines.

Past researchers (VanSickle et al., 2016) demonstrated the perceptions of Marine non-commissioned officers (NCO's) and their perceptions of the diagnoses with PTSD. The study revealed barriers to receiving treatment for PTSD and how the Marines received the post-deployment screening process. This research exposed Marines with higher education and training were more likely to have barriers to seeking care for PTSD. Marines with little or no education and experience tend to have fewer perceptions and barriers to care for PTSD (VanSickle et al., 2016). This tie into the current study to demonstrate the relationship of perceptions of Marines and the PTSD screening process. It noticeably correlates experienced Marines are inclined to withhold information due to the fear of stigmatization of PTSD and inexperienced Marines are inclined to fewer perceptions and barriers to care.

Other studies address perceptions of stigma associated with PTSD. A particular study conducted by Britt et al., (2015) addressed the different stigma perceptions in treatment and dropout among active duty personnel. The study examined four different stigma perceptions that included career stigma, treatment stigma, self-stigma from seeking treatment, and perceptions of stigma if the military personnel sought treatment for mental health problems. The study examined one thousand three hundred twenty-four

active duty soldiers that completed a self-report survey assessment that measured the stigma perceptions in detail by health symptoms if they received mental health treatment, and whether they had dropped out before treatment ended (Britt, et al., 2015).

Within this study, it was revealed that military personnel seeking treatment for mental health illness like PTSD had a higher probability of dropping out or not seeking treatment due to the stigma that are placed upon them. The study yielded concern and the need for further research on the outcomes of how the stigma perceptions affect the military personnel (Britt, et al., 2015). The study exposed the need for awareness among health care providers on how the stigma perceptions can influence these individuals who are seeking mental health treatment. The research focused on military personnel dropping out of treatment compared to previous military conflicts (Britt et al., 2015). Additionally, the study revealed that self-stigma from treatment correlated directly with the treatment dropout. Overall, the importance highlighted within the research expresses that the perceptions of stigma on mental illness among military personnel have predictors from those who seek treatment and self-stigma among the military personnel with treatment.

A Community in the Southern United States

The attention on this study was to seek out the perceptions of Marine veterans concerning the PTSD screening process and the attached stigma. The area was geographically located in the Southeastern section of the United States where over 16,983 Marines receive their basic training (Marines, 2014). Specifically, Marines and veteran personnel occupy this area alike. Many of whom were involved in combat tours and

experienced the PDHRA. This area was ideal for obtaining the perspectives about the PTSD screening process and the possible attached stigma of PTSD.

This community in the southern United States was part of the eastern recruiting region that encompasses 8,095 acres of land of which 3,262 are habitable, and the remaining acres was primarily salt marsh (Marines, 2014). Since 1915, this community designated training for male Marines. After that, in 1949, female training began and to date was the only base that performs initial training for all U.S. Marine recruits (Marines, 2014). This recruiting depot consists of 23,608 total individuals of the local area population. Conversely, this total was a combination of 3,204 retired military, 18,643 enlisted Marines (16,983 being recruits), and 288 officers (Marines, 2014).

MCRD Mission and Vision

The MCRD's mission and motto are "We Make Marines". This mission and motto transformed by recruiting high caliber men and women (Marines, 2014). Arduous training placed on recruits and the continued commitment to the produced legacy of MCRD, and the willingness to uphold the duty to defend the U.S nation in battle and service defines this mission (Marines, 2014).

The MCRD's vision was (Marines, 2014) viewed to be the nation's premier recruiting depot where male and female Marines are transformed into viable and sustainable Marines. The Marines adhere to the Marines' core values coupled with the selfless act to serve our U.S. nation and protect the great legacy of this community in the southern United States. The achieve vision appeared through maximizing efficiencies and

preserved integrity for the men and women who stood before them in the southern United States community.

The realization that Marines face trauma in the combat zones that leaves them scarred for periods of time or could even last a lifetime was concerning. Their lives may never be the same after these experiences. Explored methods would be useful in defeating negative stigma surrounding mental health treatment in the Marine Corp was of top priority according to (Hall, 2015). Increased understanding of the process to serve the Marines better was of equal importance due to the increased suicides involving Marines within the year of 2015 (DOD, 2015).

Nonetheless, the Marine Corps and the DOD have taken measures to continue research on different techniques and methods that would allow for improved test questions. Incorporated stepped PTSD screening and intervention procedures has evolved (Russo, Katon, & Zatzick, 2013). Yet, (Hourani et al., 2012) suggested that mandated PDHRA might not be effective due to conditions that may stimulate untruthfulness among the Marines. This untruthfulness coincides with the current problem of an inefficient screening process due to the stigma placed on Marines and therefore, they are not willing to say how they feel due to the repercussions.

Impressions of Insufficient PTSD Screening

The impressions of insufficient PTSD screening for Marines can be due to the offered screening or the environment it coupled with the behavioral components (Boden et al., 2016). A limitation of the PTSD screening process was determining if the PTSD symptoms were current or occurred over time. Data from the DOD elucidated this

evidence due to increased suicides of Marines (DOD, 2015). The ineffective PTSD screening process for the Marines and the linked stigma can prevent Marines from seeking treatment (Mittal et al., 2013). Therefore, the insufficient impressions of the PTSD screening process may need a closer evaluation.

Various limitations can affect the screening process. These limitations include studying PTSD as one entire unit disorder due to experiences and not zoning in to study a particular identified trauma (Boden et al., 2016). Time constraints and utilizing an all-male participant panel can limit the perception of an inefficient screening process because males predominantly suppress emotion and feelings (Boden et al., 2016). Therefore, an accurate representation of symptoms was not apparent when examining the Marines' screening results. Additionally, self-reporting measures can limit the ability to express the trauma-related PTSD symptoms cognitively.

Several researchers from Madigan Healthcare System and Columbia University Medical Center have studied the efficiency of the post-deployment screening process (Skopp et al., 2016). Researchers (Skopp et al., 2016) asserted that the PDHRA was a global health assessment and not a selection tool. This screening tool can examine PTSD and contribute factors such as substance and alcohol abuse. No research has examined the diagnostic efficiency of PDHRA relating to alcohol screening (Skopp et al., 2016). The PDHRA for Marines potentially can de-stigmatize mental health care. An increased efficiency screening process might sustain the effort of continuous monitoring and not stop at the three-month reassessment (Graphiq, 2016).

Summary and Conclusions

In summary, this literature review has explored previous research of the Marines PTSD screening process and the attached stigma. The SCT theory provided a foundation for addressing the underlying identification for this study. In this chapter, various research studies as Graphiq (2016) reveals how important an efficient PTSD screening process was to this mental health issue within the USMC.

I addressed past and present studies to provide an understanding of war and combat trauma and the barriers that Marines face when seeking PTSD treatment. The study delivered forthcoming answers from Marines to satisfying the PDHRA questions that misrepresent attached stigma associated with labeled mental issues and PTSD (Britt et al., 2015). This study did not display how women Marines perceive the PDHRA and attached stigma.

This study drew attention to the significance of an efficient screening process for PTSD among U.S. Marines. This literature review prompted a clearer understanding of symptoms, barriers, and stigmas connected to PTSD. Although ongoing improvements for the PDHRA are present, a gap in the literature exists because there do not appear to be any research regarding the perspectives from Marines. In sum, the study focused on developing patterns and meanings of PTSD and stigma among Marines. Mainly, the dissemination of these study's findings to stakeholders such as military chaplains and veterans' health service providers contributed to informing awareness about the PDHRA through the lens of Marines and assisted in future forthcoming answers and treatment of PTSD. The next chapter includes the purpose, research design, and rationale, role of the

researcher, methodology, participant selection logic, instrumentation, pilot study, and the study results.

Chapter 3: Research Methods

Introduction

Health professionals may realize the importance of the PTSD screening for Marines, but they may not fully understand the Marines' perspectives while experiencing the PDHRA and attached stigma. The purpose of this qualitative phenomenological study was to explore the perceptions of PTSD screening and potential stigma among Marines located in a community in the southern United States. This chapter addressed its problem and purpose of this study and methodology.

Followed by my role, as a researcher within this study was the research and design rationale addressed. Next, the method section, the participant selection logic and the criteria for the participant selection was included. Then, I revealed the data collection and instrumentation along with data analysis. After that, the issues of trustworthiness and ethical procedures that comprised of areas of credibility, transferability, and confirmability are covered. The chapter concludes with a summary and transition to chapter 4.

Research Design and Rationale

Phenomenology allows a researcher to set aside induced interpretations of phenomena. This study employed a phenomenology was because, according to Converse (2012), phenomenology allows researchers to explore and understand experiences without preconceived notions of the experiences. Some deviations exist with the phenomenological approach, but this phenomenology was a philosophical perspective that grants the researcher to be open to what the phenomenon presents. This method

permitted the researchers to understand the lived experiences and how the phenomena was perceived through the participant's veracities (Converse, 2012)

Lived experiences of the Marine participants expressed their interpretation of the PDHRA and attached stigma of PTSD in this study. The lived experiences deliver an understanding of the genuineness in regards to the Marines' experiences with the PDHRA and attached stigma with PTSD to provide an effective PDHRA and promote a healthy lifestyle post-deployment. The research questions that assisted in further understanding are:

RQ1: What are the perceptions of Marines about the PTSD screening process?

RQ2: How does the potential stigma surrounding PTSD hinder the decision of Marines to report PTSD symptoms while completing the PDHRA?

The Marines' perspectives were the primary emphasis of this study. Exploration of Marines' perspectives were to gain an understanding of the PDHRA and attached stigma. Marines' experiences encompassed behaviors, viewpoints, and perspectives. Although health professionals understand the importance of the PDHRA, they may not understand how Marine perspectives of the PDHRA can promote a stronger understanding on the attached stigma associated with PTSD and the Marines' mental stability post-deployment. Insufficient understanding of the PDHRA can lead to minimized evidenced-based practices according to (Wisco et al., 2012) and may cause unforeseen mental health issues like PTSD that might result in death. A consistent implementation of the PDHRA may lead to effective treatment planning for Marines.

Within this qualitative phenomenological study, the method used to analyze the interviews may distinctively use Colaizzi's (1978) strategy and qualitative approach. This approach encourages the researcher to make an explicit theoretical position (Sosha, 2012). It delivers the stance for obtaining appropriate reliability and validity through the established analytical lens of examined and identified data. An Applied phenomenological method can provide the exploration of in-depth interviews and identify lived experiences of the participants (Cooper & Endacott, 2007). Within this study open-ended interview, questions used comprehensive perspectives from the participants' viewpoints and experiences. Colaizzi's (1978) approach according to Shosha (2012) enhances rich, in-depth descriptions. Colaizzi's approach was ideal for this study and might assist in producing relevant health care findings for Marines. Additionally, another paradigm would be less effective because they do not draw from lived experiences of phenomena.

The use of Colaizzi's (1978) strategy employed for this study's data analysis incorporates several steps. The seven unique steps represent Colaizzi's (1978) strategy. The first step was to read and re-read each transcript to obtain a general understanding of the overall content (Shosha, 2012). Second, I recorded significant statements and placed them on a single sheet that denotes specific lines and page numbers. In the third step, meanings conveyed from these significant statements. Fourth, I articulated the meaning and categorized them in clusters of themes. Fifth, an exhaustive description of the study's phenomenon may result from the findings. Sixth, I described the fundamental construction of the phenomenon. The seventh and final step, I validated finding derived

from the research participants in order to evaluate the descriptive results from the researcher and the participant's experiences.

Through Colaizzi's (1978) phenomenological strategy and methodological approach, it exposed ways to find meaning of the participant's experiences through their point of view. The Colaizzi's (1978) strategy proves successful within studies associated with health care and human behavior (Bertram & Magnuusen, 2008). The use of this methodological approach for the eidetic phenomenological study directed the preposition of uniquely human experiences. Additionally, this phenomenological method provided in-depth responses and reliable descriptions that the researcher furnished.

Role of the Researcher

The role as a researcher encompassed data collection and analysis of a pilot study that was comprised of two participants with health care experience. Marine participants had no affiliation with me on a personal or professional level. Not being associated to the participants allowed for an authentic line of communication because there were no imposed authorities to sway the Marine participants' when answering the open-ended interview questions.

The use of face-to-face interviews can create biases. As a researcher, I managed my biases by being well versed in the topic. Managed biases at the beginning of the study and continuing through the data analysis process assisted the research with unintended biases. The questions are complete in nature with no modified questions that lead to induced responses (Silva et al., 2015). I organized the data by placing it into specific themes and trends. This allowed me as the researcher to set aside preconceived thoughts

that might impede with developing themes within the collected and analyzed data (Krauth, Woodruff, & Bero, 2013). This accomplished organization used a journal that reflected and organized my thoughts and ideas.

Ensured credibility and trustworthiness was also a role of mine as a researcher. The use of employed triangulation according to Bandura's (1986) captured relationships, environment, and behavior to ensure the credibility and trustworthiness of this study. Next, as a researcher, the field notes and audio recordings from the participant interviews was compared to my coded data in NVivo as suggested by Bergin (2011) and presented an audit trail for reviewers that establishes credibility and validity. Throughout the data, collection and analysis process a kept journal provided reflection.

