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Reintegration Among Combat Veterans Suffering From Psychological Conditions

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Walden University
2018

Abstract

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MA, University of Guam, 2008

BS, Norfolk State University, 1989

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Human Services, Criminal Justice and Counseling

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Abstract

Active duty personnel as well as combat veterans of the United States often engage in military operations during their service that require deployments to participate in missions, which may lead to extended periods away from home. When active duty men and women are appointed to combat zones, they may return with psychological burdens such as post traumatic stress disorder, which can complicate their reintegration into civilian life. This study explored the experiences of combat veterans who faced challenges when returning home from a war zone, along with the experiences of their family members. The study involved 26 combat veterans, spouses, significant others, and parents. In data analysis, semistructured interview responses were given concerning personal experiences. The interviews produced a vast amount of information with manual notes. Participants discussed treatment, interventions, and strategies for family reintegration. Many of the veteran participants shared that family members did the ñbest they couldò to help them reintegrate. The themes received for the study were family reintegration, command strategies and intervention, community services, and mental health services. The study showed how combat veterans and family members can successfully complete family reintegration with social support as well as support from mental health professionals. In association with social change, psychologists, psychiatrists, mental health practioners, and licensed professional counselors may benefit from the findings of this study. Professionals involved with mental health treatments and assessments would learn how to connect with combat veterans and family members. This study supports the recommendation that combat veterans and family members receive services from mental health professionals.

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Dedication

ñGrace to you and peace from God the Father, and from our Lord Jesus Christ.ò Psalm 96:2

To my husband, Paul my best friend, my rock, and my supporter, for encouraging me to pursue higher education. I love you.

To my children, Jamirah and Jeremiah: I appreciate the patience and peace while pursuing my higher education. I love you.

Acknowledgments

ñMany are the plans in a manôs, heart, but it is the Lordôs purpose that prevails.ò Proverbs 19:21

First, giving honor to God, I humbly express sincere gratefulness to the following people who helped to complete this proposal and achieved another milestone in my life:

In loving memory of my guardian mother, Mrs. Dorothy H. Royal, who ultimately raised me to the path of understanding and righteousness filled with morals and values.

In loving memory of my parents, Thomas Douglas Johnson and Bettie M. Woodley, gone but not forgotten. I would love to have you present; yet, God needed you more.

To all veterans and family members who participated in this study and served our country with bravery, without hesitation: Thank you from the bottom of my heart.

To all my true friends, family and professors who constantly reminded me to keep overachieving and believing. Also, Dr. M. Bold and Dr. Chenoweth, thank you for your time.

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Chapter 1: Introduction to the Study

Background of the Study

The 21st century has been marked with the legacy of combat tours on foreign soil by U.S. soldiers. Research has shown that challenges persisted among combat veterans and mental health conditions from the Department of Defense (DoD), Veterans Administration (VHA) and many community systems, which required enhancement and expansion (Pickett et al., 2015). In 2007, the White House formed the Presidentôs Commission on Care for Americaôs Returning Wounded Warrior (Executive Order 13426). In 2007, the Veterans Administration (VA) reported that the Commission on Care for Americaôs Returning Wounded Warriors had recommended fundamental changes to the military health care system, including aggressive steps to prevent and treat posttraumatic stress disorder (PTSD) and traumatic brain injury (TBI) suffered during war.

In 2013, the National Center for PTSD reported that 20% of veterans returning from the combat deployments Operations Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) met the clinical criteria for PTSD, depression, anxiety, and/or TBI. Warden (2006) contended TBI, a disorder associated with combat veterans in Iraq and Afghanistan, has been commonly related as an important source of morbidity. The incidence of TBI increased in combat veterans due to explosions and war injuries (McKee & Robinson, 2014).

Brain injuries can have persistent, progressive, and long-term debilitating effects. In fact, TBI can incite the development of chronic traumatic encephalopathy (McKee & Robinson, 2014). Chronic traumatic encephalopathy is associated with ñbehavioral changes, executive dysfunction, memory loss, and cognitive impairments that begin insidiously and progress slowly over decadesò (McKee & Robinson, 2014 p. s242).

In 2013, the Substance Abuse and Mental Health Services Administration reported that a victim associated with trauma has a higher percentage of mental health, violence, or self-injury. Psychological conditions and trauma are common issues facing combat veterans, and there is a gap in the current literature on the effect of military related trauma processes on readjustment and family reintegration (Sayers, Farrow, Ross, & Oslin, 2009). Tyson (2006) pointed out that diagnosis of PTSD and TBI were highest among those veterans deployed 12 months or more and in those exposed to combat zones. Cantrell and Dean (2005) suggested that combat stress was significantly higher among soldiers with at least one previous tour of combat; in fact, soldiers had returned to Iraq and other war zones with unresolved symptoms of combat stress from previous tours.

White, Mulvey, Fox, and Choate (2011) reported that among veterans involved in Iraq and Afghanistan who received care from the Department of Veterans Affairs between 2001 and 2005, nearly-one third were diagnosed with mental health or psychosocial problems and one-fifth were diagnosed with a substance use disorder. In 2010 the National Defense Council reported that approximately 5,800 combat soldiers returning from combat and 25-40 % of veterans had less visible wounds, such as

psychological and neurological injuries associated with PTSD or TBI (White et al., 2011). The National Defense Authorization Act (2014) provided assistance to eligible veterans with TBI to enhance their rehabilitation, quality of life, and community integration. The Veterans Traumatic Brain Injury Care Improvement Act of 2014 amended the National Defense Authorization Act for Fiscal Year 2008 to alter the reporting requirements under the pilot program to assess the effectiveness of providing assistance to eligible veterans with TBI to enhance their rehabilitation, quality of life, and community integration.

Combat veterans and mental health professionals understand the significance and applicability of the phenomena under study (Reeves, Albert, Kuper, & Hodges, 2008). In addition, a study has shown combat veterans with histories of TBI or trauma may be incorrectly attributing symptoms to incorrectly diagnosis (Miles et al., 2017). The aim of this study was to identify supports and interventions that assist combat veterans in the postdeployment period to determine the accessibility of social supports predicts a soldierôs successful reintegration into the family and community after war.

Problem Statement

Vincent et al. (2012) pointed out that some combat veterans struggled with family reintegration following combat tours due to psychological problems. They suggested that such problems can lead to other destructive behaviors, including such as domestic violence, substance abuse, and alcohol abuse. In 2008, the VA reported that more than 76,000 returning veterans had a probable diagnosis of PTSD, and possibly other psychological conditions such as clinical depression, hyper-vigilance, insomnia, emotional numbing, recurring nightmares, and intrusive thoughts. Returning service members are at greater risk for increased levels of aggression along with difficulty in finding meaning in life. PTSD symptoms include burnout and other mental health symptoms that tend to increase in severity throughout the postdeployment reintegration period (McCreary, Peach, Blais, & Fikretoglu, 2014).

The Veterans Administration (2009) reported no provision for ensuring that community mental health professionals have appropriate expertise to effectively treat combat veterans (*Testimony by the Wounded Warrior Project in front of the Veterans Affairs Committee,* 2009). In 2009 Mental Health Advisory reported that veterans with untreated mental health problems may face severe consequences to their overall health and ability to fully reintegrate into their communities, exacerbating the potential for chronic mental health conditions. In comparison, Franciskovic, Stevanovic, and Klaric (2014) claimed that ñveteransô suffering from PTSD may isolate themselves from other people, even from their spouses because of painful traumatic events that can be difficult to communicate and express.ò

Purpose of the Study

Study of the reintegration stages of the deployment cycle has typically focused on the links between stressors or trauma experienced during memberôs deployment and postdeployment clinical issues or psychological problems (McCreary et al., 2014). Williamson and Mulhall (2009) that research indicated that lack of screenings and shortages of mental health professionals were keeping veterans from receiving the professional and psychological assistance they needed after deployment.

Participants reported using mental health services were not utilized after returning home due to stigma and classified as ñweakò; in fact, younger the veteran less likely the service (Kulesza et al., 2017). Degeneffe and Tucker (2014) stated that research was lacking regarding community-based support and unmet needs among families of persons with brain injuries. The purpose of this study was to provide information for mental health and clinical professionals on the stressors of reintegration and the availability of support services for combat veterans.

Research Questions

The research questions that I used to guide this study were designed to identify the supports and interventions that assist combat veterans postdeployment to determine whether the accessibility of social supports influences a soldierôs successful reintegration into family and community after war. With the return of many soldiers needing help following war, there is a need to understand how reintegration into the family can come

with many challenges. A combat veteran reintegrating home and community is an ongoing process (Gerlock et al., 2014).

RQ1: How did supports and interventions provided to combat veteranôs postdeployment prepared them for successful reintegration with the family?

RQ2: What interactions and transitions enabled a successful reintegration into the community?

RQ3: What barriers do combat veterans and their families report before and after deployment?

RQ4: What tools were given to combat veterans and family members to integrate successfully into the community?

RQ5: How does being assigned to a mental health coordinator assist combat veterans and family members when returning from war zones?

Theoretical Framework

This study used two psychological theories pertaining to support, coping, and community awareness. Symbolic interaction and social cognitive theory provided insight into combat veteransô psychological changes from war to family reintegration. Symbolic interactionism involves the process of interaction in the formation of meanings for individuals. Through symbolic interaction combat veterans expressed their perceptions of their daily environments to me as the researcher (Blumer, 2008).

Moreover, symbolic interaction theory examines how personal perceptions can affect veteransô views of reality, regardless of whether those perceptions are accurate. For example, a researcher applying this theory can gather information regarding how veterans with psychological disorders interpret the world around them, asking questions such as ñDo they feel safe?ò Further, symbolic interactionism theory explains how combat veterans express their perceptions of their daily environment, symbolic interactionism theory involves two core principles, *meaning and situation,* which lead to conclusions about the creation of a personôs self and socialization (Reeves et al., 2008). Symbolic interactionism theory can serve as a theoretical perspective for conceptually clear and soundly implemented multiple method research to expand understanding of human health behavior (Benzies & Allen, 2001).

Social cognitive learning theory is an interpersonal social-cognitive theory of the self that draws on theory and research in social cognition, personal psychology, and clinical psychology (Andersen & Chen, 2002). With this theory, one can examine the influence of others' behaviors on personal development (Reeves et al., 2008). Resilience can be applied to the individual, dyads, families, groups, communities, and larger units of analysis (Bowen, Martin, & Mancini, 2013). Moreover, Bowen et al. (2013) suggested that family resilience is presenting circumstances in a combat veteransô life; in addition, family resilience is a process to describe the capacity of a family system to successfully manage life circumstances. In other words, family resilience involves adapting following exposure to significant adversities or crises (Bowen et al., 2013).

Nature of the Study

This study had a qualitative focus. Qualitative research is designed to explore, investigate, and describe (Palinkas, 2014). This study was unique because it explored how combat veterans are fighting another war upon returning home (Hoge et al., 2004). The criteria established for participation in this research were that participants needed to be combat veterans who had served in a war zone and had been deployed for a year or more while participating in Operation Enduring Freedom (OEF) or Operations Iraqi Freedom (OIF). Further, participants needed to serve more one tour of duty in Afghanistan, Iraq, Africa, or any war zone. Individuals could take part in the study between 0 and 10 years after serving in combat. Participation could be enlisted or retired, as well as single or married. Data collection occurred through face-to-face interviews with combat veterans and their spouses, significant others, and parents.

Study of family reintegration stages following deployment has focused on the links between stressors or trauma experienced during the memberôs deployment and postdeployment (McCreary et al., 2014). Williamson and Mulhall (2009) suggested that research indicates that screenings and shortages of mental health professionals are keeping veterans from getting the professional and psychological assistance they need after deployment. Kulesza et al. (2015) identified that although many veterans were concerned about negative perceptions about seeking treatment, a smaller group reported that they would judge a fellow veteran negatively in a similar situation of counseling assistance; therefore, combat veterans underutilized mental health services.

I used a multiple case study design. Yin (2004) suggested that case study research enables a researcher to investigate important topics not easily covered by other methods. Yin (2012) presented four types of designs for case studies: single-case holistic designs, single-case embedded designs, multiple-case holistic designs, and multiple-case embedded designs. The multiple case designs can construct a framework in which literal replication predicts comparable results across multiple cases, or it can produce theoretical replication whereby different results are likely for theoretical reasons (Yin, 2009).

