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From War to Home: The Systematic Issues Operation Enduring and Iraqi Freedom Veterans Face Transitioning with PTSD

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From War to Home: The Systematic Issues Operation Enduring and Iraqi Freedom Veterans Face Transitioning with PTSD

A Dissertation by

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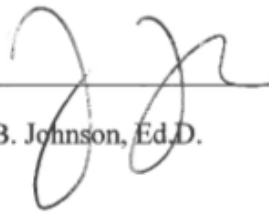

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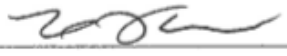

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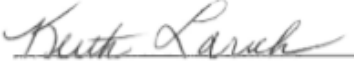

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DEDICATION

To my beautiful angel, Grandma Libby. You will forever be in my heart. This study is dedicated to you because I know in your heart you would see its relevance. I cannot wait to meet you again one day. Rest in Peace beautiful butterfly.

ACKNOWLEDGEMENTS

This dissertation is devoted to all the men and women who are currently and have previously served in the United States Armed Forces. As a former U.S. Army Soldier and a current combat Posttraumatic Stress Disorder (PTSD) veteran, I understand the hard work, dedication, and sacrifices it takes to protect and serve our nation. Words cannot express the appreciation I have in being able to find a way to help better serve our disabled veterans transitioning from active duty into the civilian sector. It is my hope that the results from this study helps bring better awareness on how transitioning with medical issues, particularly PTSD, truly affects our veterans everyday lifestyles and how the systems in place can better help.

I would like to give thanks to my lord and savior Jesus Christ for being my rock throughout my dissertation process, without him I do not think this could have been possible. It has not been an easy road, but with prayer and faith, I have truly done the impossible.

To my love, Kyle Ware, thank you for being my support system and loving me through the hectic editing, discussions, and presentations. I bet you are happier than I am that I have finally completed this program, HA! All seriousness, you have truly shown me that our love is endless and that being married to you has been worth wild. I love you ever more!

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To my parents, Melody and Craig Needam, words can never describe the love I have for you two. Throughout my life, you have both showed me that life will never be easy, but if you fight the outcomes will be endless. Thank you for always being the backbone and support I need.

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To my Grandpa, Freeman Ledford, no one will ever understand the connection I have with you, it is something indescribable. You have been a true warrior and I thank God for you being in my life. Though Grandma is in a better place now, I know she is so proud the support you have given this family. Thank you for always caring!

To the rest of my family and friends, I want to thank you all for your support and love. Everything I do is for you and without your support I would not be where I am today. I have learned so much from you all and it has made me the person I am today. God bless and keep spreading love!

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together. I am so grateful for our time spent together and hope this will be an everlasting relationship. To our great leader Dr. Johnson, who has truly pushed us to our limits and gave us a kick when we thought we knew what we were doing; thank you for keeping us on our feet, especially me. I truly appreciate your support and love as a leader. Delta Transformers always remember we roll out together! Fight on!

"It's up to you how far you'll go. If you don't try, you'll never know."

-Merlin, The Sword in the Stone

ABSTRACT

From War to Home: The Systematic Issues Operation Enduring and Iraqi Freedom Veterans Face Transitioning with PTSD

by Tiffany D. Ware

Purpose: The purpose of this phenomenological study was to describe the perceptions of Operation Enduring and Iraqi Freedom veterans with PTSD, who are transitioning from active duty to civilian life, regarding their participation in the Disabled Transition Assistance Program.

Methodology: The methodology for this research study will be qualitative from a phenomenological perspective. When thinking of research as it pertains to qualitative methods, it is appropriate to use when a researcher is trying to study the lived experiences of individuals (Flipp, 2014; Patton, 2015). This method will describe perceptions of Operation Enduring and Iraqi Freedom veterans with PTSD, who are transitioning from active duty to civilian life, regarding their participation in the Disabled Transition Assistance Program. The interviews created for this study included particulars of the interviewees lived experiences to the observers in the interviewee's personal disputes. Narratives provided by the OEF/OIF PTSD veterans can help future researchers in gathering further analyses on this understudied topic.