A conducted pilot study ensued to validate my research questions and further ensure credibility. The pilot study assisted in the confirmation of my research questions and validate that the questions are in line with what they are supposed to do. Like Heidegger, it allowed me to uncover the essence of the phenomenon (Converse, 2012). To further my study's credibility, a participant follow-up transpired if the data collected was in question or for further clarification.

The protection of human subjects was a priority during this study. To ensure this protection, I completed the National Institute of Health's human research subject training (Appendix E). At the beginning of this research, there was no anticipation of ethical concerns as it relates to my research questions. PTSD can be a sensitive issue so there was implemented comfort and support for diversity during the face-to-face interviews (Parent et al., 2015). If at any point during my interviews, the participant becomes

emotional or withdrawn due to the interview questions I immediately stopped and provide them another opportunity to finish or complete the interview by way of internet or telephone. Eliminated risk of emotional stress for the participants might promote a willingness for continued honesty with the participant’s answers.

The Walden University’s Institutional Review Board (IRB) allows the researcher to provide thank you gifts to the participants that may not exceed $5 in value (Walden, 2015). At the end of my interviews, I provided an ice cream gift voucher that was valued at $5. I presented each Marine interviewee at the close of each interview with this voucher. The voucher had an attached personalized note that thanked each participant for taking the time to answer the research questions and joining the efforts to promote social change by providing their experiences to help support an understanding of the PDHRA and PTSD attached stigma. Additionally, in the latter part of chapter 3, was an explained detailed description of this study’s ethical procedures and trustworthiness.

Methodology

Participant Selection Logic

The population was post-deployment USMC veterans located in a community in the southern United States. The Marine Corps Base location was ideal due to the proximity of the respondents. The study’s sample included 10 from this study. The gender was all-male population because the male gender tends to withhold feelings and emotions. The age and race ranged in diversity. A presented convenience-based sampling across this USMC veteran population and the use of open-ended interview questions helped safeguard validity (Marshall et al., 2013). Additionally, this phenomenological

study incorporates this specific group of USMC veterans because they have experienced the similar phenomenon researched.

Inclusion Criteria and Sample

The logic for participant selection within this study was grounded upon post-deployment USMC veterans who range in age and rank and speak English. The participants are willing to sign an agreed informed consent. The number of participants was 10 Marines. The selection for this sample size are rationalized according to the guidelines of researcher methodologists Marshall et al., (2013) because it fell into the range of 6-10 participants and did not exceed 10 participants.

The smaller sample size was practical and less time consuming and may alleviate useless material (Marshall et al., 2013). A Focus on the question during the interview process was necessary for collecting a study's data, and the synchronous communication allows for spontaneous answers with no extended reflection (Opdenakker, 2006). The overall data collection incorporated an interview population of 10 Marines located in a community in the southern United States and utilized open-ended interview questions.

When the Walden University IRB approval was granted for this study, there was an outline of my procedures. This outline was located within my IRB application and denoted the procedures used to recruit and identify participants for this research study. Communication through former colleagues was used to obtain the qualified participants. Once each participant accepted the invitation to be a part of this study, an informed consent was completed. An interview protocol was provided to each participant before the interview. This sample size was recommended by (Marshall et al., 2013) and

suggested that an appropriate size to reach data saturation. This study will fall within these guidelines and will reach the above- suggested research saturation.

Data Collection and Instrumentation

This data collection instrument for consisted of me as the researcher and an interview tool that consisted of open-ended questions derived from suggested prior studies noted in my literature review (Appendix C). Once I receive IRB approval from Walden University (12-12-16-0300960), participants were recruited. Communication through internet-based media sites and individuals in the community was used to obtain participants. In addition, a flyer was provided to currently employed DOD veterans to post on the USMC base bulletin boards and health facilities upon their employer's approval.

After receiving the required informed consent from the participants, interviews were conducted. The interviews were through face-to-face interviews, and an audio recorder was present to recall information provided by the participants. The interviews were transcribed and NVivo 11 analyzed the qualitative data for this study (Bergin, 2011). The transcription will provide a review of the data collected and an organized management of the data. The assurance of the participant's involvement was compared to each participant and the number they are provided within the research study. Field notes assisted me as the researcher in the case of a failed interview recording session. Finally, establishing a good rapport with the participants provided a variety of interview parts. This might allow the participant to disclose additional information regarding the experiences with the PDHRA and PTSD attached stigma.

An incorporated interview protocol (Appendix C) provided prior instructions for the interview. The use of probing questions and the ontology of the phenomenological study can assist me as the researcher to bracket out assumptions and discover the essence of the phenomena (Converse, 2011). This study's questions were reviewed and validated by two Marines that were involved in the PDHRA and potentially had PTSD stigma associated to their name. The expert review aligned with my scope and content within this study. The rationale provided was in accordance with my interview questions and their association and alignment of the study's research questions.

Procedures for Pilot Study

My pilot study will consist of the two Marine veterans who are not participants in my study to pre-test the interpretation of my interview questions. The Selection of two participants will help me to narrow down the feasibility of the study and my research participants will display appropriate strategy for a pilot study according to Kannan and Gowri's (2015) recommendations. This procedure helped me to adjust any errors and enable me to correct or reformat my questions before my interviews of the participants take place. Furthermore, it provided an understanding of proper vocabulary used when phrasing my study's interview questions.

Within the procedures of this pilot study, I presented an informed consent, interview tool, and recruiting flyer (Appendix A) to the participant. These items are found in the appendix section of this study. There are no foreseen issues with this pilot study, but if there are needed corrections the modifications were presented before the study's interviews take place. The corrections would be upon IRB request for approval.

Procedures for Recruitment, Participation, and Data Collection

The data collected for this study will derive from Marines and will encompass convenience-based sampling within the community in the southern United States. As mentioned earlier, upon IRB approval the interviews were conducted through face-to-face interviews that will use an audio recorder. The audio recorder used depends on the reluctance of each Marine. Thereafter, the interviews were transcribed and a report was formulated to provide accuracy of the information that was collected from the face-to-face interviews. Throughout this interview process, there will be a continued recruitment for participants until the set goal reaches 10 participants. The completion occurred by a continuance use of internet-based media and recruiting flyers.

The interviews will provide each participant the option to withdraw from the interview process. If this occurs, I will proceed with continuing to engage in recruiting for participants to replace the dismissed ones. There will be follow-up arrangements made with each of the Marines if there was a need for additional clarification.

Data Analysis Plan

This study’s data analysis plan replicated Colaizzi’s (1978) strategy that includes six of Calaizzi’s seven steps. The following represent the steps and actions taken and how the steps were used within the data analysis process.

1) Each interview will be transcribed from the Marines interview dialog and place within the NVivo data analysis software to generalize the sense of the content
2) Significant statements that pertain to the phenomena should be extracted

3) The meanings should be interpreted from the Marines' significant statements
4) Categorize the interpretations into clusters and themes
5) Narrate the findings of the study and integrate this information into an exhaustive description
6) Describe the fundamental structure of the phenomenon

The above list replicates Colaizzi's (1978) strategy, and the information incorporated into NVivo software was to organize the data collection and form the Marine interviews. The NVivo tool (Bergin, 2011) allowed appropriate themes and trends in the data collection to. This arrangement promotes an understanding of the primary phenomena through the Marines' lived experiences.

Issues of Trustworthiness

Credibility

The perspectives of this phenomenological study are credibility and trustworthiness. As asserted by Lincoln and Guba (1985), there are specific criteria utilized for the quality of a phenomenological research that include credibility, dependability, confirmability, transferability, and most recently added was authenticity in 1994 (Cope, 2014). Before my research began, I completed a trustworthiness training that certified me through the National Institute of Health Office of Extramural Research. This training was to protect human participants involved in the research (Appendix E). I will maintain credibility by following the IRB collection of data process and maintain a professional manner while conducting my research interviews.

Consider this study credible due to the recognized descriptions of individuals who experienced the same phenomena as Cope (2014) asserted. I will allow one hour for each interview to ensure a good rapport with the participants to obtain detailed and rich descriptions of the participants' experiences. To support the credibility of this study, I will display observation methods and audit trails from a reflexive journal. Additionally, this reflexive journal will reflect on thoughts and feelings and enable me to bracket the perceptions and reduce biases (Cope, 2014). Followed by each interview, I will transcribe the interview and provide the transcribed report to the participant to confirm the information was accurate.

Transferability

This research study applied an established transferability. Results provided meaning to other readers that associated the results and generalized the experience of the PDHRA and PTSD attached stigma (Cope, 2014). This study provided the reader with sufficient information on the context of the study and enabled to investigations of other studies on the PDHRA and PTSD attached stigma. This information can be transferable and provide dissemination to stakeholders such as military chaplains, veterans' health services, and possibly filter over into outside health services to help inform and prompt discussion on the issue of attached stigma with PTSD and the screening tool for PTSD.

Dependability

Within this study, the constancy of the data reached dependability. There was attained consistency of the data through audit trails and triangulation where multiple sources utilized rich data to draw conclusions (Cope, 2014). NVivo 11 software

organized the interviews and questions into themes and trends, to allow for interpretation by other readers (Bergin, 2011). Additionally, the use of Colaizzi's (1978) methodology and 7 steps allowed other researchers to replicate within similar circumstances for future studies.

Confirmability

Confirmability and reliability achieved in this study through checkpoints of reviewing each transcription and assuring the use of member checking that gives respondents provisional findings, or associating a number with each participant. As the researcher, I established interpretations that derive from the data (Cope, 2014). The exhibited interpretations in the study by providing rich quotes from the participant that described emerging themes (Cope, 2014). In the case of arising issues, my committee was responsible for informing me.

Ethical Procedures

I identified ethical procedures and followed them throughout this research study. My IRB approval number was 12-12-16-0300960. Provided to the interviews and informed consents was the approval number and expiration date. The recruited participants were in an ethical manner by recruitment flyers, communication, and informed consents. I treated each participant with courtesy and professionalism. The identity of the participants was confidential. The obtained confidentiality resulted from concealing the participants' names and using a numeric identifier, along with false names. During the interviews, I am empathetic to each situation and incorporate

appropriate listening techniques that provided the interviewee time to explain their thoughts and concerns.

Within this study, the participants provided information that they are participating in a voluntary interview. The participants will have an understanding that the interview will last approximately one hour in length. Again, after the interview, I will provide the participant with a written report of the transcribed interview. This will allow the participant to review for verification of accurate information. In addition, there will be an understanding of the participants that at any moment during the interview they become uncomfortable it was their right to decline the forward movement or continuance of the interview. As a qualitative researcher, I will provide a listing of available free resources (Appendix F) if the participant becomes emotional or withdraws.

As the researcher, along with my dissertation committee at Walden University will obtain the confidentiality of this study's results. There was no believed associated risk for participating in this study. Although, if a Marines becomes emotional a continuance of the interview can be obtained by telephone or the internet. The electronic information provided by NVivo 11 was a secure and protected password. Placed in a locked and secured box were all the written documents. Additionally, all documents will remain in a secure storage place for five years according to, Walden University (2015).

Lastly, I ensured all interviews took place in a safe environment. The venue was in a nearby location that was in proximity to me as the researcher and the participants. Adherence to the Walden University IRB in regards to the thank you gifts for participants that will not exceed $5 in value was upheld (Walden University, 2015). Provided to each

participant was an attached $5 ice cream voucher. An attached personal letter thanked the participants for their involvement in promoting social change for the PDHRA and PTSD attached stigma.

Summary

Throughout this chapter, a description of the research design and rationale, role of the researcher, methodology, participant selection logic, instrumentation, pilot study procedures, recruitment, participation, data collection, data analysis, issues of trustworthiness and ethical procedures provided. In the following chapter, a summary of the pilot study, research settings, demographics, data collection, data analysis, evidence of trustworthiness, and a detailed description of the study's findings provided.

Chapter 4: Results

Introduction

The purpose of this qualitative phenomenological research study was to explore the perceptions about PTSD screening and potential stigma among Marines located in a community in the southern United States. The research questions (RQ) were the following:

RQ1: What are the perceptions of Marines about the PTSD screening process?

RQ2: How does the potential stigma surrounding PTSD hinder the decision of Marines to report PTSD symptoms while completing the PDHRA?

In this chapter, I provide an overview of key results on Marines perspectives on PTSD screening process and attached stigma that guide to the conclusions in Chapter 5. In this chapter, I describe the pilot study, research setting, demographics, data collection, data analysis, evidence of trustworthiness, and results. In the next chapter, I provide final discussions, conclusions, and recommendations.

Pilot Study

My pilot study consisted of the two Marine veterans who were not participants in the study to pre-test the interpretation of my interview questions. The selection of two participants helped me to narrow down the feasibility of the study and my research participants to display appropriate strategy for a pilot study according to Kannan and Gowri’s (2015) recommendations. I conducted a pilot study in December of 2016. The selection of two Marines for the pilot study assisted with corrections of any flaws before conducting the main study. I conducted a pilot study to test interview questions before I

interviewed selected participants of my study. The pilot study was conducted separately. I did not include the results in the dissertation because the pilot study only helped to refine the research methodology. Two Marine veterans were recruited for the pilot study using recruitment flyers (Appendix A), informed consent (Appendix B), and interview tool (Appendix C).