Significance of the Study

This study is significant because a reintegration process is needed for combat veterans and their family members upon returning from any combat zone. McCreary et al., (2014) suggested that reintegration starts as soon as a combat veteran returns home and may last several months. Through this study, I sought to *i*dentify the supports and interventions that assist combat veterans postdeployment and determine whether accessibility of social supports predicts a combat veteranôs successful reintegration. Such a prediction supports a combat veteranôs successful reintegration into the family and community after participation in OEF and OIF. Further, study of the reintegration stages of the deployment cycle has typically focused on the links between stressors or trauma experienced during the member's deployment and postdeployment clinical issues or psychological problems (McCreary et al., 2014). Moreover, this study was designed to determine whether veterans have the appropriate support available to allow family reintegration upon ending deployment.

The Presidentôs Commission on Care for Americaôs Returning Wounded Warriors-recommended fundamental changes to the military health care system, including aggressive steps to prevent and treat PTSD and TBI (VA, 2012). To address the issue of accessibility of services, the DoD is making changes to support military veterans and assist with psychological and neurological injuries. However, research indicates that lack of screenings and shortages of mental health professionals are keeping veterans from getting the professional and psychological assistance they need (Williamson & Mulhall, 2009).

In 2016 the Department of Veterans Affairs implemented several programs for combat veterans, including the use of mental health treatment coordinators, the availability of emergency mental health care 24 hours per day, evidence-based treatment, and couple services. The Department of Veteran Affairs stated that veterans who received specialty mental health care would be given mental health treatment coordinators (MHTCS) for overall assistance in meeting mental health goals along with evidence-based treatment. Further, emergency mental health facilities would provide 24-hour services as well as a national crisis hotline. Finally, veterans and immediate family members could also receive services such as family therapy, marriage counseling, or grief counseling. Researchers have shown that individuals returning from deployment are at increased risk for a wide range of mental health concerns, including PTSD; furthermore, data have shown that rates of mental health symptoms tend to increase throughout the postdeployment reintegration period (McCreary et al., 2014).

Franciskovic, Stevanovic, and Klaric (2014) contended that researchers have shown that combat veterans are also at risk of being victims or perpetrators of domestic violence, as well as for psychological conditions, mental disorders, and trauma conditions. They argued that such situations could result in *redistribution* or increased burden placed on spouses that may lead to burnout, transmission of PTSD, and/or development of other mental disorders (Franciskovic et al., 2014). Albert, Kuper, and Hodges (2008) note that literature has not focused on the phenomena of psychological trauma and family integration as they relate to treatment. The data derived from this study may give mental health and clinical professionals information on the stressors of reintegration, as well as on the usage and availability of support services for combat veterans.

Definition of Key Terms

The following key terms were used in this study:

Governing bodies: Governing bodies are local, state, and federal agencies that conduct policies, actions, and affairs.

Mental health clinicians: Mental health clinicians are technicians or doctors who are responsible for assessments and theoretical studies.

Posttraumatic Stress Disorder (PTSD): PTSD can occur after a person goes through a traumatic event such as combat, assault, or disaster (Veterans Affairs, 2016). Diagnostic criteria for PTSD include a history of exposure to a traumatic event that meets specific stipulations, as well as symptoms from each of four symptom clusters: intrusion,

avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity (American Psychiatric Association, 2013).

Psychological trauma: A type of damage to the psyche that occurs as a result of a severely distressing event (American Psychiatric Association, 2013).

Traumatic brain injury (TBI): TBI is an injury to the head. Most often, TBI are improvised explosive devices (IED) such as roadside bombs as well as artillery, rocket and mortar shells, traps, aerial bombs, and rocket-propelled grenades (Department of Veterans Affairs, 2016).

Veteran: A veteran is an experienced serviced to the United States military.

Scope and Delimitations

The scope of this study included an overview of reintegration for combat veterans and their family members. The study involved 26 combat veterans, spouses, significant others, and parents. A delimitation of my study was the omission of children. Although family members such as parents and siblings may have had similar experiences with reintegration, this study was not intended to provide generalized data. Each participant gave personal views of family reintegration experiences, which I incorporated within a qualitative methodological design to capture a whole picture and personal viewpoints.

Limitations

There were limitations to this study. First, the sample was small. However, qualitative samples are generally small. Second, the findings from this study should not be generalized to other populations; they are limited to the population under study only. For example, another population might include children of combat veterans, who would be protected by law and consent provisions when participating in research. Finally, documentation concerning mental health services is protected and confidential. Moreover, privileged communications between therapists and clients are protected. Combat veterans and family members might not have been willing to disclose treatment provided during their experiences.

Summary

In this chapter, I have introduced the problem of how to support combat veteransôsuccessful reintegration into their families and communities after participation in OEF and OIF. I have provided relevant background, the statement of the problem, the purpose of the study, the research questions, the theoretical framework, the nature of the study, definitions of term used, limitations of the study, significance of the research, assumptions underlying the study, and the scope and delimitations of the study.

Data derived from the study may give mental health and clinical professionals information on the stressors of reintegration, as well as utilization and availability of support services for combat veterans. The literature marginally addresses the difficulties faced by combat veterans and their families as they reintegrate into society, home, and

work. The impact of reintegration and family stability is important. To recap, this study was designed to determine available to allow family reintegration upon ending deployment.

Chapter 2: Literature Review

Overview

Military armed forces began Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) on October 7, 2001, and March 19, 2003, respectively. There were approximately 1.3 million combat veterans deployed in OIF and OEF (Lowe et al., 2012). Foran et al. (2013) contended that veterans of these conflicts were at risk of mental health problems, such as PTSD, depression, alcohol abuse, and relationship difficulties following deployment from Afghanistan and Iraqi. In 2004, the U.S. Army conducted a study of more than 3,600 veterans returning from Afghanistan and Iraq and found that veterans met the criteria for major depression, generalized anxiety, or PTSD.

The National Defense Council noted that approximately 5,800 soldiers returning from Afghanistan and Iraqi, as well as 25-40% of veterans had less visible wounds such as psychological and neurological in injuries associated with PTSD and TBI (White et al., 2011). Degeneffe and Tucker (2014) suggested that TBI is a *silent epidemic* because it receives less attention than any other illness or injury (p. 293). Similarly, Gorman et al. (2014) noted that psychological injuries such as psychological trauma and TBI cannot readily be identified by nonprofessionals. The silent epidemic of psychological injuries extends beyond the veterans themselves, affecting parents, spouses, children, and the social environment (Lowe et al., 2012). Military veterans returning home from Afghanistan and Iraq with trauma and psychological conditions are faced with increased risk of postdeployment psychiatric disturbance (Sayers et al., 2009).

Research conducted to understand combat veteransô post deployment psychological trauma, can be found as far back as World War I (Williamson & Mulhall, 2009). As early as 1919, doctors tracked psychological and neurological injuries from combat veterans of World War I. Decades later, the Vietnam War deployment increased rates of family adjustment problems, interpersonal violence, PTSD, depression, alcohol and drug abuse (Marmar, 2009). Since World War I, various terms have been used to describe the psychological trauma incurred by combat veterans, such as *shell shocked, battle fatigue,* and *nosology.* In the early 19th century military doctors had begun diagnosing military soldiers with *exhaustion* or *fatigue* after stressful battles; in this content, *exhaustion* or *fatigue* was characterized by mental shutdown due to individual or group trauma.

The National Defense Council Commission stated that a sizeable fraction of service members returning from Iraq and Afghanistan suffered from PTSD, reporting 52,375 returnees had been seen in the VA (Veterans Administration, 2007). Williamson and Mulhall (2009) noted that many combat veterans received prescriptions for antidepressants or sleeping medications. Thus, Degeneffe and Tucker (2014) suggested that traumatic brain injury is ñoften referred as the *silent epidemic* because it receives less attention than any other illness or injuryò (p. 293).

The Department of Veterans Affairs (2010) suggested that less than 10 % of the general population of combat veterans would develop PTSD, whereas 1 in 6 soldiers returning from Iraq would be diagnosed with suffer from PTSD. The National Alliance on Mental Illness (2014) stated that in 2002 and 2003, an estimated 1.2 million male

veterans were identified as living with serious mental illness; further, 340,000 of these individuals had co-occurring substance abuse disorders. During the same period, 209,000 female veterans (13.1%) reported serious mental illness leaving 25,000 (1.6 %) reported co-occurring substance use disorder with mental illness (National Alliance on Mental Illness, 2014). White et al (2011) argued that common signs and symptoms of war-related wounds include lack of motivation, irritability, depression, anxiety, disrupted sleep, and behavioral issues. Although there are mental health programs, programs were not adequately validated (Foran et al., 2013).

Mental health care for military veterans has been in dangerously short supply at a time when 1 in 3 soldiers and Marines tests positive for PTSD upon screening when returning home (Williamson & Mulhall, 2009). White et al. (2011) contended that among veterans involved in Iraq and Afghanistan who received care from the Department of Veterans Affairs between 2001 and 2005, nearly-one third were diagnosed with mental health or psychosocial problems, while one-fifth were diagnosed with a substance use disorder. In comparison, approximately 17% of the general population of military veterans has been diagnosed with a serious mental disorder (DoD Task Force on Mental Health, 2007). Among returning soldiers from Iraq, 20% to 40%, were in need of treatment for mental health problems (DoD Task Force on Mental Health, 2007). Victims of trauma are at much higher risk for co-occurring mental health and substance abuse disorders, violence victimization and perpetration, self-injury, and a host of other coping mechanisms that themselves have devastating human, social, and economic costs (McCreary et al., 2014).

Combat veterans may experience declines in cognitive functioning as a result of ongoing or recent exposure to stressful or harsh environments and deployment stressors such as sleep deprivation, psychological stress, and fatigue (Franciskovic et al., 2014). While psychological conditions and trauma have become common issues facing military veterans, research is still lacking on the effectiveness of readjustment and family reintegration (Sayers et al., 2009). Sayer et al. (2009) concluded that mental health problems may complicate veteransô readjustment and reintegration into family life. Bowling and Sherman (2008) argued that veteransô exposure to psychological stressors has led to trauma, suffering, and violence for their children and families since the Global War on Terrorism as cited in (Lowe, Adams, Browne, & Hinkle, 2012).

Sayers et al. (2009) suggested that few studies have systematically examined family readjustment or domestic violence among veterans of recent military conflicts, with little research focusing on specific problems such as reintegrating into the family context. Flynn (2013) posited that effective reintegration of military members into family and civilian life will require ongoing research on the long-term impacts of military service during sustained years of combat deployments.

Lowe et al. (2012) contended that if reintegration after deployment is not properly addressed, it may negatively impact the long term stability of the family. Additionally, Marmar (2009) indicated that integration of care for military veterans involves many challenges and struggles to confront problems as well as reach out for mental health services in relation of psychological health.

Combat veterans are at risk of mental health problems such as PTSD, depression, alcohol abuse, and relationship difficulties following deployment (Foran et. al, 2013). In March 2007, the White House formed the Presidentôs Commission on Care for Americaôs Returning Wounded Warriors. The commission has recommended fundamental changes to the military health care system, including aggressive steps to prevent and treat PTSD and TBI, two key injuries in the current conflicts.

Marmar (2009) indicated that integration of care for military veterans involves many challenges and struggles to confront problems as well as reach out for mental health services because of a psychological condition. Sayer et al. (2009) concluded that mental health problems may complicate combat veteransô readjustment and reintegration into family life. Bowling and Sherman (2008) contended that combat veteransô exposure to psychological stressors has created trauma, suffering, and violence for their children and families since the Global War on Terrorism (Lowe et al., 2012).

Literature Search Strategy

I used the following keywords to search for prior studies: *veterans, trauma, mental health, clinical professionals, psychological theories, psychological factors, maladaptive health behaviors, anxiety, domestic violence, mental disorders, psychological conditions, Iraq, Afghanistan, post-traumatic stress disorder, therapy, family services, depression, Veterans Administration, integration, Self-determination Theory, Existential Therapy, Social Cognitive Theory, Self-Control Theory, Critical Theory, mental health evaluation, physiology, violence, and transiting from war to home.* I searched the following databases for relevant peer-reviewed literature: Sage, Education

Resources Information Center (ERIC), Digital Research Tools/Humanities & Science (DiRT), Computers & Applied Sciences, Education Research Complete, WHO | Data and Statistics- World Health Organization, and SocINDEX with Full Text. Only studies from peer-reviewed journals were used, and the articles publication ranged from 2007 through 2013. The EBSCO system and academic database revealed several journals and articles about Domestic Violence and Mental Health.