Findings: The major findings of this study are described coinciding to the research questions. The most dominant themes that were identified were based on each interview question and they were the following: (a) reasons given for separation from military: Mental health/PTSD, (b) experiences with the transitional process through the VA: Generally negative, (c) experiences with the information and process through DTAP:

Lacked information about the DTAP Program, (d) description of care provided to others through DTAP: Insufficient or lack of effective care/support, (e) description of information about DTAP provided by TAP: Insufficient; No information provided, (f) types of issues faced during the transition process: Obtaining proper care & mental health challenges, (g) description of how DTAP helped or supported the transition process: Unhelpful; It Failed, (h) suggested improvements to better support transitions needs for those with PTSD: Individualized/customized supports, (i) challenges obstructing the transition process into civilian life: Psychological repercussions.

Conclusions: It is hopeful that this study can be used as a stepping stone in finding better ways to improve the transitional system as well as help eliminate the many issues war veterans are faced with daily outside of the Military. It is our duty to help pay it forward to those who protect us.

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CHAPTER I: INTRODUCTION

"A man who is good enough to shed his blood for his country is good enough to be given a square deal afterwards. More than that no man is entitled, and less than that no man shall have." - Theodore Roosevelt

While most Americans work in secure and safe environments within the United States, military service members volunteer to risk their lives to help keep those environments safe. Today, more than 2.6 million U.S. veterans have served in the Operation Enduring and Iraqi Freedom (OEF/OIF) wars. On October 7, 2001, OEF, the war in Afghanistan, began and ended December 28, 2014. On March 20, 2003, OIF, also known as the invasion of Iraq, began and ended December 18, 2011 (Institute of Medicine, 2010; Substance Abuse and Mental Health Services Administration [SAMHSA], 2013; U.S. Department of Veteran Affairs [VA], 2015a). After returning home, war veterans face a magnitude of transitional challenges.

To help support these veterans better transition into the civilian sector, the Transitional Assistance Program (TAP) was established in the 1990s by Congress whom then made it mandatory for all separating veterans to attend a three-day program depending on the branch of service (Bascetta & General Accounting Office, W. D. C., 2002; U.S. Department of VA, 2016a). This program consists of assisting in job searches, constructing transitional plans, and other related services to help these veterans transition back into the civilian workforce. Looking even further, The Disabled Transition Assistance Program (DTAP), was integrated and sponsored by the U.S. Department of Veteran Affairs (VA), for veterans who are being separated out of the military due to service connected disabilities. Unlike TAPS, DTAP is not mandatory and

is only offered as an option to disabled veterans. Totaling around two hours, the DTAP program is there to focus more in depth on the VA's Vocational Rehabilitation and Employment (VR&E) Program, which is just to get the veterans back into the employment world, rather than focusing on the issues and effects of their service-connected disabilities (U.S. Department of VA, 2016a; Veterans Authority, 2016).

Of these disabilities, it has been revealed that more than one million veterans are suffering from Posttraumatic Stress Disorder (PTSD) related issues (Bateman, 2011; Chandrasekaren, 2014; Costello, 2015). Dating back to World War I (WWI), PTSD was acknowledged in the forms of shell shock and combat stress reaction (CSR), which were identified as mental illnesses obtained from war zones. Later, mental health doctors found that PTSD shared the same psychological outcomes, resulting in further studies on the effects of war on these veterans. PTSD was then defined by researchers as an emotional illness that derives from life threating events or severe emotional stress (Baker, 2011; Binneveld, 1997; E. Jones, Fear, & Wessely, 2007; Moore, & Reger, 2007; Sherman, 2016; Stagner, 2014).

Associated with these war veterans PTSD symptoms and transitional issues, going from active duty into the civilian sector, many severe side-effects are increasing steadily. An average of 20 OEF/OIF veterans die from suicide each day. Among these veterans, 11% are diagnosed with Substance Use Disorder (SUD) (Seal, Bertenthal, Miner, Sen, & Marmar, 2007; SAMHSA, 2013) 12,700 OEF/OIF veterans were reported as homeless in 2010, and numbers are steadily increasing everyday (U.S. Department of Housing and Urban Development, 2010). Due to the increase of OEF/OIF deployments and some veterans going more than once, an increased range of 4% to 20% of these veterans has