The study's purpose, demographic data was explained for the pilot study and a gained informed consent was obtained from each participant. The participants provided informed consent prior to commencing with the interview. If there were any questions from the participants, they were addressed prior to initiating the interview. Interviews began by recording participant demographics (Appendix C). Each participant was given a specific number. This ensured the clarity and position of each participant throughout the study.

Each of the participants were informed of using an audio recorder. The participants were asked if they desired a transcript of their interview. An explanation of the interview process occurred prior to starting each individual interview. The mailing addresses were verified for each participant so I could send a thank you note following each interview. Participants were thanked for their willingness to participate in the study at the beginning of each interview and at the conclusion of each interview.

After each individual interview, the transcribed data was placed in to a secure folder for future reference. Both participants did not want to view the transcribed copy due to time constraints or they had confidence that the interviewer would provide their stated answers to each interview question in a truthful form.

The pilot study was productive because it allowed me to continue forward with the main study without changes to the original proposal. The pilot study saved time and revisions to move forward with my study. The use of recruitment flyers and informed consent proved to be successful tools to generate participants. The recruitment flyers allowed me to explain what the study included and the type of participants needed.

To provide an understanding of proper vocabulary used when phrasing my study's interview questions a flight surgeon was consulted. The flight surgeon, who was a subject matter expert for my study, ensured the phenomenological interview questions aligned with my research questions response validity. The pilot interviews averaged 30-35 minutes and spawn pages of rich and descriptive information. No changes were necessary for the instrumentation or data analysis strategies. The same data collection and analysis procedures was used for both the pilot participants and the main participants. No major issues arose during the pilot study. If issues arose then the IRB was contacted to request approval for any modifications.

Research Setting

Conducted research for this qualitative, phenomenological study took place in December 2015 by private recorded face-to-face interviews with 10 Marines from a community in the southern United States. The location was ideal due to the proximity of the respondents. The interviews were in a private library room with only the interviewer and the interviewee. This setting mitigated stress and anxiety with a private room and reassurance that the interview would remain confidential. An audio device recorded the interview session. All interviews were in the private library setting to ensure no issues or

discrepancies would occur within my study's results by using a safe environment that was convenient to the participant and interviewer.

A retained log came about when scheduling my interviews with Marines. This log consisted of dates, times, and contact information. There were no personal or organizational information attached to this document. To preserve confidentiality the use of only the first name appeared on the schedule. No outside sources or conditions influence participants at the time of the study. The main participants never withdrew from the study. All scheduled interviews occurred during the scheduled time. There were no rescheduled interviews due to unforeseen circumstances or prior obligations.

Demographics

The demographics and characteristics of the 10 face-to-face interviews from a southern community in the southern United States vicinity included rank, age, years of service, and number of deployments. The demographics and characteristics are relevant to the study because they provided clarification to the study and defined each participant. Each of these characteristics were listed in Table 2

Table 2

Characteristics of Participants

Participant Demographics

Participant	Rank	Age	Gender	Years of Service	# of Deployments
Participant 1	First Sergeant	41	Male	22	1
Participant 2	Chief Warrant Officer III	43	Male	25	4
Participant 3	Major	42	Male	20	3
Participant 4	Major	44	Male	24	6
Participant 5	Chief Warrant Officer IV	52	Male	22	7
Participant 6	Chief Warrant Officer II	48	Male	20	5
Participant 7	Gunnery Sergeant	56	Male	20	2
Participant 8	Staff Sergeant	38	Male	18	5
Participant 9	Staff Sergeant	36	Male	16	2
Participant 10	Staff Sergeant	47	Male	20	5

Data Collection

Interviews

The data collection derived from 10 audio-recorded face-to-face interviews in a private library room that lasted approximately 35 to 40 minutes. Participants consisted of male Marines who lived in close proximity to a community in the southern United States. Appendix C displays the interview protocol used. The protocol comprised of interview questions and validated by two Marine veterans and a subject matter expert to ensure the alignment of the interview questions were within the scope and content of the study.

Data Masking

I protected the identity and confidentiality of the participants by masking their names and using participant numbers. An Audio recorder documented my face-to-face interviews. My laptop computer with secure passwords to ensure privacy saved the interviews. The use of unique participant numbers allowed me to honor the privacy of all parties involved. The unique identifiers provided in Table 3 included participant ages, rank, and number of deployments.

Table 3

Data Masking

#	Unique Numeric Identifier	Participant Rank	Pseudonym Name	Gender	Participant Age	Military Status
1	01-12182016-1000	First Sergeant	Jema	Male	41	Retired
2	02-12182016-1100	Chief Warrant Officer III	Toda	Male	43	Retired
3	03-12182016-1300	Major	Hoje	Male	42	Retired
4	04-12182016-1600	Major	Meru	Male	44	Retired
5	05-12202016-1500	Chief Warrant Officer IV	Irao	Male	52	Retired
6	06-12222016-1100	Chief Warrant Officer II	Demo	Male	48	Retired
7	07-12222016-1200	Gunnery Sergeant	Fike	Male	56	Retired
8	08-12232016-0800	Staff Sergeant	Roba	Male	38	Retired
9	09-12232016-0900	Staff Sergeant	Abbri	Male	36	Retired
10	10-12232016-1000	Staff Sergeant	Dijo	Male	47	Retired

Participant Profiles (Pseudonyms)

Throughout the data collection, information profiles of the Marines emerged during the face-to-face interviews process. Below are the provided profiles in narrative format. The profiles include possible used background and content for future discussion. Variations or unusual circumstances associated with the participant are included in the profiles. The profiles were summarized by the denoting the participant number and unique identifier. The summary was based on age, rank, and number of times of deployment.

Participant 1, # 01-121816-1000, Jema, was a 41-year-old First Sergeant Marine male who provided the USMC 22 years of service. He resides in a community in the southern United States. He has experienced one wartime deployment outside the United States. This deployment was in Iraq and lasted seven months in length. He is now retired and notes he received disability from the USMC due to PTSD and combat affiliated experiences. He received therapy in the past and still deals with the wartime experiences and flashbacks to date. He now owns his own landscaping business that allows him to enjoy an outside environment.

Participant 2, # 02-121816-1100, Toda, was a 43-year-old Chief Warrant Officer III Marine male who provided the USMC 24 and a half years. He resides in a community in the southern United States. He has experienced four wartime deployments outside the United States. Each deployment lasted seven months in length. He is now retired and receives a percentage of disability pay from the USMC due to PTSD and combat injuries.

To date, he was employed as a retired veteran with a government agency. Some medications for aches and pains are taken daily.

Participant 3, #03-121816-1300, Hoje, was a 42-year-old male Marine Major who provided the USMC 20 years of service. He resides in a community in the southern United States. Major Hoje has completed three wartime deployments outside the United States during his career as a Marine. The deployments were seven months in length. Throughout one deployment, he was shot in the upper lip region. He is now retired and receives a small percentage of disability from the USMC for his service. Today, he continues to work as a Marine veteran at the local naval hospital.

Participant 4, #04-12-1816-1600, Meru, a 44-year-old male Marine Major who provided the USMC 24 years of service. He resides in a community in the southern United States. He has completed six wartime deployments outside the United States during his Marine career. Each deployment lasted seven months in length. He is now retired and receives an increased percentage of disability due to PTSD and combat experiences. He slept on his couch for two years to protect from unintentionally hurting his wife during his sleep. Currently, he is involved in his self-owned business. He received some treatment from the VA.

Participant 5, #05-12202016-1500, Irao, a 52-year-old male Marine Chief Warrant Officer IV who provided the USMC 22 years of service. He resides in a community in the southern United States. He completed seven wartime deployments outside the United States during his Marine career. The deployments were seven months

in length. He is now retired and receives minimal percentage disability from the USMC. Presently, he holds a governmental position on a USMC base.

Participant 6, #06-1222016-1100, Demo, a 44-year-old male Chief Warrant Officer II Marine who provided 20 years to the USMC. He resides in a community in the southern United States. Demo, experienced five wartime deployments outside of the United States. Each deployment was seven months in length. He received minimal disability percentage from the USMC due to PTSD and combat experiences. Currently, he is retired and holds a governmental position with the USMC.

Participant 7, #07-1222016-1200, Fike, 56-year-old male Gunnery Sergeant Marine who provided 20 years of service to the USMC. He experienced two deployments outside the United States. Each deployment was seven months in length. He did not receive disability from the USMC upon retirement. He resides in a community in the southern United States. After retirement, he continued to work for the government in an overseas military arena.

Participant 8, #08-12232016-0800, Roba, 38-year-old male Staff Sergeant male Marine who provided 18 years of service to the UMSC. He experienced five combat deployments outside the United States. Each deployment was seven months in length. He resides in a community in the southern United States. He receives an increased percentage of disability from the USMC due to PTSD and combat issues. After retirement, he continues to seek counseling and medical treatment for PTSD. Presently, he holds a position at a private local company.

Participant 9, #09-12232016-0900, Abbri, 36-year-old male Staff Sergeant male Marine who provided sixteen years of service to the USMC. He participated in two combat deployments outside of the United States. The deployments were seven months in length. He resides in a community in the southern United States. He receives an increased percentage of disability from the USMC due to PTSD and deployment experiences. To date, he continues to receive medication and treatment for PTSD. Currently, he holds a position with the local sheriff’s department.

Participant 10, #10-12232016-1000, Dijo, 48-year-old Staff Sergeant male Marine who provided twenty years of service to the UMSC. He participated in five combat deployments outside the United States. Each combat tour was seven months in length. He resides in a community in the southern United States. He receives minimal percentage of disability from the USMC due to combat issues and PTSD. Currently, he is retired and works as a security guard after retiring from the USMC.

Data Analysis

Data analysis using Colaizzi’s (1978) six-steps of the seven-step strategy and the software program NVivo 11 were used to organize and analyze the collected data within this study. Colaizzi’s six of the seven-step strategy as outline in my data analysis plan was used to transcribe, extract, interpret, categorize, narrate, conceptualize, and validate the data collected. The NVivo 11 software allowed for themes and trends to emerge through the understanding and lived experience of the participant.

The coded data represented through categories and themes was used to analyze the data for this study by using the SCT illustrated in the conceptual framework diagram

in Figure 1. The framework was designed to investigate how the Marines perspective phenomenon may promote a revised PDHRA for improved ways to recognize and educate Marines suffering from PTSD and attached stigma. The results from the collected data of this study were bracketed and aligned with the SCT and further coded by the 13 questions within the interview tool and were reported through common themes and clusters that emerged during the interviews with the Marines.

The specific categories, codes, and themes were articulated from the two research questions and 13 interview questions outlined in the theoretical foundation outlined in Table 2. The foundation included:

- Bandura's (1986) SLT was aligned with the first research question (RQ1). Interview question one (IQ1), Interview question two (IQ2), Interview question three (IQ3) and Interview question four (IQ4), and interview question 5 (IQ5) coupled with Interview questions six through nine (IQ6-IQ9) that all dealt with perceptions of the PTSD screening process.
- Bandura's (1986) SLT was aligned with the second research question (RQ2). Interview question ten (IQ10), Interview question eleven (IQ11), Interview question twelve (IQ12), and Interview question thirteen (IQ13) that all dealt with PTSD and attached stigma.

Data Codes, Categories, and Themes

A number of themes emerged from the data regarding the Marines' perceptions of PTSD and attached stigma. Identified themes included military culture, repercussions, and career. Multiple sub-themes emerged including beliefs, customs, norms, rules,

structure, integrity, concerns, impacts, and professional growth. The themes and sub-themes aligned well with my conceptual framework and theoretical model. Below are the main emerging themes:

- Military Culture - Refers to military beliefs, customs, norms, rules, and organizational structure that affect perceptions of PTSD and may influence the integrity of assessment responses.
- Repercussions - Refers to an awareness or concern about repercussions for Marines that are a result of completing the PDHRA assessment. The repercussions might range from not being allowed to carry a weapon to security clearance.
- Career – The perceived impacts of PTSD diagnosis or assessment responses on respondent's career (keeping, promotion, retirement) or ability to perform job related tasks.

Military culture and the privacy appeared to be an important part of the lived experiences of Marines. This was evident by Participant 1's statement,

> I think surveys are just a check in the box, but if you have to sit down a healthcare worker, it will be easy to tie a connection. The healthcare worker should understand what the unit went through on deployment and the healthcare worker will get a better idea if the Marine is answering the questions truthful or not. Put an individual in a private atmosphere where they feel comfortable and not sitting behind a computer punching several buttons in a classroom setting. I would suggest taking the PDHRA in the home, but the majority of marines that

> experience this sort of stuff live in the barracks. Therefore, home to that young man or woman is many miles away from where they live. Home in their mind is where the Marine comes from a year or two years ago than where they are at now.

Another example that was evident was the belief that Marines needed to be tough and should not display weakness or admit to needing help for current alcohol issues. This was evident in Participant 2's statement,

> They have pushed down to us for years that there is no consequences you know to drinking too much or if you or if you put on there you drink more than four to five glasses of alcohol. You know, they say there are no consequences, but there actually is. The consequences would be that you are sent to alcohol treatment and if you did not finish treatment, you could be kicked out of the Marine Corps. I have seen this happen a few times. I am sure that this is very important to maybe the medical providers, but I am not sure the Marines know how important this is and it is for their benefit. I am not sure they really know that. I would suggest that the Marine Corps should nail down that the PDHRA and show its importance and it is actually important and beneficial to their families to make sure the Marines are getting the best care as possible.