Theoretical Framework

In developing a theoretical framework for this study, I focused on symbolic interaction and social cognitive theory. The stressors, associated with combat veterans, are best dealt with using strategies that involves elements such as intellect, coping, and support (Cipriano & Moore, 2010). This study encompassed psychological theories pertaining to support, coping, and community awareness. Symbolic interaction assisted in providing further insight on the combat veteransôpsychological changes from ending deployment to family reintegration.

Symbolic interactionism serves as a theoretical perspective for conceptually clear and soundly implemented multiple method research to expand understanding of human health behavior (Benzies & Allen, 2001). Symbolic interactionism allowed me to construct a framework in which veterans could explain their perceptions of reality and coping with the home environment upon return from the combat zone. Meanwhile, I gathered information regarding how veterans with psychological disorders interpret the world around them. I asked questions such as the following: Do they feel safe? Do they

feel that they can return to similar relationships with their spouse or with their children? Do they perceive threats in their environment?

Trochim (2006) described a case study as an intensive study of a specific individual or context. No single way exists to conduct a case study; a combination of methods (e.g., unstructured, semistructured interviews, direct observation) can be used. Yin (2014) stated that the use of logic models in case study research explains the ultimate outcomes because the analysis technique consists of matching empirically observed clients to theoretically predicted events (p. 109); as a result, usage of a multiple case study design approach allowed me the opportunity to investigate experiences among combat veterans and family members with a unstructured interview. Baskarada (2014) pointed out that unstructured interviews cannot be answered ñyesò or ñno,ò noting semistructured interviews allow participants to discuss various experiences (p. 12). McLeod (2014) explained that unstructured interviews, sometimes referred to as ñdiscovery interviewsò or ñguided conversation,ò are flexible, in that questions can be adapted and may change depending on respondent'sô answers.

In contrast, data from a structured interview, which may be numerical data in nature, can be reported succinctly in tables and graphs. Yin (2014) described three applications of case studies: (a) as part of a larger evaluation, with the case study portion viewed as complementary and providing explanatory information; (b) as the primary evaluation method where the initiative being evaluated becomes the main case, and (c) as part of a dual-level evaluation arrangement, in which a single evaluation consists of one or more sub evaluations, with the potential for case study to play various roles to inform

the program evaluation as a whole (p. 109). Moreover, the multiple case study method allowed me to use semistructured questions and direct observation.

Blumer (2008) contended that symbolic interactionism involves the process interaction in the formation of meanings for individuals. Dewey (as cited in Anderson, 2014), who introduced symbolic interactionism, posited that human beings are best understood in practical and interactive relation to their environment. Mead (n.d.), developer of interactionism (not symbolic interactionism) explained that interactionism is an approach that involves examining the symbols, especially the language, that individuals use in their daily encounters while seeking to understand their social actions, interactions, and reactions (Reeves et al., 2008).

Also, Reeves et al. (2008) noted that ñmeaningò is defined as a central concept in symbolic interactionism due to the significance or importance that individuals and family members attach to their experience on the basis of their actions; further, symbolic interactionism holds the principle of meaning to be the central aspect of human behavior. Griffin (1997) described past research on symbolic interactionism theory as consisting three core principles of meaning, language and core principles.

Blumer (1997) described core principles that lead to conclusions about the creation of a personôs self and socialization into a larger community. The first core principle is meaning that humans act toward people and things according to the meanings that they give to those people or things. Symbolic interactionism holds the principle of meaning to be the central aspect of human behavior. Secondly, language gives humans a means by which to negotiate meaning through symbols. Third, thought is a mental

conversation that requires different points of view. With these three elements, the concept of the self can be framed while one look into the glass and imagines how one looks to another person (Griffin, 1997).

Using symbolic interaction theory, it is possible to examine how personal perception can affect a veteranôs view of reality, regardless of whether that perception is accurate. Social relationships provide an important context for how individuals and families define and respond to presenting situations and circumstances (Bowen et al., 2013). The Department of Veterans Affairs (2017) identified coping and self-efficacy as psychological outcomes, stating that when individuals feel that they can cope no matter what happens to them, tend to do better following a disaster. Bowen et al. (2013) explained that symbolic interactionism is valuable in apprehending the ñbig pictureò of the shared outlook or situation of a military veteranôs family. A situation is weighing, examining, and evaluating any event or crisis presented to the family after deployment while the veteran reintegrates back into the home. Blumer (1996) presented symbolic interactionism theory in *The Society for More Creative Speech* an effective means of evaluating human interaction.

Bowen et al. (2013) suggested that symbolic interactionism assist in the ñbig pictureò of veteranôs family by outlook or situation. A situation is weighing, examining, and evaluating any event or crisis presented to the family after deployment while reintegrating home. Next, social cognitive theory serves as a support to symbolic interaction. Social cognitive learning theory is an interpersonal social-cognitive theory of self that reflect on social cognition, personal psychology, and clinical psychology

(Andersen & Chen, 2002). The social cognitive learning theory examined the influence of others' behaviors on personal development (Reeves et al., 2008). Bandura (2002) showed social cognitive theory illustration in figure 1.

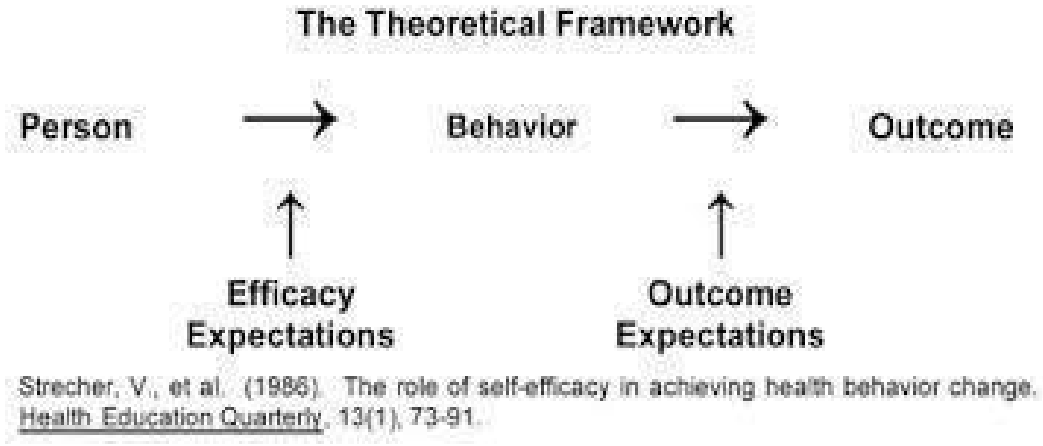

Fig. 1: Stretcher et al. (1986). The role of self-efficacy in achieving health behavior change. *Health Education Quarterly. 13*(1), 73-79

Incidentally, Kurose (2013) agreed that social cognitive theory sees motivation and behavior as resulting from an ongoing, dynamic interaction among cognitive, social, and environmental variables. There are environmental variables that consist of goal setting, values, and social norms. The variables of social cognitive theory are fundamentals agented perspective on human motivation and behavior, as well as agents who act intentionally to shape their life circumstances (Kurose, 2013). Bowen et al. (2013) suggested military life and their duties have always been stressful and intensify, and placed heavy burden on military families. Kurose (2013) stated that people are agents who act intentionally to shape by their surroundings and more than just the products of their environments. Social cognitive theory is an interpersonal theory which reflects on

self that draws on research in social cognition, personality psychology, and clinical psychology (Andersen & Chen, 2002).

Social cognitive theory examined past assumptions and experiences in relationships with new people, family, environments, and new people (Andersen & Chen, 2002). Also, most theories provided complex and comprehensive conceptual understanding of circumstances that cannot be pinned such as why people interact in certain ways (Reeves et al., 2008). Reeves et al. (2008) suggested theories provide one large lens for researcher to look at complicated problems and social issues. Andersen and Chen (2002) proposed that social cognitive theory focuses on self as related to other individuals such as significant others, social entities, and social groups.

History

The United States of America declared war, which prompted OEF on October 7, 2001 and OIF on March 19, 2003 (Erbes, 2007). While military veterans served in OEF and OIF the intense stress and horrendous trauma associated with the tours included serious injury or death, enduring the loss of comrades, and being forced to kill to survive (National Center for PTSD, 2010). Tyson (2006) indicated studies conducted by the Army have shown that 30% of troops deployed to Iraq suffer from depression, anxiety, and PTSD. For many combat veterans symptoms emerge after returning home from war zones or returning to their civilian lifestyles (Bowen et al., 2013).

Henceforth, military personnel are at risk of mental health problems such as anxiety, PTSD, depression, alcohol abuse, and relationship difficulties along with traumatic stressors (Foran et al., 2013). There are many combat veterans returning home

with misconceptions of psychological and traumatic stressors with phrases such as *"You will get over it,"* ñ*Put it behind you,"* ñ*Forget about it," "Let it go,"* and ñ*Those things happen"* (National Center for PTSD, 2010).

Bowen et al. (2013) suggested that military duties have always been stressful whether in combat or a general mission. Moreover, veteransô mission endures pace, intensity, repeat deployments, lengthy deployments, and family separations. The Global War on terrorism has presented psychological stressors such as trauma and violence for combat veterans, their spouses and children (Bowling & Sherman, 2008). Many deployments have family distress with psychological trauma and physical injuries (Gorman, et al., 2014). The National Center on Family Homelessness stated military veterans, men and women, returning home after a deployment revealed getting back into routine in the home was very challenging for the veteran, spouse, and children (Military Literature and Resource Review, n.d.).

The current literature on combat veterans from conflicts in the Middle East during the Global War on Terrorism is clear that military personnel faced intense stressors that often lead to trauma during and postdeployment. Military families under various degrees of their own stressors are severely impacted returning home from war. Combat veterans return with physical or psychological injury; as a result, impacts the latterôs ability to reintegrate with the family. Hence, high stress is reported by all family members. Combat veterans have reported stressful renegotiate roles, responsibilities, and boundaries with their spouse and children; however, combat veterans and spouses had to readjust in order to resume back to their daily routines and life before deployment (Faber et al., 2008).

Gorman et al. (2014) explained that PTSD affects spouses and children of combat veterans while experience more parenting challenges such as scheduling, household duties, and discipline (p. 244). Franciskovic et al. (2014) stated the effects of PTSD to combat veterans experience emotional numbness, depression, anger, isolation and abandonment. Moreover, disorders, such as PTSD, have an effect on veterans which may prohibit parental roles and spousal duties (Franciskovic et al., 2014). Most symptoms such as avoidance and numbness are presented during family routines and reintegration (p. 281-285).

Franciskovic et al. (2014) noted that studies have shown that persons in close contact with a traumatized person can develop painful and severe symptoms of trauma. Further, Franciskovic et al. (2014) stated ñpsychological profiles of war veteranôs wives reveal poorer social adjustment, greater interpersonal sensitivity, greater anxiety and higher levels of social introversionò (p. 287). The challenges faced for combat veterans and family members during the postdeployment can be persistent and stressful (McCreary et al., 2014). In summary, family reintegration literature focused on the family helping committed to making the veteranôs transition from deployment to civilian (Hinojosa & Hinojosa, 2011). Most often, veterans were returning from deployment struggling and facing challenges transitioning home.

Overview of Issues Related to Reintegration

Domestic Violence and Reintegration

Polusny et al. (2014) reported that families, parents, spouses or partners, has shown to be a key source of support for military personnel across the deployment cycle. According to National Coalition against Domestic Violence, domestic violence ñis the willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior perpetrated by an intimate partner against another; It is an epidemic affecting individuals in every community, regardless of age, economic status, religion, nationality or educational backgroundò (2014).