This theme is also evident in Participant 8's statement,

> Most people are worried about their careers and if you have been in ten or fifteen years you know, you are still looking at being promoted. You are still worried about your career and you are going to lie. Most people say when you put the retirement papers in is when most people start going to the doctor and they start

> telling the truth because that is what they do because they know they are retiring and will not have to face being portrayed as weak. In addition, if they answer honestly of having more than several drinks a week on the alcohol consumption question they are sent to medical for counseling and treatment.

Repercussions seemed to be an important theme as well. This was evident by Participant 3's statement:

> I think there is a place that asked about night sweats and I would not answer this truthfully in fear of repercussions such as my weapon being taken away or my security clearance being revoked if I answered that I experienced night sweats.

The theme of career was exposed by Participant 2's statement:

> Most people are worried about their careers and if you have been in ten or fifteen years you know you are still looking at getting promoted. You are still worried about your career and you are going to lie. Most people say that when you put the retirement papers in most people start going to the doctor and they start telling the truth because that is what they do because they know they are retiring and need the additional medical benefits.

Participant 4 expressed he was honest on the PDHRA because he wanted to help others that assumed his role. He gave in-depth detail about his night terrors and waking up to having his wife in a chokehold position. The experiences led to sleeping on the couch for two years. When he slept on the couch it not because he did not love his wife and did not want to sleep with her, but to protect his wife from the actions that resulted from PTSD.

The participant's quotes are important to this study because they reveal the feelings of Marines relating to the PDHRA and their experience with PTSD and attached stigma. No discrepant cases were identified during the data collection process. All data was reviewed using Colaizzi's (1978) data analysis method. Themes were extracted based on each participant's perspective and their experience with the PDHRA and attached PTSD's attached stigma. All collected data was analyzed to reflect the lived experiences of Marines and therefore, no discrepancies were identified.

Evidence of Trustworthiness

Credibility

Once my data collection was completed, one last literature review was conducted to verify the credibility of the literature gap and to verify recent publications that pertained to Marines' perspectives to promote awareness of PTSD and attached stigma amongst Marines. I did not find any new publications. Trustworthiness was assured in this qualitative phenomenological research without threats that jeopardize the research participants or quality of the study. All trustworthiness training learned from the National Institute of Health Office of Extramural Research was applied to protect human research participants (Appendix E). Credibility was obtained within the data collection process through professional behavior with the Marine participants. As Cope (2014) asserted, this study's credibility was due to the recognized descriptions of individuals who experience the same phenomena. Approximately 35-40 minutes was allotted for each interview to ensure rich and detailed responses. The sampling was limited to 10 participants. Observation methods and audit trails from a reflexive journal supported credibility of this

study. In addition, this reflexive journal reflected on thoughts and feelings that enable me to bracket the perceptions and reduce biases (Cope, 2014). Followed by each interview, the interviews were transcribed and reviewed. The transcription and review was completed for accuracy by the researcher.

Transferability

An established transferability was applied to this research study. Provided results had meaning to other readers and might associate the results and generalize the experience of the PDHRA and PTSD attached stigma (Cope, 2014). This study provided the reader with sufficient information on the context of the study and enabled to investigations of other studies on the PDHRA and PTSD attached stigma. This information can be transferable and provide dissemination to stakeholders such as military chaplains, veterans' health services, and possibly filter over into outside health services to help inform and prompt discussion on the issue of attached stigma with PTSD and the screening tool for PTSD.

Dependability

Within this study, dependability was reached by the constancy of the data. The consistency of the data was attained by audit trails and triangulation where multiple sources are utilized to obtain rich data and draw conclusions (Cope, 2014). NVivo software organized the interviews and questions into themes and trends, to allow for interpretation by other readers (Bergin, 2011). Additionally, the use of Colaizzi's (1978) methodology and 7 steps allowed other researchers to replicate within similar circumstances for future studies.

Confirmability

Confirmability and reliability was achieved in this study through checkpoints of reviewing each transcription and assuring the use of member checking that gives respondents provisional findings, or associating a number with each participant. As the researcher, I established interpretations that derive from the data (Cope, 2014). The interpretations exhibited in the study provided rich quotes and described emerging themes (Cope, 2014). In the case of arising issues, my committee was responsible for informing me.

Study Results

The results of this study, as shown in Figure 3, arranged according to the alignment of the research questions within the theory of SCT. The results illustrated align the SCT theory with each research question.

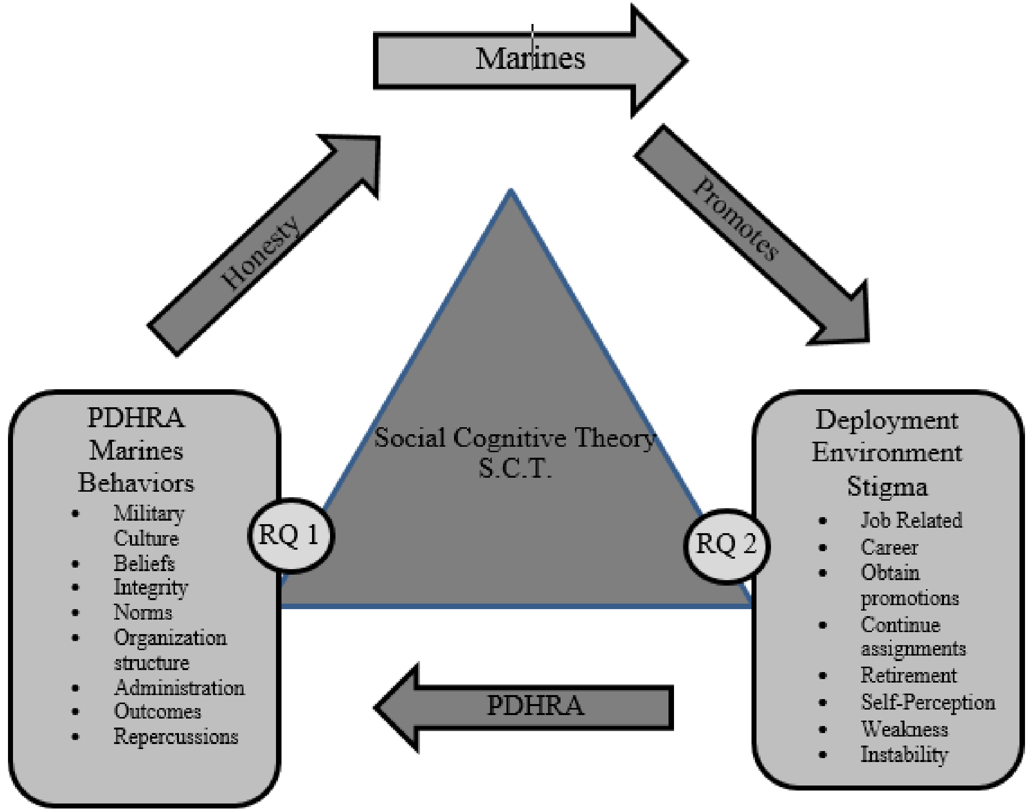

Figure 3. Study Results

As illustrated in Figure 3, the results were incorporated in the theoretical framework of SCT that was originally shown in Figure 1. The SCT results related to personal factors, environmental factors, and behavioral factors. The personal factors related to interpersonal characteristics including age, rank, number of years in the military, the number of times deployed, and references to family life. The environmental factors included environmental or external factors related to deployment and experiences during deployment. The behavioral factors referred to PTSD related behaviors and symptoms.

In the upcoming sections, the results expanded within the SCT framework. Throughout each section, the clustered results reported as the emerging top three themes from each interview question within the interview tool. Additionally, this complete detail from each interview question are displayed the tables located in this study. The tables involve common themes reported by the Marines perceptions.

Social Cognitive Theory (SCT)

The use of Bandura's (1986) social-cognitive theory (SCT) provided the foundation that related to this study's research problem of the PTSD screening and potential stigma among Marines. The SCT established that military culture, repercussions, and career influence Marines about PTSD, attached stigma, and the way they answer the questions on the PDHRA. In figure 3, I depicted how the SCT aligned with RQ1 and RQ2 and how they related to Marines and their concepts of PTSD and attached stigma. As noted in the interview tool (Appendix C), there are seven formulated interview questions to help answer RQ1 and explore the Marines experience with PTSD and taking the PDHRA. Formulated interview questions eight through thirteen explore the perceptions of the Marines about PTSD and attached stigma.

With IQ1 through IQ5 aligned to RQ1. These questions allowed for investigation into the characteristics of each Marine along with their rank, age, gender, years of service, and number of deployments outside the United States. Marines reported different results:

- IQ1 inquired participant's names that will be kept anonymous (10 of 10 [100%]);

A listing of each Marine and associated characteristics is in Table 2. The unique characteristics from each Marine provided different perspectives on PTSD and attached stigma.

With IQ2 aligned to RQ1 examined the age of each Marine. Marines reported different:

- Male Staff Sergeant was 36 years of age (1 of 10 [10%]);
- Male Staff Sergeant was 38 years of age (1 of 10 [10%]);
- Male First Sergeant was 41 years of age (1 of 10 [10%];
- Male Major was 42 years of age (1 of 10 [10%]);
- Male Chief Warrant Officer III was 43 years of age (1 of 10 [10%]);
- Male Major was 44 years of age (1 of 10 [10%]);
- Male Staff Sergeant was 47 years of age (1 of 10 [10%]);
- Male Chief Warrant Officer IV was 52 years of age (1 of 10 [10%]);
- Male Gunnery Sergeant was 56 years of age (1 of 10 [10%]).

A complete listing of the Marines characteristics is in Table 2. The Marine age and gender are effective for USMC when evaluating for PTSD.

With IQ3 aligned to RQ1, examined the last rank served with in the Marine Corps while still on active duty. Marines reported:

- Three participants were Staff Sergeants (3 of 10 [30%]);
- One participant was a Gunnery Sergeant (1 of 10 [10%]);
- One participant was a First Sergeant (1 of 10 [10%]);
- Three participants were Chief Warrant Officers (3 of 10 [30%]);

- Two participants were Majors (2 of 10 [20%]);

The participant's rank are displayed on Table 2 within this study.

With IQ4 aligned to RQ1, examined how many years of service did the participants provide to the USMC. Marines reported:

- One participant provided 16 years of service (1 of 10 [10%]);
- One participant provided 18 years of service (1 of 10 [10%]);
- Four participants provided 20 years of service (4 of 10 [40%]);
- Two participants provide 22 years of service (2 of 10 [20%]);
- One participant provided 24 years of service (1 of 10 [10%]);
- One participant provided 25 years of service (1 of 10 [10%]).

The participant's years of service are displayed in Table 4. The service years provided understanding about the different ages within this study.

With IQ5 aligned to RQ1, explored how many times the Marines deployed outside the United States while working as an active duty Marine. Marines reported:

- One participant deployed one time (1 of 10 [10%]);
- Two participants deployed two times (2 of 10 [20%]);
- One participant deployed three times (1 of 10 [10%]);
- One participant deployed four times (1 of 10 [10%]);
- Three participants deployed five times (3 of 10 [30%]);
- One participant deployed six times (1 of 10 [10%]);
- One participant deployed seven times (1 of 10 [10%]);

A listing of deployments of the participants are located in Table 2. The number of deployments enabled themes to emerge on PTSD amongst Marines.

With IQ6 aligned to RQ1, examined the experience each Marine had with taking the PDHRA

- Waste of Time (8 of 10 [80%]);
- Helpful for future Junior Marines (3 of 10 [30%]);
- PDHRA was not anonymous (10 of 10 [100%]).

Referenced were a list of common responses associated with common themes in Table 5. These responses are most effective for USMC during revisions of the PDHRA.

With IQ7 aligned with RQ1, explored any difficulties the Marines experience with taking the PDHRA. The Marines reported:

- Clarity (6 of 10 [80%]);
- Redundancy (7 of 10 [70%]);
- Length of Exam was too long/Time consuming (10 of 10 [100%]).

With IQ8 aligned with RQ2, examined sections of the PDHRA that the Marine might not be forthcoming with honest answers. Marines reported:

- Alcohol and drug questions (8 of 10 [80%]);
- Trouble falling asleep or staying asleep (9 of 10 [90%]);
- Repeated disturbing dreams (7 of 10 [70%]);
- Feeling bad about yourself (6 of 10 [60%]).

With IQ9 aligned with RQ2, examined factors that might hinder the Marines in answering the questions on the PDHRA in an honest manner. Marines reported:

- Attached stigma (8 of 10 [80%]);
- Promotion (10 of 10 [100%]);
- Ability to obtain or complete assignments (6 of 10 [60%]);
- Retirement (9 of 10 [90%])

With IQ10 aligned with RQ2, examined examples of reasons why it is important for Marines to answer certain PDHRA questions in specific ways. Marines reported:

- Administration (10 of 10 [100%]);
- Perceived as weak (10 of 10 [100%]);
- Referred to Medical (8 of 10 [80%]);
- Outcomes (6 of 10 [60%]);
- Questions (6 of 10 [60%]);
- Repercussions (8 of 10 [80%]).

The above Marine responses are located on Figure 4.

With IQ11 aligned with RQ2, examined if any negative stigma was attached to PTSD within the USMC. Marines reported:

- Job related (6 of 10 [60%]);
- Self-Perception (8 of 10 [80%]).

The above Marine responses are in Table 5. The responses enabled emerging themes that are effective for USMC and providing health professionals.

With IQ 12 aligned with RQ2, examined if negative stigma hindered the way the Marine answered specific questions on the PDHRA. Marines reported:

- Administration (10 of 10 [100%]);

- Outcomes (6 of 10 [60%]);
- Questions (6 of 10 [60%]);
- Repercussions (8 of 10 [80%]).

The responses were demonstrated in Table 4 within this study.

With IQ13 aligned with RQ2, explored ways that may assist the Marine to be honest while answering the question on the PDHRA. For instance, would a Marine answer the PDHRA in a more honest manner if they knew there would be no attached stigma or future consequences with their position or rank. Marines Reported:

- Make changes to the assessment environment (9 of 10 [90%]);
- Maintain Anonymity (10 of 10 [100%]);
- Involve family when possible (3 of 10 [30%]);
- Remove the repercussions associated with responses that indicate PTSD symptoms, especially those related to career (military and post-military) (10 of 10 [100%]);
- Use the results to provide help to Marines (10 of 10 [100%]).

A list of these results was displayed in chapter 5 to promote recommendations for the USMC on the PDHRA, PTSD, and attached stigma.

Table 4

Results

Participant	Rank	Age	Years of Service	# of Deployments	Administration	Outcomes	Questions	Repercussions	Job Related	Self-Perception
1	First Sergeant	41	22	1	1	1	1	0	1	1
2	Chief Warrant Officer III	43	25	4	1	0	0	1	1	1
3	Major	42	20	3	1	0	0	1	0	0
4	Major	44	24	6	1	1	1	1	1	1
5	Chief Warrant Officer IV	52	22	7	1	1	1	1	1	1
6	Chief Warrant Officer II	48	20	5	1	1	1	1	0	1
7	Gunnery Sergeant	56	20	2	1	0	0	1	0	1
8	Staff Sergeant	38	18	5	1	1	1	0	1	1
9	Staff Sergeant	36	16	2	1	1	1	1	0	0
10	Staff Sergeant	47	20	5	1	0	0	1	1	1

Summary

In summary, the purpose of this qualitative phenomenological study was to investigate the problems with PTSD screening and attached stigma among United States Marines. This study focused on Male Marines' perceptions from a community in the southern United States. The research questions prompted Marines to express their perceptions on the PTSD heath assessment along with PTSD and attached stigma to

promote a better health assessment and health care treatment for Marines diagnosed with PTSD.

Key findings included the realization that Marines answer certain questions on the PDHRA in specific ways to avoid a PSTD diagnosis. Specific repercussions from answering the PDHRA in an honest manner could result in additional medical visits, loss of work, promotions, and not allowed to carry their weapons. Associated with RQ1 was the environment in which the assessment was administered that influenced the integrity of responses. Perceived value and positive outcomes associated with the PDHRA responses was important to Marines coupled with how the formatted questions appeared on the PDHRA.

Additionally, repercussions were of concern regarding the completion of the PDHRA. For RQ2, the uncovered results related to attached stigma of PTSD and perceptions related to PTSD diagnosis behaviors or negative consequences that occur because of a PTSD diagnosis or behavior. Job related concerns were revealed about the attached stigma from a PTSD diagnosis. Concerns included, not being able to obtain or continue assignments, complete job, obtain promotions, or retire. Furthermore, self-perception of Marines that revealed the attached stigma from a PTSD diagnosis was viewed as weak, crazy, and lacks stability. Supported by the SCT the research questions overlapped one another. The value for an effective PTSD health screening was prevalent coupled in the way health care providers treat PTSD diagnosed Marines.

This Chapter 4 provided an overview of significant results of U.S. Marine Corps veterans' perceptions of PTSD screening process and potential stigma. In this chapter, the

researcher described the pilot study, research setting, demographics, data collection, data analysis, evidence of trustworthiness, and results. The next chapter 5 will include discussion, interpretation, conclusions, and recommendations.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative phenomenological study was to explore the perceptions about PTSD screening and potential stigma among Marines located in a community in the southern United States. The MCRD location was ideal due to the close proximity of respondents. Researchers respect convenience study participants. This descriptive approach allowed me to devour into the intense perspectives of Marines as it related to post-deployment PTSD health screening process and the possibility of attached stigma. The study attempted to conclude that areas of the PDHRA might not fully identify the symptoms of PTSD among Marines. This study searched to determine factors that may prevent Marines from accurately reporting their symptoms of PTSD. Furthermore, this study determined these factors were due to the stigma that surrounds mental health disorders among Marines.

The descriptive approach enabled me to obtain rich and exhaustive details to the phenomenon of Marines perceptions of the PTSD screening process and potential stigma. Prior scholars have focused on the relevance of the Post-Deployment Health Assessment (PDHA) and its importance of assisting in diagnosing Marines. Perceptions of Marines on active duty have been studied as it relates to the PTSD screening process. However, few, if any, scholars have examined the perceptions of Marine veterans about the PTSD screening process of the PDHRA and attached stigma. To further, understand how their experiences as active members influence the outcomes of taking the PDHRA and the relationship with PTSD diagnosis and attached stigma the goal of my study was to focus

on the perceptions held by Marines that are not on active duty. Various revisions may influence a positive experience for Marines in accordance to completing the PDHRA. In turn, the revisions could play a role in helping healthcare providers attain a better understanding of how to promote an intervention process to assist in early detection of PTSD and possible attached stigma.

For the nature of the study, a qualitative, phenomenological study was developed by using Colaizzi's strategy of methodology for the data analysis process. The data collection involved semi structured, open-ended interview questions for data collection to understand the fundamental nature of Marines' perceptions to promote a better understanding of the Marines PTSD screening process and attached stigma. The interview questions were used to collect an in-depth description of Marines lived experiences and their role with the screening process for PTSD and attached stigma. The motivation for this qualitative design was that there were no measurable variables to quantify to assist in answering this study's research questions. Likewise using phenomenological research strategy allowed for an understanding of Marines' lived experiences of PTSD screening and potential stigma. Additionally, denoted as a philosophy were these lived experiences (Blackburn & Owens, 2015).

This study's key findings centered on the lived experiences of Marines located in a community in the southern United States. Key findings discovered the need for awareness of PTSD among Marines and revisions for an effective PTSD screening process. Initially, strategies that health care providers and other Marine affiliated individuals (RQ1) can maintain anonymity and make changes to the assessment

environment. Instead of using a classroom full of computers, a Marine might take the assessment in the privacy of the home where surroundings are comfortable and familiar; also, the USMC could provide Marines a private room setting to take the assessment. Health care workers and affiliate individuals can promote a healthier environment for taking the PDHRA by including family members when possible. Next, with PTSD and attached stigma amongst Marines (RQ2), the health care personnel and affiliated individuals can obtain understanding to better promote privacy, communication, and realize the stigma was real. Marines never want to display weakness or instability (Hall, 2015). By providing avenues to escape the repercussions of PTSD diagnosis, but at the same time protecting the Marines' privacy can influence a Marines' behavior and outcomes from PTSD and attached stigma.

Warranted in the future is the need to ensure ways to protect Marines and promote effective avenues to assist in their ability to obtain and continue assignments, complete jobs, and obtain promotions and retirement without the stigma following the Marine. For example, if a Marine was at the point of retirement, a diagnosis of PTSD might hinder their ability to obtain a civilian position as a police officer, governmental position, or transportation affiliate. If the stigma followed them throughout their future, civilian existence, it can cause life issues for the Marine. Medical records kept confidential was essential in promoting a positive outcome for a future Marine civilian. A promoted repercussion awareness amongst health care providers and commanding officers in regard to a Marine and the way they complete the PDHRA might be accomplished through

educational flyers and transparency in communication. Denoting military norms, military beliefs, and organizational structure may affect Marines with PTSD and attached stigma

Interpretation of Findings

The findings from this qualitative, phenomenological study might permit health professionals to understand Marines' perceptions to enhance treatment plans and strategies to assist in coping with PTSD post-deployment. The study's findings provide viewpoints from the Marines regarding their lived experiences with the PTSD screening process and potential stigma associated with PTSD diagnosis. The Marines' lived experiences provided examples to assist in promoting an effective PDHRA and extended from the information reported within the literature review of Chapter 2 relating to influencing an effective screening tool to gauge PTSD and expunge stigma for PTSD diagnosed Marines. Insights gained from the Marines was essential in relaying the understanding of the types of stigma that placed on Marines diagnosed with PTSD.

The condensed results from the interviews were for interpretation of findings. In Chapter 4 the interviews reported meaningful findings and were aligned with the research questions and theory and outlined in Table 3. Applying graphs and charts allowed the researcher to condense information of data into a simplistic format that effectively communicated valid points. The use of bar graphs enabled me to present grouped data in which the bars length represented the values provided by the 10 participants (Y-axis). Reported on the X-axis represented the condensed responses were the emerging themes (Smith, 2014).

Social Cognitive Theory (SCT)

Marine participants in this study reported that administration, outcomes, questions, and repercussions are all related to the PDHRA and promoting an effective PTSD assessment. In figure 4, the illustrated top findings relate to the SCT versus the number of 10 Marine participants. RQ1used the perceptions of the PDHRA to investigate and recognize areas of concern with this assessment. To answer RQ1, the SCT was aligned with interview question one (IQ1) through seven (IQ7) and explored areas of behavior, environment, and Marine participant perceptions. The exhibited findings are in the following Figure 4.

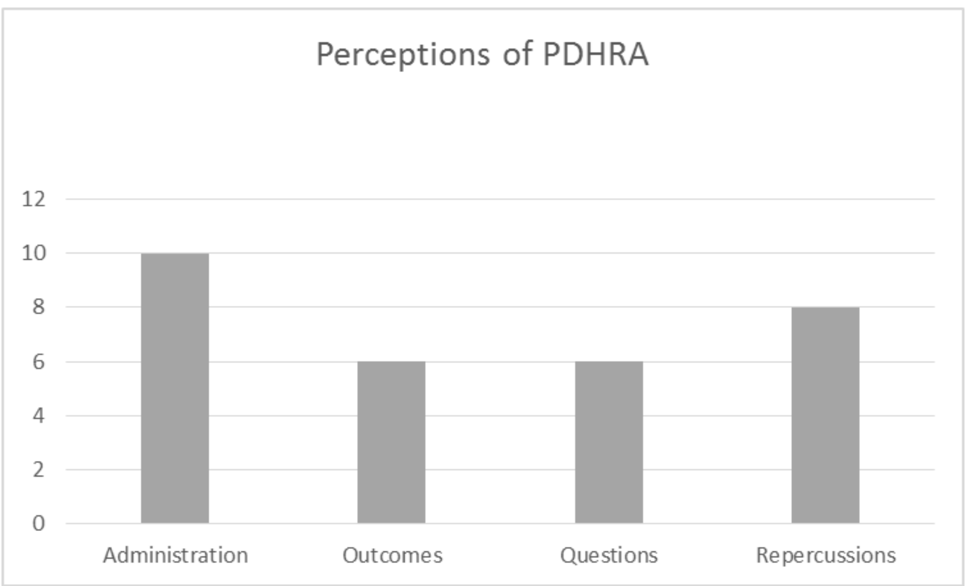

Figure 4. Findings related to SCT

With the use of the second research question (RQ2), I could investigate a couple of issue areas that emerged during the interview process. Marine participants reported that attached stigma resulting from the diagnosis of PTSD could affect the ability to

obtain or continue assignments, complete a job, obtain promotions, and retire. Likewise, the self-perception of the attached stigma affected how the Marine viewed themselves and how other individuals or Marines may see them as weak or mentally unstable. In Figure 5, the tope findings were illustrated and related to the SCT versus the frequency reported from the 10 Marine participants. To answer RQ2, the SCT was aligned and explored the reasoning behind this perception that included a Marine should be tough and never display weakness along with never showing instability with behaviors. This was the Marine culture and beliefs and the norm for a military environment.

The findings are revealed in the below Figure 5.