Also, American Psychiatric Association (APA) and Diagnostic and Statistical Manual (DSM) (2013) reported that ñpartner psychological abuse encompasses non-accidental verbal or symbolic acts by one partner that result, or have reasonable potential to result, in significant harm to the other partnerò (p.721). Griffin (2010) contended that deployment may be stressful for combat veterans and family members who are less prepared for prolonged separations and receive less support. The National Alliance on Mental Illness (2014) released a study indicating several mental health cases among combat veterans, including PTSD, drug and alcohol dependency, depression grew by 58 % from 63,767 in 2006 to 100,580 in 2007. In comparison, a study released in 2007 stated that of 103,788 OEF and OIF veterans, respectively, were seen in the VA. There were 25,658 (25%) combat veterans received mental health diagnoses with related diagnoses of 56 % of with 2 or more distinct mental health diagnoses (NAMI, 2014).

The VA (2017) noted that negative social support is a strong correlate to long-term PTSD. The family conflicts may arise because differing exposure levels among family members sets up different courses of recovery; in fact, family members may serve as distressing reminders to each other of the circumstances surrounding a war zone (Department of Veterans Affairs, 2017). Researchers suggested that risk factors for intimate partner violence (IPV) along with family separations includes individual issues such as depression, anger, isolation from others, and relationship factors such as marital conflicts (Campbell et al., 2010). Moreover, marital stress has been found to increase after disasters such as mental and physical injuries (Department of Veterans Affairs, 2017). The VA (2013) spent close to $900 million as well as $10,880 per military sexual assault survivor, on health services related to sexual assault on combat veterans or spouses. The Invisible War Discussion and Resource Guide (2012) indicated help is needed to focus on the recent incidents involving veteran perpetrators recently returned from tours of duty in Afghanistan.

Knobloch and Theiss (2014) suggested military couples may enjoy a ñhoneymoon periodò of tranquility immediately after homecoming. The reintegration period becomes challenging after the initial excitement of the reunion. Flynn (2014) stated reintegration of military members into families and civilian life will require ongoing research on the long-term impacts of military service during sustained years of combat deployment. The transition and integration is a period that could last hours, weeks, months, and sometimes years. After deployment mental health assessment has shown that significant increases in mental health problems occur 120 days past deployment and beyond (Hinojosa &

Hinojosa, 2011). Walker (1979) described three phases of domestic violence and illustrated how welcoming phases for combat veterans are related. Walker (1979) contended the common pattern or cycle of violence as illustrated in Figure 2:

Figure 2: Walkerôs Cycle of violence. From *Cycle of Violence* p.1 by L. Walker, 1979, New York, NY: Harper & Row 1979 by Copyright ï Reprinted with permission

Treatment for Military Veterans with Psychological Trauma

Many veterans are coming home and attempting to suppress experiences and symptoms (Cantrell & Dean, 2009). Most combat veterans experienced psychological trauma, recurring experiences such as still feeling as if their still in combat with emotional shutdown, avoidance and numbing emotions. Some combat veterans had a hard time relaxing, on guard, and not concentrate on a new beginning (National Center for PTSD, 2010). Substance Abuse & Mental Health Services Administration (SAMHSA, 2013) is an organization building a behavioral health system that enable Americans to find effective treatments and services in their communities for mental

and/or substance use disorders. The delegates of the American Counseling Association (ACA) defined counseling as ña professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goalsò (Castro et al., 2015). PTSD is an anxiety that may occur following a traumatic event and require effective treatment and intervention. PTSD may involve a combination of pharmacotherapy and psychotherapeutic modalities (APA, 2013). SAMHSA (2013) reported there are numerous interventions and treatment models for veterans, service members, and families with co-occurring disorders. Consequently, treatment of traumatized combat veterans should certainly include spouses and children (Franciskovic et al., 2014).

Franciskovic et al. (2014) studied 77 veterans, spouses and children that concluded chronic PTSD was still prevalent among the veteran population 15 years after the war; also, spouses and children exhibited symptoms of traumatization along with emotional and behavioral symptoms (Franciskovic et al., 2014). Cipriano and Moore (2010) outlined that stressors are best dealt with strategies such as intellect, coping, and support. Counseling (mental health education) served to normalize many of the reactions and symptoms that combat veterans might experience following their deployment; hence, counseling is not just for those experiencing mental illness (Castro et al., 2015).

McCreary et al. (2014) explained there are 3 domains or strategies important to service members and military veterans. The domains or strategies, used by mental health clinicians, should focus on positive and negative experiences for returning military

veterans; in addition, domain and strategies are stages used for reintegrating back into a positive work environment, family relationships, and deployment experiences into oneôs personal identity (McCreary et al., 2014).

McCreary et al. (2014) contended domains or strategies should be used and broken down into stages; for example, stages such as predeployment, deployment separated in operations from combat zone to home, and postdeployment reintegration stage. Also, McCreary et al. (2014) suggested stages would re-establish veterans back into a new job, community and family integration. Since predeployment and post deployment can become very stressful for family members, these domains or stages are important to military personnel and their family. Bowen et al. (2013) contended challenges of a demanding military lifestyle strive on contiguous to make a positive life experience.

Interventions

In 2013, the APA revised the PTSD diagnostic criteria in the fifth edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-5). PTSD is included in a new category in DSM-5, trauma and stress disorders. All of the conditions included in this classification require exposure to a traumatic or stressful event as a diagnostic criterion (U. S. Department of Veterans Affairs, 2017). Early interventions need to focus on safety, reducing initial distress, gathering information, and offering practical assistance. Interventions are available for combat veterans and family members to confront psychological, medical, or readjustment problems caused by war related

interception (U. S. Department of Veterans Affairs, 2017). The Veterans Health Administration (VHA) has begun to explore research programs and interventions to assist combat veterans who have been deployed for an extensive amount of time. The Department of Veterans Affairs (2017) certifies that psychological first aid is an appropriate initial intervention but that it does not serve a therapeutic or preventive function; moreover, initial screening is required so that preventive interventions can be used for those individuals who may have difficulty recovering on their own. The Secretary of Veteran Affairs David Shulkin identified the VAôs long hiring process and bureaucratic human services requirements as barriers to hiring more high quality mental health professionals (VFW Action Corps, 2017). Furthermore, Veterans Treatment Courts is working on service dogs for combat veterans as an intervention or strategy plan (VFW Action Corps, 2017).

Hinojosa and Hinojosa (2011) stated that research shows contentious post-deployment interactions with civilian family members are linked with poor mental health outcomes. Although many understand counseling as lying on a couch, these images represent only a part of the diverse continuum of practices that can serve as prevention and early intervention models for the combat veteran (Castro et al., 2015). Lastly, National Institute of Mental Health shared that cognitive behavioral therapy as an effective option that lasts 6 to 12 weeks; however, some people require longer evaluations and assessments than 6 to 12 weeks (ADAA, 2016).

Programs and Resources for Military Veterans

Veterans Administration (VA) is the second largest federal department and committed to "putting veterans first". The mission is ñto serve America's veterans and their families with dignity and compassion and to be their principal advocate in ensuring that they receive the care, support, and recognition earned in service to this nationò (VA, 2013). Also, Combat and Domestic Readjustment Education Program (CADRE Program) mission provided combat veterans with treatment to address PTSD that manifests in domestic violence. The CADRE program assisted veterans and their family with treatments and intervention programs. Additionally, The Regional Psycho-trauma Center in Croatia is a facility that specializes in war veterans seeking psychological help for traumas and disorders such as PTSD since 1991; consequently, this center not only assists military veterans but spouses with understanding the pressure and psychological emotions living with a combat veteran (Franciskovic et al., 2014). Postdeployment reintegration has important implications for combat veterans, clinicians or practitioners who work with service members through difficult times (McCreary et al., 2014, p. 187).

Lastly, Mindfulness-Based Stress Reduction (MBSR) is a group-based program used with clients experiencing a wide range of physical and mental health problems. Readiness and Resilience in National Guard Soldiers (RINGS-2) is a project working with Minneapolis Veterans Affairs Health Care System conducting a series of longitudinal studies assessing soldiers and their family before, during, and after multiple deployments to OEF/OIF/OND (Polusny et al., 2014). Knobloch and Theiss (2014) stated that reintegration, transitions, and reunions after deployments resulted in uncertainty such

as relationship turbulence. Albert et al. (2008) suggested literature has not focused on the phenomenon of psychological trauma and family integration as it relates to treatment while assisting combat veterans against violence and reintegration.

Summary

Veterans Administration (VA) is the second largest federal department and committed to "putting veterans first". The mission is ñto serve America's veterans and their families with dignity and compassion and to be their principal advocate in ensuring that they receive the care, support, and recognition earned in service to this nationò (VA, 2013). Reintegration is a period for combat veterans that can last a few hours, weeks, months, and/or years. Upon returning home, combat veterans face challenges from deployment to home; mentally another war zone.

Flynn (2014) contended that reintegration of combat veterans into civilian life will require ongoing research. I provided an in depth analysis of combat veterans and family reintegration as it relates to psychological trauma and long-term impact. Today, combat veterans are facing many challenges such as psychological trauma, reintegration, social networks, resources and postdeployment. Military families should be encouraged to seek mental health and clinical professionals with reintegration and postdeployment (Vincent et. al, 2012). Research is required to understand the perceptions of war; as well as combat veteransô mental health care, acceptability of care, willingness to continue treatment, and ways to communicate with their experiences as warriors (Hoge, 2011, p. 551). My next chapter will be based on the methodology and how the research design

will give an overview returning home from a combat zone. I will discuss the data collection, data analysis, verification of trustworthiness, and ethical considerations.

Chapter 3: Research Method

Overview of the Methodology

The section on methodology is an overview of how the research design was suggested for the problem. Additionally, this section assists in understanding how the research questions were developed and how data were collected from the participants. The methodology overview addressed the research design, qualitative methodology, participants, research procedure, and role of the researcher in the data collection procedure, and concluding with a summary. Qualitative methodology was appropriate to answer my research questions:

RQ1: How did supports and interventions provided to combat veteranôs postdeployment prepared them for successful reintegration with the family?

RQ2: What interactions and transitions enabled a successful reintegration into the community?

RQ3: What barriers do combat veterans and their families report before and after deployment?

RQ4: What tools were given to combat veterans and family members to integrate successfully into the community?

RQ5: How does being assigned to a mental health coordinator assist combat veterans and family members when returning from war zones?

Introduction

This study used qualitative research design. I used this method to answer the research questions with detailed and substantive knowledge. Using the qualitative research design, I understood how families prepared for the service member. This study is significant because the reintegration process starts as soon as a combat veteran returns home and may last several months (McCreary et al., 2014). The study addressed family reintegration of combat veterans, spouses, and parents as well as any negative results from deployment (Lowe et al., 2012). Although I am a previous military spouse, I reframed from reacting with bias and focused on the participants. I explored the experiences of combat veteransô in relation to family reintegration. The study is significant as reintegration has proven to start when combat veterans finish a mission and come home. Study of the reintegration stages of the deployment cycle has typically focused on the links between stressors or trauma experienced during a member deployment and postdeployment clinical issues or psychological problems (McCreary et al., 2014).

Research is required to understand war veteransô mental health care, willingness to continue with treatment, and ways to communicate their experiences as warriors (American Medical Association, 2011). Phenomenology is analyzing meanings, perception, thought, imagination, emotion, and action (Smith, 2013). For centuries, phenomenology has practiced in various guises; subsequently, phenomenology came into its own in the early 20th century in the works of Husserl, Heidegger, Sartre, Merleau-

Ponty and others (Trochim, 2006). In comparison, Husserl (2001) suggested that we characterize experiences of seeing, hearing, imagining, thinking, feeling (i.e., emotion), wishing, desiring, willing; and acting is embodied volitional activities of walking and talking.

Research Design

The qualitative method can be applied relatively easily in real world settings to gain an in depth understanding of the ways in which families think or feel (McLeod, 2014). Qualitative research was used to learn about problems while obtaining answers for research questions. Saleem, Tabusum, and Batcha (2014) described a research design as an essential condition and analysis of data in a form that aims to combine relevance to research. The qualitative research paradigm is descriptive and is less predictive than the quantitative method. Qualitative research may be used to focus on a process that is occurring.

Trochim (2006) contended that case study is an intensive study of a specific individual or specific context; Freud developed case studies for the theory of psychoanalysis as well as Piaget conducted case studies of children in developmental phases. The questions in unstructured interviews cannot be answered with ñyesò or ñnoò (Baskarada, 2014, p. 12). Case studies allow for confirmatory (deductive) as well as explanatory (inductive) findings and can be based on single or multiple cases (Yin, 2009, p. 3). Further, qualitative research occurs in natural settings where human behavior and

events take place. I investigated the experiences of combat veterans as well as family members, applying a conceptual outlook while using a multiple case study design.