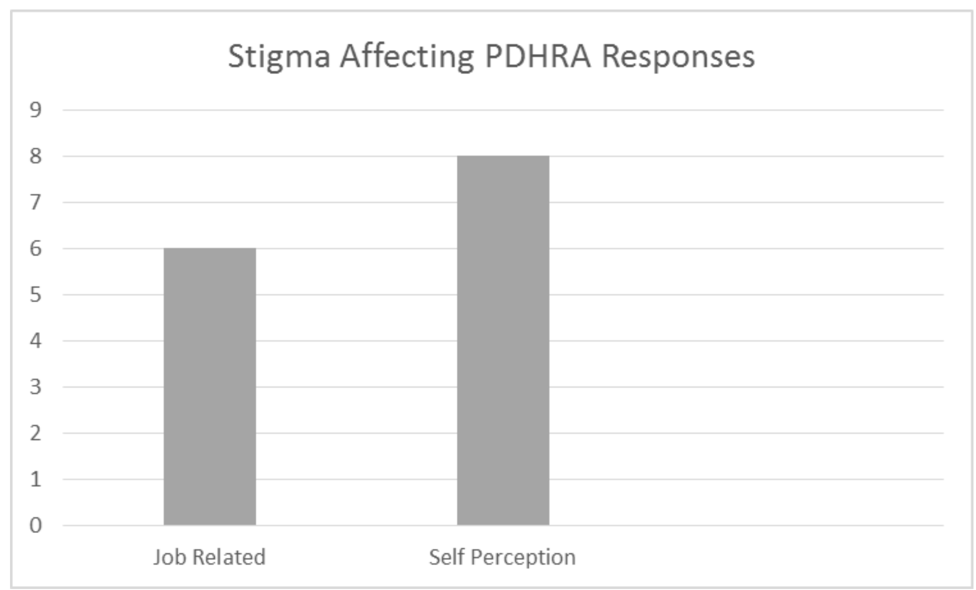

Figure 5. Stigma affecting PDHRA responses

Limitations of the Study

Limitations of this qualitative phenomenological study included providing information about PTSD and the attached stigma of Marines. The limitations are

comprised of time, sample size, gender specific, funding, along with guilt and shame. First, time constraints were relevant due to the Marines busy schedule and availability. Second, having a small study with convenience-based sample of 10 Marines limited the perspectives of the PTSD screening process due to this narrowed defined group. Third, a potential limitation of the study may include utilizing all-male participants. For example, utilizing an all-male participant panel can limit the perception of an inefficient screening process because males predominantly suppress emotion and feelings according to Boden (Boden et al., 2016). Likewise, the findings may not be generalizable to female perspectives. Fourth, the funding for this study was limited due to its size in nature. Fifth, trauma-related guilt and shame may be a potential limitation because the guilt and shame may differ from each Marine due to their experience and might affect this study's results. The limitations for this study is not a representation of the entire DOD (Owens & Anderson, 2015). This study's findings are still important because Marines' perceptions on the PTSD screening process and attached stigma can promote better understanding of concerns about the PTSD screening tool and attached stigma.

Recommendations

After investigating U. S. Marines' perceptions on the PTSD screening process and attached stigma to promote an effective screening process, the recommendation for continuing an expanded study in other parts of the U. S. was prevalent. Other recommendations might include exploring female perceptions within a comparison study of male participants. Moreover, including additional participants to get a broader perspective from a combination of male and female participants.

Marine participants suggested the diagnosis of PTSD should remain private throughout their diagnosis and treatment. The Marines suggested not informing their superiors and others of their condition. Grant access to a Marines' PTSD diagnosis only to the health care providers. The Marines felt if superiors revealed the diagnosis they were treated different. In addition, there are needed changes to the environment in which the Marines take the assessment. Instead of a room full of Marines and computers, the assessment needs to occur in a private setting with no distractions or feeling rushed to return to their job of the day.

Moreover, the need to involve family when possible may prove beneficial when taking the PTSD assessment. At times, Marines may not reveal or even realize their behaviors are abnormal. A family member can speak to the actions and uncover behaviors that normally not presented if the Marine took the assessment privately.

Likewise, removing repercussions associated with the Marines responses that indicate PTSD symptoms. Especially, those related to the Marines' career in the military and post-military positions. Eliminated repercussions can allow the Marine to answer the questions in a more honest manner. This will alleviate concerns of the Marines for current positions and future positions. For instance, a Marine may not fear losing access to his weapon, losing promotion, or having to attend medical appointments often and missing their previous job assignments. The Eliminated repercussions can allow the Marine to feel at ease and comfortable taking the assessment with an open mind and not having to fear consequences for their answers on the assessment.

Furthermore, the Marines recommend using the results from the assessment to help the Marine. Marines suggested not just pushing them through the system, but take their answers and put the answers towards helping others that have the same issues. In addition, Marines recommend health care providers need to look at the bigger picture, see that Marines' lives matter, provide them with positive reinforcement, and not take away what makes them a Marine.

Implications

This qualitative phenomenological research study was unique because study findings provided insights of Marines' experiences with the PDHRA and potential stigma. PTSD among Marines was largely misunderstood (Kok et al., 2015). Dissemination of study findings contributed to positive social change for health services by increased understanding of Marines' experiences with the PTSD screening processes and potential stigma. Dissemination of study findings to stakeholders such as military chaplains and veterans' health service providers contribute to informing understanding about the PDHRA through the lens of Marines.

Potential Impact for Positive Social Change

The current body of literature provided an increased awareness of the PTSD screening process and the possible stigma placed on Marines. Potential contributions included the awareness of perspectives of Marines concerning the stigma of PTSD and the effectiveness of screening process. The contributions can assist a veterans' health care provider and military chaplain to be well versed in the understanding of a Marines thought process on the effectiveness of the PDHRA. In essence, assisting these providers

with additional supportive capabilities and awareness of the Marines authentic thoughts of the PDHRA and stigma in order to have an encouraging outcome after returning from combat deployment and experiencing PTSD.

Methodological, Theoretical, and/or Empirical Implications

This study did not have any methodological, theoretical, and/or empirical implications. Identified, as the population for this study were Marines from a community in the southern United States. The Marines ranged in age from 36 to 56 and were all male participants. In Chapter 2, this population was justified and significant with filling in the gap that little was known about Marines' perceptions of the PTSD screening process and potential stigma.

Recommendations for Practice

Within this qualitative phenomenological study, there are potential contributions to policies, practices, and progressed knowledge. The contributions can lead to a positive social change in health services and provide awareness of the PDHRA and the stigma that might be placed on a Marine being diagnosed with PTSD. Although combat tours continue and Marines return from deployments, it might be helpful to understand the perspectives of the veteran Marines about the screening process. These particular individuals have no straight stakes or consequences in voicing their thoughts about the PDHRA and attached stigma. Therefore, gaining advanced knowledge from Marines provided a deeper meaning to the effectiveness of the PDHRA. Unfortunately, Marines continue to carry burdens from PTSD and attached stigma, but through their perceptions,

health care providers can seek to promote, educate, and grow in the understanding of this illness.

Conclusion

This qualitative phenomenological study conveys knowledge in the understanding of how Marines perceive taking the PTSD screening assessment along with attached stigma. The study will allow health professionals and stakeholders to understand Marine perceptions to promote an effective PTSD screening assessment and process. Research questions one and two and the theoretical foundation of the SCT revealed key findings and concerns reported by Marines to promote a better understanding of the PTSD assessment and attached stigma. The first research question revealed Marines' concerns for administration, outcomes, questions, and repercussions. Research question two revealed Marines' concerns of career, job related, self-perceptions, personal factors and military culture.

The findings provided meaningful viewpoints from Marines. The Marines' lived experiences may contribute to plans and new approaches towards caring for Marines with PTSD and its attached stigma. The results may also contribute to revised instruments by which health care providers can recognize PTSD earlier and promote healthier lifestyles of these diagnosed individuals. This knowledge may also assist chaplains to recognize the symptoms earlier and the provided additional knowledge will help them promote effective coping mechanisms and a way to control certain behaviors. Lastly, these results may give insight on how to examine Marines who may have PTSD and expedite

treatment and services to ensure behaviors do not become out of control and ultimately result with a tragic ending of suicide.

Key findings of this study indicated that PTSD and attached stigma have a significant impact on Marines. This study was important and the greatest finding for positive social change or health services perhaps was Marines indicated that overall, they were not forthcoming with their answers on the PDHRA. This is of great concern because PTSD is serious and can go unidentified or undiagnosed. This knowledge can help inform health care providers, chaplains, and stakeholders by positively affecting the livelihood of Marines diagnosed with PTSD through support for an effective PDHRA and positive caring environment. Health care providers and leaders can influence and play a pivotal role in providing a private and safe environment for Marines while taking the PDHRA and involve family when possible. The Marine culture may want to focus on removing repercussions for Marines with PTSD. By removing repercussions, according to Marines, would allow them to be honest and forthcoming with their answers on the PDHRA and a willingness to seek help for PTSD. This focus can promote better communication and may lend to a healthier lifestyle for Marines. Through these benefits, it may control expense, reduce governmental costs for medical treatments, and help promote preventive education for Marines. The understanding of the perceptions of Marines as it pertains to their lived experiences of PTSD and attached stigma should not be underestimated. Through the recognition of these concepts, faster intervention may be provided and ultimately save a Marine’s life.

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Appendix A: Recruitment Flyer

Doctoral Research Study

Marine Veterans' Perceptions of
Post-Traumatic Stress Disorder
Screening Process

I am Tiffany Schweitzer, a PhD Candidate in the Health Services program at Walden University, conducting a research related to Marine veterans' perceptions of the post-traumatic stress disorder screening process.

I am seeking Marine male veteran participants to interview face-to-face, who speaks English fluently and has experienced the Post-Deployment Health Reassessment (PDHRA).

The interview will last approximately 30-40 minutes in length. The research participants have the right to withdraw at any time if they become uncomfortable with the content material or interview process.

The Institutional Review Board (IRB) approval number from Walden University for this research study is 12-12-16-0300960 and expires on 12-11-2017. If you are interested, please contact me.

Tiffany Schweitzer BSHCM, MHA, RT(R)
PhD Health Services Candidate
Walden University
College of Health Sciences

Note: PTSD promotion photo reprinted with permission of Military Justice for all.

Appendix B: Informed Consent Letter

Date:

Dear Prospective Research Participant,

My name is Tiffany Schweitzer and I am a PhD candidate in Health Services at Walden University. I am currently conducting a research study related to Marine veterans' perceptions of post-traumatic stress disorder (PTSD) screening process. The purpose of this research is to explore the perceptions of United States Marine Corps (USMC) veterans in regards to the effectiveness post-deployment health reassessment (PDHRA) and obtain information on the USMC veteran's health after deployment outside the United States.

The research participation is voluntary. Participants are required to be USMC veterans. The veteran participants should be able to speak English fluently and have experienced the PDHRA. There will be a small ice cream voucher valued at $5 given to each participant at the beginning of the interview. The interview will last approximately 30-40 minutes in length through a face-to-face interview. This interview will be transcribed and placed into a written report for the participant to view following the interview. At this time, the participant will be allowed the opportunity to provide any corrections or clarifications of misunderstood statements. This will ensure accuracy of the information the participant provided for this research study.

During the interview process you can withdraw at any time if you become uncomfortable with the content or the interview itself. Your participation in this research is confidential. The data collected will remain anonymous and your identity will not be linked to the summarized data. Only I as the researcher and my Walden University research committee will have access to the qualitative data. I am only affiliated with Walden University where I am pursuing my PhD in Health Services. Being a participant in this research can bring forward new information to improve the PTSD screening process for USMC.

If you agree to participate in this research you will need to sign and date and time on the line below to state that you are in agreement to participate in this study. Please feel free to retain a copy of this informed consent for your records. The approval number from Walden University's IRB is 12-12-46-0300960 and expires on 12-11-2017. If you have additional questions about your participation in this research study please contact Dr. Leilani Endicott at (612) 312-1210.

Sincerely,
Tiffany Schweitzer, MHA, RT(R)
PhD Health Services Candidate
Participant
Signature______________________________Date/Time___________________________

Appendix C: Interview Tool

Introduce myself as the researcher by stating my name and title. Disclose the research purpose and my IRB approval number. Obtain participant's demographics that include gender, age, rank, years of service, and number of deployments outside the United States while employed as a United States Marine. State that the interview will be approximately 30-40 minutes in length. Take measures to ensure that the participant feels comfortable as the interview begins.

Interview Questions

1. What is your name?
2. What is your age?
3. What was your last rank within the Marine Corps while you were still on active duty?
4. How many years of service did you provide to the United States Marine Corps?
5. How many times were you deployed outside the United States while working as an active duty Marine?
6. What has been your experience with the PDHRA?
7. What, if any difficulties have you experienced taking the PDHRA?
8. What are the section or sections of the PDHRA that you might not be forthcoming with honest answers?
9. What, if any factors might hinder you in answering the questions on the PDHRA in an honest manner?
10. Can you provide some examples of reasons why it is important to answer certain PDHRA questions in specific ways?

11. What, if any negative stigma is attached to PTSD within the United States Marine Corps?
12. How does negative stigma hinder the way you answer specific questions on the PDHRA?
13. Please elaborate on ways that may assist you to be honest while answering the questions on the PDHRA. For instance, would you answer the PDHRA in a more honest manner if you knew there would be no attached stigma or future consequences with your position and rank?

Appendix D: PDHRA

This form must be completed electronically. Handwritten forms will not be accepted.

POST DEPLOYMENT HEALTH RE-ASSESSMENT (PDHRA)

PRIVACY ACT STATEMENT

This statement serves to inform you of the purpose for collecting personally identifiable information through the DD Form 2900, Post-Deployment Health Re-Assessment (PDHRA).