This study was based upon qualitative design. I collected data through open-ended questions and face-to- face interviews (Appendix B). Trochim (2006) stated that are no clear guidelines for choosing the correct method; researchers must rely on their own understanding of the situation while exercising their own judgement.

Scientific research involves detailed examination of phenomena which should be accurately described and explained (Christensen, Johnson, & Turner, 2011). The case study process involves seven phases: organizing; immersion in the data; generating case summaries; categories and themes; coding; interpretations through analytic memos; and writing the report. A multiple case study design can construct or produce theoretical replication for theoretical reasons (Yin, 2009).

Participants

The sample consisted of 26 participants: 16 combat veterans and 10 family members from 10 different families with individuals in the armed forces. Participants included enlisted and retired members of the military, as well as single and married individuals Interactions were presented to ensure that the combat veterans and family members felt understood and respected. In working with veterans who may have been exposed to previous traumatic experiences, I sought to ensure that I did not make them feel as though I was conducting a new assessment with the interview. Moreover, during the interviews, I attempted to follow the participantsô lead. I was careful not to lead

participants with questions because I wanted to prevent any harm or emotional distress from arising from the interviews. Moreover, I attentively watched for any exposure or trauma.

The combat veterans who participated in this study had served more than one tour of duty in Afghanistan, Iraq, Africa, or any war zone. Other participants included combat veteransô spouses, significant others, and parents. As indicated, the participants were 16 combat veterans and 10 family members. The participants reflected on their experiences in the U.S. Navy, Marines, Army, or Air Force. I recruited participants through flyers, email, Skype, phone, and outreach to my professional contacts in the military. Prior to research implementation, an application to conduct the study was approved by the Institutional Review Board (IRB) at Walden University.

Sample Strategy

The sampling strategy was nonprobability convenience sampling. Christensen et al. (2011) suggested that convenience sampling is a method based on convenience individuals who are readily available to participate. I offered participants a meeting location of their preference. The best advantage of convenience sampling is that participants are involved in the study and easily recruited (Christensen, et al., 2011).

The role of the researcher involves pursuing a scientific approach in order to gain knowledge, become curious, and develop patience, and be objective by not displaying oneôs own observation (Christensen, Johnson, & Turner, 2011). Qualitative methodology

may be applied relatively easily in real world settings to find out about ways families think or feel (McLeod, 2014).

I sought participants from eastern Texas and analyzed data gathered through an interview process. Marshall and Rossman (2013) suggested that theoretical saturation is a sense of any additional data collected with the same findings. Saturation occurs when no new concepts emerge from additional data; as well as theory makes sense of the data and that theory is well validated (Christensen et al., 2011). A sample in qualitative research is not completed until data saturation has been reached and no new insights are noted in interviews. After receiving Waldenôs IRB approval for my project, I began the process of scheduling with participants who met the criteria for the study.

Research Procedure

In the beginning of each interview, I provided a consent form, in compliance with the IRB, to notify each respondent that the nature of the information presented could possibly cause distress during the interview process. I made sure that participants fully understood that they had the right to refuse participation and to leave the study at any time, without ramifications. Sessions lasted approximately 30-45 minutes. Participants were notified of their rights and assured of the confidentiality of their responses. I skipped questions or stopped the interview when necessary. Further, I provided a list of professional counseling services during or following the interview process or follow-up conversations. I prepared a resource listing of mental health and community health services and told participants to contact these resources should they feel any discomfort

that day or in the future as a result of the interview. A copy of the consent form was provided to each participant.

Data Collection

The data collected from all participants were secured in a password - protected file. All participants were identified by pseudonyms only. The identity of each participant was coded with a pseudonym for confidentiality. My research notes did not identify any participant by name, rank, or demographic.

Marshall and Rossman (2016) argued that when a research is using real-life data, codes emerge from the data during the collection process. The important task in data is collection and transcripts (Marshall & Rossman, 2016, p. 182). I read each thoroughly and became familiar with each statement from the participants. Next, I identified specific verbiage pertaining to my study. Third, I sorted data by themes, topics, and categories associated with my research and interview questions.

Data Analysis

Qualitative data analysis is pursuing the relationship between categories and themes to increase the understanding of the phenomena (Hilal and Alabri, 2013 p.1). Qualitative research is designed to occur in natural settings this design is geared toward human behavior and events that occur within a lifetime (Marshall & Rossman, 2016).

After completing a transcript for each interview, I stored the information with password protection in a safe, where it will remain for 5 years. Specifically, qualitative data analysis is inductive and involves patterns or relationships of the study. Gibbs (2010)

suggested that codes should be ñgiven meaningful names that given an indication of the idea or concept that underpins theme or category.ò I used various codes and labels for the answers gathered from respondents. I conducted data analysis using my personal computer, which is password protected.

Baskarada (2014) stated that after interviews have been completed, a researcher should involve participants in discussion and review of the interview transcripts to resolve any misunderstanding. After each interview, I immediately created a transcript to ensure accuracy. I reviewed the transcripts for similar answers and categorized themes through coding. I conducted manual coding using colored sheets and then transcribed the interviews into NVivo. NVivo and Qualitative Data Analysis (QDA) are software systems used to assist researchers in managing data and ideas, querying data, modeling visually and reporting (Hilal & Alabri, 2013). By using NVivo for data analysis, researchers can ensure that they are working methodically, thoroughly, and attentively while coding (Hilal & Alabri, 2013). I used my field notes and my personal computer to organize questions, statements, and experiences.

Measures for Ethical Protection

The participants for this study were combat veterans and their family members. Qualified veterans were interviewed and asked to share their experiences with family reintegration. With respect to the American Counseling Association Code of Ethics (ACA, 2014), I followed specific guidelines set forth in Section G, Research and Publication, and Section H.2.a., Informed Consent and Disclosure. By obtaining informed

consent from each participant, explaining the parameters of the study, assuring confidentiality, and being careful to avoid causing any psychological, emotional, social, or physical injury to participants, I met my goal of respecting ACA guidelines and those participating in this research project. I took the following specific measures:

- In obtaining informed consent from the participants, I informed them about all aspects of the study. While respecting ACA guidelines, I informed the participants of all materials associated with the research, and described the purpose and procedures of the study, risks and benefits, and any incentives for participation. Research participant were able to make informed decisions concerning whether to decline to participate or whether to give informed consent.

- I explained the scope of the study to participants. I provided contact information by email to allow potential participants to ask questions they had about the study. As part of the informed consent procedure, I reiterated the study procedure and details concerning participation for the potential participants. In addition, I explained participantsô role in the research.
- For safety and comfort, meetings were held at a location of each participantôs choice. As indicated, every effort was made to protect their identity.
- All research material and information pertaining to this study, including but not limited to transcripts of interviews and field notes, are secured in a locked cabinet in my home. In addition, raw data will be kept for a minimum of 5 years, and after the tenure of 5 years paperwork will be shredded.

- The participants were identified by first name pseudonyms in lieu of real names.

Role of the Researcher in the Data Collection Procedure

I requested assistance from the Family Advocacy and Mental Diagnostic Services for participants. In respect to protect identity of the participants, I was mindful of my connection with the United States Armed forces as a former Ombudsman. In the U.S. Navy, an ombudsman is selected as a liaison between military families and a command. Particularly, an Ombudsman is known as ñprotecting the rights of the peopleò. Furthermore, an Ombudsman becomes a volunteer at permanent change of stations (PCS). The Ombudsman is appointed by the commanding officer after being screened and completing a training program. Although I was an Ombudsman, I refrained from any notations or personal responses and respectfully used only necessary tools for documentation purposes.

Summary

The reintegration of military members into family and civilian life will require ongoing research, and the impact service members endured during years of deployments (Flynn, 2014). The scope of this study was combat veteransô reintegration into the family and community after participation in the OEF and OIF. I used case study design to describe specific individualsô experiences.

The results answered my research questions based on open-ended questions and face to face interviews. After recruitment, I scheduled appointments to meet, and then received informed consents from the participants. Participants were informed of

their rights and confidentiality. I provided a list of professional counseling services during or following the interview process or follow-up conversations. I prepared a resource listing of mental health and community health services and told participants to contact these resources should they feel any discomfort.

Chapter 4: Results

Introduction

The purpose of this qualitative phenomenological research study was to explore the lived experiences of combat veterans in relation to family reintegration. Through data analysis, I identified emerging themes and associated categories to identify the lived experiences of combat veterans pertaining to family reintegration. To conduct the study, it was necessary to use themes that were substantiated by interview responses and observations from study participants. Moustakas (1994) stated that qualitative research occurs through the interpretation of data, with researchers using bracketing to develop descriptive statements about participantsô lived experiences.

In Chapter 4, I present semistructured interview responses from combat veterans and their family members concerning their personal experiences and observations. I developed five research questions designed with the aim of understanding the lived experiences and perceptions of combat veterans with 1- 20 years of service. I interviewed the participants to understand how treatment, interventions, and strategies may assist the family reintegration process. In this study, the participants presented with various years of service, demographics, and missions in the military. The interviews with family members centered on experiences related to the service members and the family reintegration process after they returned home.

Setting

Recruitment of and interviews with participants took place in a metropolitan area in the southwestern United States. I conducted the participant interviews at American Legion and Veterans of Foreign Wars (VFW) buildings. According to their websites, the American Legion and VFW are nonprofit national organizations that are committed to serving veterans nationwide. The purpose of these organizations is to provide support and assistance to veterans and their family members in times of need.

Demographics

Combat veterans and various family members participated in the study. The sample consisted of 16 combat veterans and 10 family members with family members selected through snowball sampling. All participants in the study matched the inclusion criteria. All combat veterans who participated met the inclusion criteria of having served more than one tour of duty in any war zone. Family members met the inclusion criteria if they had a relative who had served in a combat zone while serving two or more tours. Participating combat veterans service years had 2-34 years of service. Participants included 11 Army veterans, three Navy veterans, one Air Force veteran and one Marine veteran. The population sample was composed of 26 participants (16 combat veterans and 10 family members) with the U.S. Armed Forces (see Table 1). Table 2 presents a summary of the family members who participated in the study.

Table 1

Combat Veterans Participants

Participant	Gender	Armed forces	Years of service	Married with Family
Abe 1	Male	Army	13	None
Buck 2	Male	Navy	24	None
Charlie 3	Male	Army	6	None
David 4	Male	Army	14	Married
Elie 5	Male	Navy	13	Married
Fred 6	Male	Navy	24	Married
George 7	Male	Army	21	None
Henry 8	Male	Navy	8	None
Ida 9	Female	Army	24	Married
John 10	Male	Army	9	None
Keith 11	Male	Army	4	None
Larry 12	Male	Marine	4	None
Michael 13	Male	Army	4	None
Nathan 14	Male	Air Force	24	Married
Oscar 15	Male	Marine	30	Married
Pat 16	Female	Navy	12	None

Table 2

Summary of Study of Family Participants

Participant	Gender	Armed forces	Years of service	Family Member
April 1-FAM	Female	N/A	N/A	Spouse
Betty 2-FA	Female	N/A	N/A	Spouse
Cindy 3-FA	Female	N/A	N/A	Spouse
Donna 4-FA	Female	N/A	N/A	Mother
Edith 5-FA	Female	N/A	N/A	Spouse
Frances 6-FA	Female	N/A	N/A	Mother
Gail 7-FA	Female	N/A	N/A	Granddaughter
Helen	N/A	N/A	N/A	Daughter
Indy 9-FA	Female	N/A	N/A	Sister
Joyce 10-FA	Female	N/A	N/A	Mother

Data Collection

Conduct of Interviews

As the researcher, I followed protocols and guidelines from the Institutional Review Board (IRB) of Walden University. Recruitment flyers were placed in various areas to solicit combat veterans who met the inclusion criteria (Appendix F). Potential participants indicated interest by contacting me as directed on the recruitment flyer. Once participants had been identified, I conducted a series of face-to-face interviews approximately 30-45 minutes each with members of the Armed Forces and various selected family members. I conducted participant interviews at American Legion and VFW buildings. Each of the participants received a written copy of an informed consent form. I read the description and purpose of the study to each participant paused for any questions or concerns from the participants, and confirmed permission that the participant could end interview at any time due to any discomfort. I also reiterated the importance of confidentiality during the interview. I never led or coerced the participants to obtain answers.

My goal was to express the utmost respect, understanding, and compassion towards participants. I asked each participant to sign a consent form. Furthermore, each participant scheduled an interview session, indicating a preferred time and location. I arranged interview times and venues via email or cell phone. I maintained a procedure activity log for all participants. I labeled the participant interviews with pseudonyms and numbers, (e.g. Abe1-1) for confidentiality. I did not make any voice recordings because

the participants said that they were not comfortable with having their interviews recorded. I used a field journal to take notes during and after the interviews. Additionally, I developed an interview protocol (Appendix C). I used the interview protocol to gain in-depth observations of experiences related to the study. Finally, I ensured that copies of resource listings with information on Licensed Professional Counselors (LPCs) and community health services were available and provided to three participants during the study.

Data Analysis

Coding Process

The interviews produced a vast amount of information, which I reviewed and captured on manual notes during the interview process. I used the Huberman and Miles (1994) strategy, which encompasses writing field notes and reflective passages to recall participantsô responses to the questions. I summarized the field notes and developed metaphors to assist in recalling significant statements presented by each participant. Through coded memos, I developed patterns and themes.

My coding process was informed by theories that underlay the studyôs qualitative design: symbolic interactionism and social cognitive theory. Further, open coding can be used with inductive, deductive or verification modes of inquiry too (Khandkar, 2015). Many of the coding strategies employed for analyzing qualitative data in mental health services fall under the general rubric of ñcontentò or ñthematicò analysis (Palinkas, 2014). Marshall and Rossman (2016) described open coding as an initial process that helps the researcher see patterns and key ideas.

Wagner et al. (2010) theorized that in order to move data inductively from coded units to larger representation of categories and themes, researchers must take several steps. The first step in the coding process is open coding. *Open coding* requires the researcher to assign codes or descriptive labels to phrases or words. The second phase is axial coding. *Axial coding* involves the identification of various concepts, categories, or themes that form patterns or phrases that form connections and relationships between concepts, categories, or themes in inductive analysis (Wagner et al., 2010). The third phase is defined as *selective or substantive coding*, which is the deepest level of analysis (Wagner et al., 2010). In this phase, the researcher interprets and synthesizes meaning.

Themes and Subthemes

The data were coded, analyzed, and categorized by theme. The themes centered on (a) family reintegration, (b) command strategies, and intervention, (c) community services, and (d) mental health services based on inductive analysis. Table 3 presents a summary of the themes, as well as the sub theme. I coded, analyzed, and categorized the data I received according to theme.

Table 3

Summary of Themes and Subtheme

Themes	Subthemes
Family Reintegration Services	Lack of communication, lack of command, community services, referrals and guidance
Military Command Services	Lack of protocol, lack of sensitivity
Community Services	Lack of access, lack of time to use
Mental Health Services	Psychological disorders, stigma of getting help, reliving the mission

Family Reintegration

Participants were asked to describe any experiences with family reunification that they had upon the return of their combat veteran. Combat veterans and family members described family reunification in the following ways: (a) being alone upon returning home, and (b) being held in command briefings and (c) no allotted time with their family members. Consequently, more than half of the participants responded by indicating that they had no family reunification experiences upon the veteranôs return home. Ida-9, identified as an Army service member with 24 years of service, stated, ñNone. We filled out a questionnaire but that was pretty much it.ò Likewise, Fred-6, identified as a Navy service member with 24 years of service, stated, ñI received little to none.ò Similarly, participant Henry-8, identified as a Navy service member with 8 years of service, stated,

ñI had very little.ò Finally, many participants elaborated that there were no family members to ñcelebrateò with upon returning home. Participants acknowledged that their family connections had begun to diminish before they returned home due to lack of communication, marriage failure, and lack of support.

Command Intervention and Strategies

Combat veterans and family members were asked to share experiences of medical conditions they had and treatments they received after returning home from a combat zone.

> Nathan 14, identified as an Air Force service member with 24 years of service, stated ñWe all had fill out a questionnaire about experiences while deployed and immediately follow-up the same questionnaire months later. I think the conventional wisdom was that nobody would ever answer any of the questions that asked if you were on edge, had nightmare, couldnôt stop thinking about traumatic experiences, etc. because of two reasons: a sign of weakness and time spent in a doctorôs office and not doing your job.ò

> Oscar-15 noted, I was shell-shocked and bad dreams waking me up every night. I felt the need to get some help; but I knew that was not the thing to do. After I didnôt want to get help because that frown on and I didnôt want to go to the VA. I was afraid of the VA.

Reunification

When asked about command experiences that had been used to assist him or family members with reunification as well as transitioning, John-10 stated, ñI had none.ò Likewise, Ida-9 stated,

> ñNone. The unit didnôt have a FRG and the state run program was just getting on its feet; I came back from deployment and then headed out to my Office Advance Course in Fort Jackson, SC. It wasnôt until I was there, that my issues started to become apparent and I didnôt seek help because I couldnôt fail the school for any missed time.ò

Buck-2 stated, ñOur command didnôt do anything to help our troops in returning.ò Pat-16, stated, ñNone.ò Furthermore, Frances-6 mentioned, ñcommunication with our daughter-in-law about when he would be home and what help she might need; planned our trip to Utah where they are to help out.ò Joyce-10 shared, ñHe was detached, anxious, angry, hyper alert and tried to hide it all; on the surface and returning the reunification went well.ò Gail-7 stated, ñNone. There was no reunification.ò Betty-2 recalled, ñNone. I was glad to have him home.ò Finally, George-7 shared, ñIt was uncomfortable and they were not prepared.ò

Community Services

The research question concerning community services was the following: What interactions and transitions made a successful reintegration into the community for combat veterans? I asked combat veterans and family members to share experiences, thoughts, and preparedness with regard to support and community resources. I explored how to make situations better for current and future combat veterans. The participants overwhelmingly emphasized preparation of our troops and provision of resources.

Further, participants shared there were organizations assisting but not both as a family. April-1 stated, ñResources such as VFW and visits from VA psychology help.ò Edith-5 mentioned, ñEach spouse of deployed was assigned to another spouse (Called Key Spouse) that checked in on them via phone call, email, or visit, at least weekly. A list of phone numbers to contact any person or service that may be needed for the family members. Helen-8 shared, ñThere were no community resources available in my area of Texas.ò Frances-6 stated, ñNeighbors, other veteransô families, and church family.ò

Mental Health Assistance

Mental health assistance emerged as a theme. The research question was the following: How does being assigned to a Mental Health Coordinator assist combat veterans returning from war zones? The Mental Health Services Administration (2013) suggested victims of trauma are at a much higher risk for co-occurring mental health, violence, self-injury, and a host of other coping mechanisms which have devastating human, social, and economic costs. A participant expressed thoughts and experiences on mental health assistance as related to her son. Joyce-10 stated, ñWhat mental health

coordinator and assistance?ò Gail-7 stated, ñNone.ò Michael-12 stated, ñNone.ò Betty-2 mentioned, ñIt was not until later when we moved to Texas that my husband moved to Texas.ò Abe-1 stated, ñGood experience with Tricare and the VA.ò

Psychological Conditions

Lastly, psychological condition was a final theme. The research question was the following: How does being assigned to a Mental Health Coordinator assist combat veterans returning from war zones? White et al. (2011) contended that veterans involved in Iraq and Afghanistan, received care from the VA between 2001 and 2005, nearly-one third were diagnosed with mental health or psychosocial problems as well as one-fifth diagnosed with a substance use disorder. Combat veterans discussed their thoughts on diagnosis received after deployment, and transitioning home. Elie-5 stated, ñI am currently rated 100% permanent and totally disabled with PTSD. The VA was there for me all the way.ò However, Oscar-15 stated, ñI donôt go to the VA. I have bad dreams and still fight being óshell shockedô. I am afraid and donôt want to go and get help. It still comes back after all these years.ò Helen-8 stated, ñMy father had no medical conditions but stress and worried over how to take care of the family.ò Ida-9 stated, ñI did not experience any nor really was offered any while I was deployed active duty. Sadly, the military óatmosphereô is to ósuck it upô and not say anything. To do so is to appear ñweak.ò

Evidence of Trustworthiness

To ensure trustworthiness, I reduced risk of unanticipated harm, reducing exploitation, and protected information received by the participants (Bloom & Crabtree, 2006). Gunawan (2015) contended that trustworthiness is divided into credibility, transferability, dependability, and confirmability. Marshall and Rossman (2016) urged qualitative researchers seeking creditability to be in the setting for a long period of time; in order words, prolong engagement with participants until saturation is done (p.46). Although my sessions were initially set for 30-45 minutes, many of the participants were engaged in the study; therefore, some sessions were longer than the initial timing. I did not use videos or recordings. The participants were not comfortable due to concerns about confidentiality and retaliation. In addition, member checking is used to ask participants to summarize (Marshall & Rossman, 2016). After the interviews, I phoned many of the participants to summarize interpretations of their verbiage. Most of the participants, combat veterans and family members, offered no further information by phone. However, Oscar-15, noted during member checking that, ñI am doing much better today than 36 years ago.ò After member checking, I began manually transcribing personal notes and interview protocol sheets.

I was restricted in my population. I chose to use combat veterans and family members; yet, no children were involved in my study. Qualitative reliability tests such as member checking or peer checking are ways of ensuring that the researcher has analyzed the data correctly (Gunawan, 2015). Marshall and Rossman (2016) suggested that sample sizes are small, as qualitative studies aim at depth and crafting relationships; moreover,

distinguish traits that make us personally ñcredibleò and ensure that our interpretations of the data are ñtrustworthy.ò Further, peer checking is using a panel of experts or experiences colleague to reanalyze the data correctly (Gunawan, 2015). After interviewing, the participants were informed of scheduling another meeting for the outcome of the study. In addition, I have been in constant contact with my committee chairperson, Dr. Mary Bold, throughout this study.

The dependability of trustworthiness in a qualitative research design is describing strategies used to learn about the study. As suggested in Chapter 3, case studies allowed for confirmatory (deductive) as well as explanatory (inductive) findings and can be based on single or multiple cases. Qualitative research occurred in the natural settings where human behavior and events occur in the lifetime. I investigated experiences from combat veterans as well as family members with a conceptual outlook while using a multiple case study design.

I used my professional training to conduct ethical research. I included integrity and dependability as well as trustworthiness to this study. The moral principle of trust states that researchers should establish and maintain a relationship with the research participants (Christensen et al., 2011). I was mindful of my own preconceptions and bias regarding responses or personal engagement with participants. I refrained from any notations or personal responses and respectfully used only necessary tools for documentation purposes.

Results

RQ1: How did supports and interventions provided to combat veteranôs postdeployment prepare them for successful reintegration with the family?

Question 1 asked, ñWhat kinds of resources were available to you for family reintegration?ò Several participants echoed the same response, ñnoneò to this question. However, George-6 said that ñFamily Support Groups and counselorsò were available but Nathan-14 gave a more revealing understanding of the available resources, ñThe Airman and Family Readiness Center did a great job of getting everyone back into the at-home lifestyle. The Air Force also gave personnel two weeks off; and no duty but could spend time getting back into family routine.ò

Oscar-15 explained a different viewpoint regarding the receipt of services and stated that ñNone. It was frowned upon to get help.ò Participants were asked to describe any experiences with family reunification upon returning of their combat veteran. Combat veterans and family members described family reunification in the following ways: (a) being alone upon returning home, and (b) being held in command briefings and no allotted time with their family members.

Consequently, more than half of the participants responded by saying ñthere was no family reunification upon returning home or time spent with their loved one due to debriefings or feeling alone.ò For example, Ida-9, identified as an Army service member with 24 years of service, stated, ñWe filled out a questionnaire but that was pretty much it.ò Also, Fred-6, identified as a Navy service member with 24 years of service, stated, ñI received little to none.ò

RQ2: What interactions and transitions enabled a successful reintegration into the community?

Question 2 asked, ñDescribe assistance received from your command to assist your family.ò Abe 1 specified that ñmonthly phone callsò were given from the command. Yet, Buck-2 points out that ñOur command did nothing to help troops returning.ò Consequently, several participants voiced ñnone.ò Based on the response from Charlie 3, Elie-4, and Pat 16, they revealed little to no assistance was received from command. Combat veterans and family members were asked to share experiences of medical conditions treatments received after returning home for a combat zone.