AUTHORITY: 10 U.S.C. 136, Under Secretary of Defense for Personnel and Readiness; 10 U.S.C. 1074f, Medical Tracking System for Members Deployed Overseas; DoDI 1404.10, DoD Civilian Expeditionary Workforce; DoDI 6490.02E, Comprehensive Health Surveillance, and E.O. 9397 (SSN), as amended.

PURPOSE: To obtain information from an individual in order to assess the state of the individual's health after deployment outside the United States, its territories and possessions as part of a contingency, combat, or other operation and to assist health care providers in identifying and providing present and future medical care to the individual. The information provided may result in a referral for additional health care that may include medical, dental, or behavioral health care or diverse community support services.

ROUTINE USES: Your records may be disclosed to other Federal and State agencies and civilian health care providers, as necessary, in order to provide medical care and treatment. Use and disclosure of you records outside of DoD may also occur in accordance with 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, which incorporates the DoD "Blanket Routine Uses" published at: http://dpclo.defense.gov/privacy/SORNs/blanket_routine_uses.html. Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD by DoD 6025.18-R. Permitted uses and discloses of PHI include, but are not limited to, treatment, payment, and healthcare operations.

DISCLOSURE: Voluntary. If you chose not to provide information, comprehensive healthcare services may not be possible or administrative delays may occur. HOWEVER, CARE WILL NOT BE DENIED.

INSTRUCTIONS: You are encouraged to answer all questions. You must at least complete the first portion on who you are and when and where you deployed. If you do not understand a question, please discuss the question with a health care provider.

DEMOGRAPHICS

Last Name ______________ **First Name** ______________ **Middle Initial** ______

Social Security Number ______________ **Today's Date** *(dd/mmm/yyyy)* ______________

Date of Birth *(dd/mmm/yyyy)* ______________ **Gender** O Male O Female

SAMPLE

Service Branch
- O Air Force
- O Army
- O Navy
- O Marine Corps
- O Coast Guard
- O Civilian Expeditionary Workforce (CEW)
- O USPHS
- O Other Defense Agency List: ______________

Component
- O Active Duty
- O National Guard
- O Reserves
- O Civilian Government Employee

Pay Grade

O E1	O O1	O W1
O E2	O O2	O W2
O E3	O O3	O W3
O E4	O O4	O W4
O E5	O O5	O W5
O E6	O O6	
O E7	O O7	O Other
O E8	O O8	
O E9	O O9	
	O O10	

Home station/unit: ______________

Current contact information:
Phone: ______________ Cell:
DSN: ______________
Email: ______________
Address: ______________

Point of contact who can always reach you:
Name: ______________
Phone: ______________
Email: ______________
Address: ______________

PLEASE ANSWER ALL QUESTIONS BASED ON YOUR MOST RECENT DEPLOYMENT

Primary location of last deployment: ______________ **Date departed theater** *(dd/mmm/yyyy)* ______________

Total deployments in past 5 years: O 1 O 2 O 3 O 4 O 5 or more

This form must be completed electronically. Handwritten forms will not be accepted.

Deployer's SSN (Last 4 digits): ____________

1. **Overall, how would you rate your health during the PAST MONTH?**
   O Excellent O Very Good O Good O Fair O Poor

2. **Compared to before your most recent deployment, how would you rate your health in general now?**
   O Much better now than before I deployed
   O Somewhat better now than before I deployed
   O About the same as before I deployed
   O Somewhat worse now than before I deployed Please explain: ____________
   O Much worse now than before I deployed Please explain: ____________

3. **Were you wounded, injured, assaulted or otherwise hurt during your deployment?** O Yes O No

   If yes, are you still having any problems or concerns related to the event(s)? O Yes O No

   If yes, please explain: ____________

4. **During your deployment:**
   a. Did you ever feel like you were in great danger of being killed? O Yes O No
   b. Did you encounter dead bodies or see people killed or wounded during this deployment? O Yes O No
   c. Did you engage in direct combat where you discharged a weapon? O Yes O No

5. **Since you returned from deployment, how many times have you gone to a health care provider for a medical, dental, or mental health problem/concern?**
   O No visits O 1 visit O 2-3 visits O 4-5 visits O 6 or more

6. **Since you returned from deployment, have you been hospitalized?** O Yes O No

   If yes, please list date and brief details: ____________

7. **During the PAST MONTH, how difficult have physical health problems *(illness or injury)* made it for you to do your work or other regular daily activities?**
   O Not difficult at all O Somewhat difficult O Very difficult O Extremely difficult

8. **During the PAST MONTH, how much have you been bothered by any of the following problems?**

Symptom	Not bothered at all	Bothered a little	Bothered a lot
a. Stomach pain	O	O	O
b. Back pain	O	O	O
c. Pain in the arms, legs, or joints (knees, hips, etc.)	O	O	O
d. Menstrual cramps or other problems with your periods (Women only)	O	O	O
e. Headaches	O	O	O
f. Chest pain	O	O	O
g. Dizziness	O	O	O
h. Fainting spells	O	O	O
i. Feeling your heart pound or race	O	O	O
j. Shortness of breath	O	O	O
k. Pain or problems during sexual intercourse	O	O	O
l. Constipation, loose bowels, or diarrhea	O	O	O
m. Nausea, gas, or indigestion	O	O	O
n. Feeling tired or having low energy	O	O	O
o. Trouble sleeping	O	O	O
p. Trouble concentrating on things (such as reading a newspaper or watching television)	O	O	O
q. Memory problems	O	O	O
r. Balance problems	O	O	O
s. Noises in your head or ears (such as ringing, buzzing, crickets, humming, tone, etc.)	O	O	O
t. Trouble hearing	O	O	O
u. Sensitivity to bright light	O	O	O
v. Becoming easily annoyed or irritable	O	O	O
w. Fever	O	O	O
x. Cough lasting more than 3 weeks	O	O	O
y. Numbness or tingling in the hands or feet	O	O	O
z. Hard to make up your mind or make decisions	O	O	O
aa. Watery, red eyes	O	O	O
bb. Dimming of vision, like the lights were going out	O	O	O
cc. Skin rash and/or lesion	O	O	O
dd. Bleeding gums, tooth pain, or broken tooth	O	O	O

SAMPLE

This form must be completed electronically. Handwritten forms will not be accepted.

Deployer's SSN (Last 4 digits): ____________________

9. a. **Over the PAST MONTH, what major life stressors have you experienced that are a cause of significant concern or make it difficult for you to do your work, take care of things at home, or get along with other people (for example, serious conflicts with others, relationship problems, or a legal, disciplinary or financial problem)?**

O None or
O Please list and explain: ____________________

b. **Are you currently in treatment or getting professional help for this concern?** O Yes O No

10. **In the PAST YEAR did you receive care for any mental health condition or concern such as, but not limited to post traumatic stress disorder (PTSD), depression, anxiety disorder, alcohol abuse or substance abuse?** O Yes O No

If yes, please explain: ____________________

11. What prescription or over-the-counter medications (including **herbals/supplements) for sleep, pain, combat stress, or a mental health problem are you CURRENTLY taking?**

O Please list: ____________________
O None

12. a. **How often do you have a drink containing alcohol?**
O Never O Monthly or less O 2-4 times a month O 2-3 times per week O 4 or more times a week

b. **How many drinks containing alcohol do you have on a typical day when you are drinking?**
O 1 or 2 O 3 or 4 O 5 or 6 O 7 to 9 O 10 or more

c. **How often do you have six or more drinks on one occasion?**
O Never O Less than monthly O Monthly O Weekly O Daily or almost daily

13. **Have you ever had any experience that was so frightening, horrible, or upsetting that, in the PAST MONTH, you:**

a. Have had nightmares about it or thought about it when you did not want to? O Yes O No
b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it? O Yes O No
c. Were constantly on guard, watchful or easily startled? O Yes O No
d. Felt numb or detached from others, activities, or your surroundings? O Yes O No

SAMPLE

NOTE: If two or more items in 13a through 13d are marked yes, continue to answer items 13e through 13v.

Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each question carefully and check the box for how much you have been bothered by that problem in the LAST MONTH. Please answer all items.

	Not at all	A little bit	Moderately	Quite a bit	Extremely
13e. Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?	O	O	O	O	O
13f. Repeated, disturbing dreams of a stressful experience from the past?	O	O	O	O	O
13g. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?	O	O	O	O	O
13h. Feeling very upset when something reminded you of a stressful experience from the past?	O	O	O	O	O
13i. Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?	O	O	O	O	O
13j. Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?	O	O	O	O	O
13k. Avoid activities or situations because they remind you of a stressful experience from the past?	O	O	O	O	O
13l. Trouble remembering important parts of a stressful experience from the past?	O	O	O	O	O
13m. Loss of interest in things that you used to enjoy?	O	O	O	O	O
13n. Feeling distant or cut off from other people?	O	O	O	O	O
13o. Feeling emotionally numb or being unable to have loving feelings for those close to you?	O	O	O	O	O
13p. Feeling as if your future will somehow be cut short?	O	O	O	O	O
13q. Trouble falling or staying asleep?	O	O	O	O	O
13r. Feeling irritable or having angry outbursts?	O	O	O	O	O
13s. Having difficulty concentrating?	O	O	O	O	O
13t. Being "super alert" or watchful, on guard?	O	O	O	O	O
13u. Feeling jumpy or easily startled?	O	O	O	O	O

	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
13v. How difficult have these problems (13e through 13u) made it for you to do your work, take care of things at home, or get along with other people?	O	O	O	O

This form must be completed electronically. Handwritten forms will not be accepted.

Deployer's SSN (Last 4 digits): ____________

14. Over the LAST 2 WEEKS, how often have you been bothered by the following problems?

	Not at all	Few or several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	O	O	O	O
b. Feeling down, depressed, or hopeless	O	O	O	O

NOTE: If 14a. or 14b. are marked "More than half the days" or "Nearly every day," continue to answer items 14c. through 14l.

Over the LAST 2 WEEKS, how often have you been bothered by any of the following problems?	Not at all	Few or several days	More than half the days	Nearly every day
14c. Trouble falling/staying asleep, sleep too much.	O	O	O	O
14d. Feeling tired or having little energy.	O	O	O	O
14e. Poor appetite or overeating.	O	O	O	O
14f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	O	O	O	O
14g. Trouble concentrating on things, such as reading the newspaper or watching television.	O	O	O	O
14h. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety that you have been moving around a lot more than usual.	O	O	O	O

	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
14l. How difficult have these problems (14a.-14h.) made it for you to do your work, take care of things at home, or get along with other people?	O	O	O	O

15. Are you worried about your health because you believe you were exposed to something in the environment while deployed? O Yes O No

If yes, please explain: ____________

SAMPLE

16. Were you bitten or scratched by an animal during your deployment? O Yes O No

If yes, please explain what kind of animal was involved, your injury, and what happened:

____

17. Would you like to schedule an appointment with a health care provider to discuss any health concern(s)? O Yes O No

18. Are you interested in receiving information or assistance for a stress, emotional or alcohol concern? O Yes O No

19. Are you interested in receiving assistance for a family or relationship concern? O Yes O No

20. Would you like to schedule a visit with a chaplain or a community support counselor? O Yes O No

This form must be completed electronically. Handwritten forms will not be accepted.

Deployer's SSN (Last 4 digits): ____________________

Health Care Provider Only – Provider Review, Interview, Assessment, and Recommendations:

Deployer reports most recent deployment was to ______________________________ and has deployed ___________ times before in the past five years.

1. Address concerns identified on deployer questions 1 and 2.

Deployer question	Not answered	Deployer indicated concern	Deployer's response or concern	Provider comments (if indicated)
Self health rating	O	O		
Change in health post-deployment	O	O		

2. Address wounds, injuries, assaults, etc., occurring during deployment as reported on deployer question 3.

a. Did deployer mark that he/she is still having a problem or concern related to a wound, injury, or assault that occurred during their deployment?
   - O Yes
   - O No (*go to block 3*)
   - O Not answered by deployer

b. Refer for evaluation?
   - O Yes (complete blocks 16 and 17)
   - O No
     - O *Already under care*
     - O *Already has referral*
     - O *No significant impairment*
     - O *Other reason (explain):* ________________

3. Deployment experiences as reported in deployer question 4. Consider in overall assessment: ask follow-up questions as indicated.

Deployer question	Not answered	Yes response	Provider comments (if indicated)
Danger of being killed	O	O	
Encountered bodies or saw people killed or wounded	O	O	
In direct combat and discharged weapon	O	O	

SAMPLE

4. Address concerns identified on deployer questions 5 through 7.

Deployer question	Not answered	Deployer indicated concern	Deployer's response or concern	Provider comments (if indicated)
Health care visits since return	O	O		
Hospitalized since return	O	O		
Physical limitations/problems	O	O		

5. Post-deployment general symptoms/health concerns.

List of symptoms reported as "Bothered a Lot" on Deployer Questions 8a. through 8dd.

List of symptoms reported as "Bothered a Little" on Deployer Questions 8a. through 8dd.