Nathan-14 and Oscar-15 described their conditions and treatment to me as important information to share how services were rendered upon returning from combat. Nathan-14 and Oscar-15 responded with comparison that ñif you were on edge, had nightmare, couldnôt stop thinking about traumatic experiences, etc. because of two reasons: a sign of weakness and time spent in a doctorôs office and not doing your job.ò Oscar-15 noted, ñI was shell-shocked and bad dreams waking me up every night. I felt the need to get some help; but I knew that was not the thing to do. After I didnôt want to get help because that frown on and I didnôt want to go to the VA. I was afraid of the VA.ò

Question 3 asked, ñDescribe your experiences in the military before and after heading to combat.

Ida-8 documented ñI was a working on a personal shop; I took care of the soldiers. I just gotten divorced from an abusive husband and I was an emotional wreck. After coming home, I was different (and still am). I had a hard time with empathy and still have panic attacks.ò Elie-4 responded with ñBest years of my life; I love it and it was hard and painful. I was scared but would do it all again.ò While Fred-5 emphasized, ñI went to the Navy right out of high school. I served on 14 Naval Ships and 3 shore commands.ò However, Buck-2 generalized ñI came back and wasnôt myself; my wife did not understand and I keep telling her nothing was wrong with me.ò Subsequently, Nathan-14 shared a different experience and stated, ñI trained as navigator; and for the most part it was enjoyable.ò

In comparison with Question 1 about command strategies and intervention, Question 4 asked, ñDescribe any debriefing available from command before returning home.ò Several of the participants described their debriefings as ñnone.ò Buck-2 stated ñnone from command and followed up with ñI had to ask for help.ò George-6 identified that ñIt was uncomfortable and they were unprepared; none.ò Elie-4 generalized his response with ñStandard Army briefings.ò Many of the participants shared there were organizations assisting but not both as a family. April-1 stated, ñResources such as VFW and visits from VA Psychology help.ò Edith-5 shared, ñEach spouse of deployed was assigned to another spouse (Called Key Spouse) that checked in on them via phone call, email, or visit, at least weekly. There were lists of phone numbers to contact any person or service that may be needed.ò Helen-8 stated, ñThere were no community resources available in her area of Texas.ò Frances-6 stated, ñNeighbors, other veteransô families,

and church family.ò The themes of tools for the family emerged from Question 4 (ñDescribe resources available from command for family members before soldierôs return home.ò).

RQ5: How does being assigned to a mental health coordinator assist combat veterans returning from war zones and their family members?

Question 5 asked, ñDescribe interventions and strategies with mental health coordinators used to prepare for reintegration.ò Several of the participants responded with ñlittle to none.ò Nathan 14 validated ñhis feelings byò saying, ñI donôt have any experiences with interventions especially with the mental health perspective.ò Therefore, George-6 voiced that and ñI never felt the need but remember assistance being available.ò Ida-8 stated ñI did not experience any really nor was any mental health offered. She further explained that the military ñatmosphereò is to ñsuck it up.ò

Consequently, Nathan-14 documented ñI donôt have any experiences with interventions especially with the mental health perspective.ò One participant shared thoughts and experiences on mental health assistance as related to her son. Joyce-10 stated, ñwhat mental health coordinator and assistance?ô Gail-7 stated, ñNone.ò Michael-12 stated, ñNone.ò Betty-2 stated, ñIt was not until later when we moved to Texas that my husband moved to Texas.ò Abe-1 stated, ñGood experience with Tricare and the VA.ò The theme of tools for the family emerged from Question 4 (ñDescribe resources available from command for family members before soldierôs return home.ò).

Participant Observations

During the interviews there were ñcalmò before the ñstormsò. The participants did not feel comfortable with a recorder or videotaping. Consequently, the participants, combat veterans and family, began to share many feelings in reference to their journey home after serving in the war. The participants shared personal stories in reference to marriage, isolation, and loneliness:

> Oscar-15 would ñleaveò the interview mentally and ñreturnò with more information to add to his interview. In addition, Oscar-15 became ñskepticalò with voicing information that may ñget him in trouble.ò Oscar-15 would share that upon his return he didn't know if he would ñlive or dieò due to the ñunknown.ò When asked about the uncertainty, He would be become ñsecludedò from the interview, as if he was in another era. Further, the participant began to share about his nightmares, wife, and medications. Oscar-15 would begin telling stories on how he wished he would have gotten help regardless of the ñstigmaò from other service members. Also, He would repeat and remind me that he had very little due to his ñstubbornnessò and began blaming his actions of no help; yet, the participant would quickly turn ñangryò on how the command would not help because ñback then you didn't get help because it was all about the mission.ò

Additionally, Nathan-14 gave several views of ñafter the factò that would create further thought into my observation. Nathan-14 discussed the need to turn to alcohol instead of the VA. In his words, ñVA would not work on the pain; only release any discomfort.ò I would ask to further give insight on ñreleasing pain and discomfortò, if possible. A participant shared that the VA was only there for ñshow and numbers.ò Further, the discussion was elaborated on ñhow could they help when no one has walked in my shoes or understand the military.ò Nathan-14 described the ñmissionò in Iraq was sent from war to a U. S. military base for more duties. Nathan-14 reported, ñI survived because of family assistance and my family still welcomed me home but my other family, military, let him down. ñ

> During the interview, Abel-1 also described how ñnumbò he would feel upon returning home; and his home was ñempty.ò When asked to translate, the participant stated that he wanted confidentiality; yet, he would drink to keep from being ñlonely and no one cared.ò I asked, ñWhere was your family?ò Abel-1 shared that upon returning back from Afghanistan, all service members needed to stay ñclose byò in case of returning back to the ñzone.ò Abel-1 clarified that statement with ñI went right back to war and didn't see my family.ò

Most participants suggested that medications would not do any good because ñthey wouldn't understand his troubles.ò Many combat veterans shared how stress and sadness would overcome their emotions; and many often shared ñthere was no reason to live.ò Therefore, ñsurviving after combat zonesò and ñmental health coordinatorsò are

valuable asset to service members with strategies and interventions needed upon returning. Also, lesson learned was many combat veterans shared there no need to live because of feeling ñmessed up.ò

Summary

This chapter presented and discussed the findings of this study as obtained from each combat veteran, family member, and literature on family reintegration and psychological conditions. The Mental Health Services Administration (2013) contributed that victims of trauma are at a much higher risk for co-occurring mental health, violence, self-injury, and coping mechanisms. The coping mechanisms have devastated human, social, and economic costs.

The coding of themes led to specific patterns received from the participants, and their assistance needed from command support to mental health services. These themes were grouped from combat veterans and their family members. Each of the following themes were discussed: (a) family reunification, (b) command strategies and intervention, (c) reunification, and (d) community resources and (e) mental health services. The sub themes identified were psychological disorders, stigma of getting help, reliving the mission, lack of guidance, lack of wisdom, lack of communication, and lack of sensitivity towards family. There are several direct quotes received from participants who shared experiences returning from war zones to home. Therefore, in order to make each research questions as well as overall objective of my study, guidance was needed to fully understand each personal story.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

Since the early 20th century, observers have noted a relationship between service in war and conflict zones and the experience of psychological and other issues among U.S. military veterans. As early as 1919, many doctors observed psychological and neurological inquiries in combat veterans of World War I. Researchers found that Vietnam War deployment was associated with an increase in family adjustment problems and rates of interpersonal violence, PTSD, depression, drug abuse, and alcohol abuse (Marmar, 2009). Combat veterans may or may not experience trauma from serving in a combat zone; however, research has shown that the prevalence of PTSD, TBI and anxiety disorders and TBI is increasing (McKee & Robinson, 2014).

This study concluded there is a gap in resources, mental health services, and community services for combat veterans and their family members. Castro et al. (2015) stated that participants in combat may experience injuries that affect their mental and physical health injuries. However, they noted, not having a mental or physical health injury does not mean that a combat veteran cannot benefit from counseling designed to assist this population (Castro et al., 2015).

Researchers have shown that it is necessary to provide repeated assessments, assistance for veterans who may experience symptoms after returning from a combat zone is essential as well as for their family members. Our government agencies, licensed clinicians or community members have not provided unprecedented levels of support for

combat veterans reintegrating with their family. My study confirmed these positions, with personal accounts.

White, Mulvey, Fox, and Choate (2011) found that among veterans who had served in Iraq and Afghanistan and received care from the Department of Veterans Affairs between 2001 and 2005, nearly one-third were diagnosed with mental health or psychosocial problems and one-fifth were diagnosed with a substance use disorder. The wars in Afghanistan and Iraq were the longest combat operations since Vietnam. Researchers have suggested that 19% to 44% of OEF and OIF troops are likely to have PTSD after returning from active duty (Kulesza et al., 2015).

The participants expressed ñnot knowing what to do because I don't know how.ò In addition, I learned that combat veterans did not ñparticipateò in taking medications to help them sleep, to treat a ñdisorderò, or to manage pain. Furthermore, World Wars I and II were not characterized by PTSD or TBI. It wasnôt until years later that ñshell shockò was identified as a major anxiety, PTSD, or TBI disorder. Combat veterans endure many challenges in the transition back to civilian life including psychological trauma and family reintegration.

I conducted this study to examine the needs of returning combat veterans and provide more insight about ways to promote family reintegration for this population. The purpose was to answer the following research questions:

RQ1: How did supports and interventions provided to combat veteranôs postdeployment prepare them for successful reintegration with the family?

RQ2: What interactions and transitions enabled a successful reintegration into the community?

RQ3: What barriers do combat veterans and their families report before and after deployment?

RQ4: What tools were given to combat veterans and family members to help them integrate successfully into the community?

RQ5: How does being assigned to a mental health coordinator assist combat veterans returning from war zones and their family members?

The sample consisted of 26 combat veterans and family members. I used a case study design. In respect to the case study design, I also chose to use convenience sampling. Convenience sampling is a nonprobability sampling method whereby a sample of participants is selected based on convenience and the individuals who are available (Christensen et al., 2011). As I began recruiting combat veterans and family members associated with the armed services, convenience sampling based upon location and availability made interviewing easier. Kulesza et al. (2015) described how service members are expected to be ñtough,ò ñshut downò their feelings, and do their best to cope.

Interpretation of the Findings

My findings indicate that services are needed now for returning combat veterans and their families. After speaking to the participants for a month, I formed the overall interpretation that more services (professional or community) are needed for combat veterans and family members immediately. Such services include, but are not limited to, mental health, medical, and networking services to support family integration after deployment.

As I began to put my interpretations into words, I realized there was so much data from 26 participants; I began my own audio recordings of what I learned from all of the participants. I used the recording to listen for themes. The themes that I identified centered on family reintegration, command strategies and intervention, community services and mental health services. Moreover, I learned that social change for combat veterans and their family members starts at the top chain of command. Although command strategies and interventions did not emerge as the first theme, I realized during my recording exercise that command is important to assist with policy, laws, and strategies. Policies and programs need to be planted for service members.

Participants expressed that, many times upon arrival to their previous commands there was no debriefing but only orders for the next mission. Additionally, the commander in charge can set the tone for the transition and reintegration. Also, the commanding officer decided many factors for family services, community resources for the base. To assist with social change from change of stations, combat veterans should be allowed more than a day or week to spend with their families before they leave on

another mission. The commander in charge can set the tone for the transition and reintegration.

The participants agreed that the ñmissionò is important; however, they conveyed what they interpreted as a lack of compassion for combat veterans and their family members. Additionally, emotional distress and trauma when completing 3 or more war tours was noted in the literature review as connected to mental health problems. For example, mental health disorders for combat veterans, such as TBI, PTSD, and anxiety disorders, have increased due to multiple tours in a combat zone.

Overall, the findings and themes that emerged from this study involved the experiences of combat veterans and selected family members after the veteranôs return from war zones. The participants shared their views on many topics, from reintegration to community resources. The literature review and Chapter 4 provided insight on the shortage of mental health clinicians and the underuse services underuse of services due to lack of command assistance as well as stigma toward combat veterans and family members seeking care. Further, data revealed that there had been no strategies or interventions from command targeting family reintegration. Many participants shared that they had received no assistance and were expected to ñsuck it up.ò Consequently, many participants also explained that getting assistance would mean ñless than a combat veteran.ò Many participants, especially family members, described receiving little or no care for psychological trauma or disorders. Therefore, upon veteransô return from combat, there was no conversation or communication on how to assist the combat

veteran. Many participants responded with remarks such as ñwhat mental health?ò or ñwe didnôt talk about it.ò

The research conducted for this study was valuable in increasing awareness of the silent challenges that men and women who ae veterans of the armed forces deal with every day. Social change is needed now for better laws, polices, and resources to assist with knowledge. Knowledge is power for combat veterans and family members.