Physical symptom (PHQ-15) severity score for Deployer Questions 8a. through 8o.				
	Minimal < 4	Low 5 - 9	Medium 10 - 14	High ≥ 15
Deployer's total	____	____	____	____

a. Does deployer have evidence of high generalized post- deployment physical symptoms (a score of ≥ 15 on the PHQ-15 physical symptom scale – deployer questions 8a. through 8o.) or is "bothered a lot" by specific symptoms listed in 8a. through 8dd.?
   - O Yes
   - O No
   - O Not answered by deployer

b. Based on deployer's responses to deployer questions 8a. through 8dd. is a referral indicated?
   - O Yes (complete blocks 16 and 17)
   - O No
     - O *Already under care*
     - O *Already has referral*
     - O *No significant impairment*
     - O *Other reason (explain):* ________________

This form must be completed electronically. Handwritten forms will not be accepted.

Deployer's SSN (Last 4 digits): ____________________

6. Major life stressor as reported on deployer question 9.

a. Did deployer mark they have a concern or a difficulty with a major life stressor?
- O Yes Deployer's concern: ____________________
- O No (*go to block 7*)
- O Not answered by deployer

b. If yes, ask additional questions to determine level of problem: ____________________

c. Consider need for referral. Referral indicated?
- O Yes (complete blocks 16 and 17)
- O No
  - O *Already under care*
  - O *Already has referral*
  - O *No significant impairment*
  - O *Other reason (explain)* ____________________

7. Address concerns as reported in deployer questions 10 and 11.

Deployer question	Not answered	Yes response	Deployer's response	Provider comments (if indicated)
History of mental health care	O	O		
Medications	O	O		

8. Alcohol use as reported in deployer question 12.

a. Deployer's AUDIT-C screening score was ______. *(If score between 0-4 (men) or 0-3 (women) nothing required, go to block 9).*
- O Not answered by deployer

Number of drinks per week: __________ Maximum number of drinks per occasion: __________

Based on the AUDIT-C score and assessment of alcohol use, follow the guidance below:

Alcohol Use Intervention Matrix		
Assess Alcohol Use	**AUDIT-C Score Men 5-7 Women 4-7**	**AUDIT-C Score Men and Women ≥ 8**
Alcohol use WITHIN recommended limits: Men: ≤ 14 drinks per week OR ≤ 4 drinks on any occasion Women: ≤ 7 drinks per week OR ≤ 3 drinks on any occasion	Advise patient to stay below recommended limits	Refer if indicated for further evaluation AND conduct BRIEF counseling*
Alcohol use EXCEEDS recommended limits: Men: > 14 drinks per week or > 4 drinks on any occasion Women: > 7 drinks per week or > 3 drinks on any occasion	Conduct BRIEF counseling* AND consider referral for further evaluation	

SAMPLE

* BRIEF counseling: Bring attention to elevated level of drinking; Recommend limiting use or abstaining; Inform about the effects of alcohol on health; Explore and help/support in choosing a drinking goal; Follow-up referral for specialty treatment, if indicated.

b. Referral indicated for evaluation?
- O Yes (complete blocks 16 and 17)
- O No Provide education/awareness as needed. State reason if AUDIT-C score was 8+:
  - O *Already under care*
  - O *Already has referral*
  - O *No significant impairment*
  - O *Other reason (explain):* ____________________

This form must be completed electronically. Handwritten forms will not be accepted.

Deployer's SSN (Last 4 digits): ____________________

9. PTSD screening as reported in deployer question 13.

a. Did deployer mark yes on two or more of questions 13a. through 13d.?

- O Yes
- O No (go to block 10)
- O Not answered by deployer

b. If yes, deployer's responses to questions 13e. through 13u. resulted in a PCL-C score of ________ and the deployer's response to level of impairment with life events (13v.) is indicated in the table below.

O 13e. through 13v. were not answered or are incomplete.

Based on the PCL-C score, the deployer's level of functioning, and your exploration of responses, follow the guidance below:

Post-Traumatic Stress Disorder Intervention Matrix

Self-Reported Level of Functioning	PCL-C Score <30 (Sub-threshold or no Symptoms)	PCL-C Score 30-39 (Mild Symptoms)	PCL-C Score 40-49 (Moderate Symptoms)	PCL-C Score ≥ 50 (Severe Symptoms)
O **Not Difficult at All or Somewhat Difficult**	No intervention	Provide PTSD education*		Consider referral for further evaluation AND provide PTSD education*
O **Very Difficult to Extremely Difficult**	Assess need for further evaluation AND provide PTSD education*	Consider referral for further evaluation AND provide PTSD education*		Refer for further evaluation AND provide PTSD education*

* PTSD Education = Reassurance/supportive counseling, provide literature on PTSD, encourage self-management activities, and counsel deployer to seek help for worsening symptoms.

c. Referral indicated?

- O Yes (complete blocks 16 and 17)
- O No
  - O *Already under care*
  - O *Already has referral*
  - O *No significant impairment*
  - O *Other reason (explain):* ____________________

10. Depression screening as reported in deployer question 14.

a. Did Deployer mark "More than half the days" or "Nearly every day" on question 14a. or 14b.?

- O Yes
- O No (go to block 11)
- O Not answered by deployer

SAMPLE

b. If yes, deployer's responses to questions 14a. - 14h. resulted in a total PHQ-8 score of ________ and the deployer's response to level of impairment with life events (14i.) is indicated in the table below.

O 14c. through 14i. were not answered or incomplete.

Based on the PHQ-8 score, deployer's level of functioning, and exploration of responses, follow the guidance below:

Depression Intervention Matrix

Self-Reported Level of Functioning	PHQ-8 Score 1-4 (No Symptoms)	PHQ-8 Score 5-9 (Sub-Threshold Symptoms)	PHQ-8 Score 10-14 (Mild Symptoms)	PHQ-8 Score 15-18 (Moderate Symptoms)	PHQ-8 Score 19-24 (Severe Symptoms)
O **Not Difficult at All or Somewhat Difficult**	No intervention	Depression education*		Consider referral for further evaluation AND provide depression education*	Consider referral for further evaluation AND provide depression education*
O **Very Difficult to Extremely Difficult**	Assess need for further evaluation AND provide depression education*		Consider referral for further evaluation AND provide depression education*	Consider referral for further evaluation AND provide depression education*	Refer for further evaluation AND provide depression education*

* Depression Education = Reassurance/supportive counseling, provide literature on depression, encourage self-management activities, and counsel deployer to seek help for worsening symptoms.

c. Referral indicated?

- O Yes (complete blocks 16 and 17)
- O No
  - O *Already under care*
  - O *Already has referral*
  - O *No significant impairment*
  - O *Other reason (explain):* ____________________

This form must be completed electronically. Handwritten forms will not be accepted.

Deployer's SSN (Last 4 digits): ______

11. Environmental and exposure concern/assessment as reported in deployer question 15.

a. Did deployer indicate a worry or possible exposure? ○ Yes ○ No (go to block 12)

If yes, mark deployer's exposure concern(s)	
○ Animal bites	○ Paints
○ Animal bodies (dead)	○ Pesticides
○ Chlorine gas	○ Radar/Microwaves
○ Depleted uranium	○ Sand/dust
○ Excessive vibration	○ Smoke from burning trash or feces
○ Fog oils (smoke screen)	○ Smoke from oil fire
○ Garbage	○ Solvents
○ Human blood, body fluids, body parts, or dead bodies	○ Tent heater smoke
○ Industrial pollution	○ Vehicle or truck exhaust fumes
○ Insect bites	○ Chemical, biological, radiological warfare agent
○ Ionizing radiation	○ Other exposures to toxic chemicals or materials, such as ammonia, nitric acid, etc. Please list:
○ JP8 or other fuels	
○ Lasers	
○ Loud noises	

b. If yes, referral indicated?

○ Yes (complete blocks 16 and 17)
○ No (provide risk education)
- ○ *Already under care*
- ○ *Already has referral*
- ○ *No significant impairment*
- ○ *Other reason (explain):* ______

12. Animal bite (rabies risk) as reported on deployer question 16.

a. Did deployer mark "yes" on animal bite/scratch?

○ Yes
○ No *(go to block 13)*

b. If yes, based on details of event and care received is a referral and/or follow-up indicated?
Note: Rabies incubation period can be months to years. Rabies prophylaxis can begin at anytime.

○ Yes (complete blocks 16 and 17)
○ No (provide risk education)
- ○ *Was appropriately treated*
- ○ *Already under care*
- ○ *Already has referral*
- ○ *Situation was not a risk for rabies*
- ○ *Other reason (explain):*

SAMPLE

13. Suicide risk evaluation.

a. **Ask** "Over the **PAST MONTH**, have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way?"

○ Yes
○ No (go to block 14)

b. If 13.a. was yes, **ask:** "How often have you been bothered by these thoughts?"

○ Few or several days
○ More than half of the time
○ Nearly every day

c. If 13.a. was yes, **ask:** "Have you had thoughts of actually hurting yourself?"

○ Yes **(If yes, ask questions 13d. through 13g.)**
○ No (If no thoughts of self-harm, go to block 14)

d. **Ask** "Have you thought about how you might actually hurt yourself?"

○ Yes How? ______
○ No

e. **Ask** "There's a big difference between having a thought and acting on a thought. How likely do you think it is that you will act on these thoughts about hurting yourself or ending your life over the next month?"

○ Not at all likely
○ Somewhat likely
○ Very likely

f. **Ask** "Is there anything that would prevent or keep you from harming yourself?"

○ Yes What? ______
○ No

g. **Ask** "Have you ever attempted to harm yourself in the past?"

○ Yes How? ______
○ No

h. **Conduct further risk assessment** (e.g., interpersonal conflicts, social isolation, alcohol/substance abuse, hopelessness, severe agitation/anxiety, diagnosis of depression or other psychiatric disorder, recent loss, financial stress, legal disciplinary problems, or serious physical illness).

Comments: ______

i. Does deployer pose a current risk for harm to self?

○ Yes (complete blocks 16 and 17)

This form must be completed electronically. Handwritten forms will not be accepted.

Deployer's SSN (Last 4 digits): ____________________

14. Violence/harm risk evaluation.

a. **Ask**, "Over the past month have you had thoughts or concerns that you might hurt or lose control with someone?"

O Yes
O No *(go to block 15)*

If yes, **ask** additional questions to determine extent of problem (target, plan, intent, past history) Comments: ____________________

b. Does member pose a current risk to others?

O Yes (complete blocks 16 and 17)
O No (briefly state reason): ____________________

15. Deployer issues with this assessment (mark as appropriate):
O Deployer declined to complete form
O Deployer declined to complete interview/assessment

Assessment and Referral: After review of deployer's responses and interview with the deployer, the assessment and need for further evaluation is indicated in blocks 16 through 19.

16. Summary of provider's identified concerns needing referral < Mark all that apply>	Yes	No
a. None Identified O		
b. Physical health	O	O
c. Dental health	O	O
d. Mental health symptoms	O	O
e. Alcohol use	O	O
f. PTSD symptoms	O	O
g. Depression symptoms	O	O
h. Environment/work exposure	O	O
i. Risk of self-harm	O	O
j. Risk of violence	O	O
k. Other, list:	O	O

17. Recommended referral(s) < Mark all that apply even if deployer does not desire>	Within 24 hours	Within 7 days	Within 30 days
a. Primary Care, Family Practice, Internal Medicine	O	O	O
b. Behavioral Health in Primary Care	O	O	O
c. Mental Health Specialty Care	O	O	O
d. Dental	O	O	O
e. Other specialty care:	O	O	O
Audiology	O	O	O
Dermatology	O	O	O
OB/GYN	O	O	O
Physical Therapy	O	O	O
TBI/Rehab Med	O	O	O
Podiatry	O	O	O
Other, list	O	O	O
f. Case Management/ Care Management	O	O	O
g. Substance Abuse Program	O	O	O
h. Other, list:	O	O	O

SAMPLE

18. Comments:

____

____

____

19. Address requests as reported on deployer questions 17 through 20.

Deployer question	Not answered	Yes response	Comments (if indicated)
Request medical appointment	O	O	
Request info on stress/emotional/alcohol	O	O	
Family/relationship concern assistance	O	O	
Chaplain/counselor visit request	O	O	

Appendix E: NIH Certification

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Tiffany Schweitzer** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 06/16/2014

Certification Number: 1489293

Appendix F: Free Counseling Resource List

Veteran's Crisis Line
Phone: 1-800-273-8255 (Press 1)
Confidential Veterans Chat: Text 838255 to Get Help Now
Hours: 24/7

The National Suicide Prevention Lifeline
Phone: 1-800-273-TALK (8255)
Hours: 24/7

VA's Coaching Into Care
Phone: 1-888-823-7458
Email: CoachingIntoCare@va.gov
Hours: 8am-8pm EST Monday-Friday

Vet Center Combat Call Center
Phone: 1-877-WAR-VETS (927-8387)
Hours: 24/7

Defense Centers of Excellence (DCoE) Outreach Center
Phone: 1-866-966-1020
Email: resources@dcoeoutreach.org
Live Chat: realwarriors.net/livechat
Hours: 24/7

Wounded Warrior Resource Center
Phone: 1-800-342-9647
Email: woundedwarriorresourcecenter.com
Hours: 24/7

InTransition
Phone: 1-800-510-7897
Email: dcoe.health.mil
Hours: 24/7

Note: In the event any participant experiences emotional issues from the interviews because of PTSD or attached stigma, this reference list provides a free source of assistance.