Limitations of the Study

There were limitations of this study. First, the sample was small. However, qualitative samples are generally small. Second, the findings from this study may not be generalized to other populations such as the children of combat veterans, whose participation in research would be protected by law, with parental consents needed for interviews. Therefore, the limitations of the study identified adultsôperspectives and not an entire family. The findings are limited to the sample under study only. I underestimated the impact of multiple tours on combat veterans and their family members. I needed to understand the lengths of time between deployments to get an understanding of the distress experienced or diagnosis received by each participant, especially the combat veterans. The combat veterans revealed length of service, but there was no indication of length of time away from home after each mission. Moreover, I did not attempt to document how each branch of the military implements services for combat veterans, or how the services disseminated information to family members before and after tours.

Recommendations

Based on the findings of this study, it is recommended that further research take the form of ongoing assessments of combat veterans within 3 to 6 months of returning from war, as well as exploration of follow-up reports from combat veterans. It is necessary that the reintegration process start immediately for combat veterans and family members with command debriefing and the involvement of mental health professionals and community resources. Many combat veterans, from World War I to OIF, declined services due to the ñsuck it upò stereotype. Research has indicated that increases in deployment length and in rates of TBI, prior trauma exposure, and physical injury are factors presenting continuous risk in relation to reintegration and psychological trauma for combat veterans (War Clinician Guide, n.d.).

In the United States, there are VA offices available for combat veterans and family members seeking medical, mental, and community resources. Resources and services should be made available during and after mission to facilitate better reintegration or transitioning for returning veterans. Combat veterans and family members shared that resources were not available. Combat veterans should be allowed to choose and follow-up with a mental health provider of their choice.

Most participants revealed that they had no connection with mental health coordinators upon their return; therefore, there was no need to continue sessions or therapy. Follow up should be a required aspect of the transition process 3 to 6 months after a combat veteran has returned home. It is recommended that mental health professionals be hired to provide mental health evaluations and become part of the

returning mission team. This study indicates the importance of assessing acute needs as presented, rather than determining whether needs are met based on perceptions.

Implications for Social Change

Since the Global War on Terrorism, OEF and OIF, researchers have conducted studies on combat veterans and family reintegration. Results from my study reveal a need for further services to accommodate combat veterans and their family members. Combat veterans and their families are not receiving enough information or resources when combat veterans return home. Research is required to understand war veteransô mental health care, willingness to continue with treatment, and ways to communicate their experiences as warriors (American Medical Association, 2011). The findings of this study show that the armed forces are not offering enough resources to those who may be seeking help upon returning from a combat zone as reported by the participants. Designing resources and services for combat veterans and their family members may help them in developing coping and living skills upon returning from a combat zone.

There are clinical interventions that involve the use of mindfulness skills to reduce pain, stress, anxiety, depressive relapse, psychosis, and disordered eating (Wright et al., 2010). The Mental Health Services Administration (2013) has stated that victims of trauma are at a much higher risk for co-occurring mental health disorders and violence; in addition, combat veterans and their family members are at risk for self-injury and coping mechanisms that have devastating social and economic cost.

Mental health clinicians and practitioners can accommodate veterans and their family members by focusing on becoming readjustment counselors. A readjustment counselor can assist with a range of services, including family counseling for military related issues, substance abuse assessments and referrals, benefits explanation, screening and referrals for medical issues including psychological disorders, and individual or group counseling for veterans and family members (Department of Veterans Affairs, 2017).

Symbolic interaction and social cognitive theories informed the theoretical framework and were echoed by the participants answers. Many combat veterans and family members expressed how they felt during the interviews and provided insight that returning to a ñnormal householdò was difficult. Social cognitive theory reflected on the initiating personal development as a family. This theory may be used to examine the personal development and growth of veterans and their family members during the reintegration and transition process. Symbolic interaction may afford insight with concerning questions such as the following: Do veterans feel safe? Do they feel that they can return to similar relationships with their spouses or their children? Do they perceive threats in their environment?

Conclusion

Men and women of the U.S. armed forces joined the military for various reasons. Many participants discussed serving their country and protecting the Constitution of the United States. Their willingness to deploy to combat environments represented the commitment U.S. service members make when deciding to serve their country (Castro et al., 2015). Participants in the study expressed the belief that ñit was their dutyò to serve. Veterans experienced challenges and stressors that impacted their psychological functioning in a number of ways (Iraq War Clinician Guide, n.d.). Veterans of war were likely to be exposed to a wide variety of medical and psychological challenges.

Community services were largely not visible to combat veterans or their family members. The study consisted of 16 combat veterans and 10 family members. I was able to explore experiences while using a case study design. I chose case study because of specific individuals and specific context. I chose research questions that reflected the life of combat veterans and their family members after returning from war. The research questions were designed to answer how services from mental health professional, community services, and armed forces were able to assist our combat veterans, and inspire scholars on awareness for our armed forces. Many participants provided insight on community resources and services are needed for veterans and family members. As a result, participants shared that family members did the ñbest they could.ò Today, many veterans are homeless with limited resources. The reintegration life requires ongoing research on the long term impacts of the military service during sustained years of combat deployments (Flynn, 2014).

The Department of Veterans Affairs works closely with the Veterans Treatment Courts to approve service dogs for combat veterans; also, former Secretary of Veteran Affairs David Shulkin declared that VA sought to hire 1,000 additional mental health professionals to ensure veterans have timely access to mental health care (VFW Action Corps, 2017). The former Secretary of Veterans Affairs Shulkin announced an expansion of access to health care for veterans using telehealth technology.

Through such measures, the VA will be able to deliver care to veterans regardless of their status of retired or active member; also, VA doctors are located in different states to assist with medical and mental health services (VFW Action Corps, 2017). The Care Veterans Deserve Act of 2016 was created to improve the VA Choice Card program which enhances the availability of care for veterans (Veterans Affairs, 2016). Congress is proposing *P. L. 114-255* which include reforms to mental health care system; consequently, the public law will provide provisions that will benefit coordination of mental health programs across the federal government.

This study explored lived experiences of combat veterans and their family members. I chose to focus on mental health clinicians, coordinators, and practitioners servicing our troops. Furthermore, governing bodies, mental health clinicians, PTSD, psychological trauma, TBI, domestic violence, and substance abuse disorder should continue to be studied. Clearly, combat veterans and their family members should have more access. They should be able to reintegrate successfully returning home from a war zone. After this study, future study must show the need for debriefings and scheduled

appointments with leaders of community resources, mental health coordinators, and clinical assessments.

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Appendix A: Resource Listing

Ms. Noblet Davidson, LCSW, CGP
Clinical Social Work/Therapist
2439 Sunset Boulevard
Houston, Texas 77005
(713) 819-0364
Offers counseling services in trauma and PTSD for military veterans and family members
Fee: Sliding Scale

Family Time Crisis and Counseling Center
1203 South Houston Avenue
Humble, Texas 77338
(281) 446-2615
Familytimeccc.org
Family Time Crisis and Counseling Center: Offers counseling services, parenting education classes for reintegration, anger and emotions management classes for individuals, children, and families. Fee: No fee for the intake session, all other fees are charged on a sliding scale.

Family Services of Greater Houston
719 Sawdust Road, Suite 309
Spring, Texas 77380
(713) 861-4843 (Spanish speaking services available)
family@familyservices.org
www.familyservice.org

Family Services of Greater Houston: Offers counseling for children and adults, individual and family members, and veterans. Fee: Major Insurance plans and offers a sliding scale.

Lone Star Family Heath Center
605 South Conroe Medical Drive
Conroe, Texas 77304
(936) 539-4004
(832) 246-8700
www.lonestarfamily.org

Lone Star Family Heath Center: Offers mental health by a psychiatrist and licensed counselors. Accept Medicaid, CHIP, and Medicare; self-pay; sliding fee scale for those in need.

Mrs. Kaye G. Lunsford, Med, LPC

Licensed Professional Counselor
4314 Yoakum Boulevard
Houston, Texas 77006
(713) 805-9098
Offers counseling services in trauma, EMD, and PTSD for military veterans and family members
Fee: Sliding scale

The Woodlands United Methodist Church
2200 Lake Woodlands Drive
Spring, Texas 77380
(281) 297-5953
caring@twumc.org
www.thewoodlandssumc.org

The Woodlands United Methodist Church: Offers support groups for combat trauma military veterans and family members. Fee:

Appendix B

Research Questions: Combat Veteran, Family Members and Stakeholders

Research Question:	Pertinent Interview Q that will be asked of the Vet:	Pertinent Interview Q that will be asked of the Family:
RQ1 ï with family: How did supports and interventions provided to combat veterans post-deployment prepare them for successful reintegration with the family? Why or Why Not?	What kind of resources was available to you for family reintegration?	Describe family reunification with the combat veteran returning back home?
RQ2 ï into community: What interactions and transitions made a successful reintegration into the community for combat veterans?	Describe assistance received from your command to assist your family. Describe your experiences in the military before and after heading to combat.	Describe resources available from command for family members before soldierôs return home.
RQ3 ï barriers: What barriers do the combat veterans and their families report before and after deployment?	Describe your experiences in the military before and after heading to combat.	As a family, explain how you prepared for your soldierôs return home.
RQ4 ï tools for family: What tools were given to combat veterans and family members to integrate successfully into the community?	Describe any debriefing available from command before returning home.	Explain interventions and strategies presented for the children to prepare for reintegration.
RQ5 ï MH Coordinator: How does being assigned to a Mental Health Coordinator assist combat veterans returning from war zones?	Describe interventions and strategies with mental health coordinators used to prepare for reintegration.	How did the mental health coordinator assist with interventions or debriefing for pre- and post-deployment?

Appendix C

Interview Questions:

Grand Tour Question: ñEvery human being, relationship, and situation is uniqueò, describe your experience with family reintegration returning home.

Demographic:

1. Which branch (es) of the military were you enlisted in while serving?
2. How many years of service?
3. What thoughts about deployments were shared to prepare you for the tour?
4. Describe your experiences in the military before and after heading to combat.

Family:

5. What kind of resources was available to you for family reintegration?
6. What was your experience in reconnecting with family when you returned home?
7. What kind of resources was available to you for family reintegration?
8. What was your experience with mental health assistance when you returned home?

Interventions/Strategies:

9. Describe assistance received from your command to assist your family.
10. What advice about re-connecting with family would you give the next generation in the military?
11. Describe interventions and strategies with mental health coordinators used to prepare for reintegration.
12. How were you able to receive any resources or services while in combat zones?

13. Describe any debriefing available from command before returning home.

Appendix D

Interview Questions: Family Member

1. What is your role in the family?
2. As a family, explain how you prepared for your soldierôs return home.
3. Describe any medical conditions associated with the service member after returning from combat zone.
4. What community resources were available after returning from deployment?
5. Describe family reunification with the combat veteran returning back home.
6. Describe assistance used for the family during the veteranôs overseas tour.
7. Describe support groups for the family.
8. Describe interventions and strategies presented for the children to prepare for reintegration.
9. Describe resources available from command for family members before soldierôs return home.
10. How did the mental health coordinator assist with interventions or debriefing for pre and post deployment?

APPENDIX E

NIH
Certificate

Certificate of Completion

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

Date of completion: 02/16/2017.

Certification Number: 2328421.

Appendix F

DOCTORAL RESEARCH STUDY FLYER

Proposal: Combat Veterans and Family Integration

Contact the Researcher with your experience….

Participants: This study will examine lived experiences of active or retired Military Veterans and their family members. Military veterans must have served one or more deployments with Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), or any combat zone. Participants must sign informed consent; also, no names will be used in the study. Information provided is solely for research purposes; No incentives or fees.

Note: Participants may agree on a location at the participants request and share your experience with family reintegration upon returning home.

Virginia E. Falck

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Venue is in no way responsible or affiliated with this proposal.