shown symptoms of PTSD post deployment life (Institute of Medicine, 2010). The lack of attention to this topic has yielded a national epidemic, causing severe consequences towards these veterans future. According to researchers, more studies need to happen on the effectiveness of these transitional services and the lived experiences of OEF/OIF PTSD veterans using the transition assistance programs, which will help better assist these veterans in eliminating the countless side effects of combat PTSD (Bascetta & General Accounting Office, 2002; Tanielian, Rand, California Community, Jaycox, & Health, 2008; Watkins et al., 2011). The Institute of Medicine (2010) also stresses how the VA must alleviate these ongoing issues among these PTSD veterans. Concluding, researchers are convinced that the effectiveness of these transitional services are lacking or inefficient. Which helps prove that there is a current gap in the integrated disability transitional program in place.

Background

Transitioning, with PTSD, from active duty into the civilian sector brings about many challenges, predominantly those challenges that occur when dealing with disability transitional services. According to Military Medicine (2014), "44% of returning troops have reported difficulties after they returned" (p. 1054). Many researchers have unveiled how many of the OEF/OIF veterans have overlapping health issues and PTSD is the most prevalent; more than 167,500 veterans are diagnosed with PTSD or seeking care in the VA medical system (Brown, 2008; C. W. Hoge, Auchterlonie, & Milliken, 2006; C. W. C. W. Hoge, Castro et al., 2004; SAMHSA, 2013).

Many veterans voluntarily choose to serve their country by signing up to go into their selected military branch; knowing that going to OEF/OIF war zones would be

highly possible. Not knowing the major effects of being in these war zones, going through the transitional phases while suffering with PTSD, becomes very mechanical for these veterans. Researchers reveal that many of the veterans returning from OEF/OIF war zones feel as though they do not get the attention they deserve from the military, VA, and other institutions while transitioning back into the civilian sector (Ahern et al., 2015; Bateman, 2011; Flournoy, 2014; Hyatt, Davis, & Barroso, 2014; Kelley, 2012). Due to this, many of these veterans suffer drastically with depression, drug addiction, self-harm, and taking their own life.

DTAP

Deriving from the TAP, DTAP was established as a two-hour briefing to give a more personalized transitional plan to those exiting out of the military with a service-connected disability. Supported by the Department of Defense (DoD) and VA, DTAP's focus and aim is to provide detailed information about the VR&E and their entitlements within it. In all actuality, DTAP is just an extension of TAP, which is more specific to those transitioning out of the service with medical disabilities. Additionally, DTAP is like an intervention for disabled military members to encourage them to use the VR&E program (Transition Assistance Program, [TAP] 2016; U.S. Department of VA, 2016a; U.S. Department of VA, Vocational Rehabilitation and Employment, 2016; Veterans Authority, 2016). The VR&E program is where service connected members are guided and mentored on how to plan, locate, and retain proper jobs based on their experiences and disability needs.

VA. In 1930, President Hoover signed an executive order on the establishment of the VA (U.S. Department of VA, 2017b). The responsibilities of the VA were identified

as covering medical services deemed necessary for these veterans. Per the U.S. VA Affairs (2017b), "Of the 24.3 million veterans alive at the start of 2006, nearly three-quarters served during a war or an official period of conflict" (p. 37). Looking even further, a report completed back in 2012 showed that there were 3,536,802 disability compensation recipients and only 121,236 of them used the VR&E program (U.S. Department of VA, 2012). The focus of the VA is to help veterans transition out of active duty more efficiently, especially those who are exiting due to combat related issues. However, looking solely at the use of the VR&E program, it can be determined that there is gap or disconnection among these veterans. It is troubling that only 3.4% of veterans receiving disability compensation are using the VR&E program, which is promoted within the DTAP briefing.

Disadvantages. The VA does offer many services for disabled veterans, however it is still not enough. Authors Ahern et al. (2015); Buckley (2013), Hyatt et al. (2014); Kelley (2012); and Lazaro-Munoz and Juengst (2015), reveal how these veterans are looking for the care they need and are not able to get effective treatments within the VA Medical System in an adequate amount of time; leading to serious outcomes such as suicide, homelessness, and drug addiction etc. Researchers share how many of these veterans are not provided proper education, through the VA transitional programs, on how the benefits work or are often unaware of the seriousness of their disorder (Ahern et al., 2015). Based on this review of literature alone, it can be concluded that there is poor implementation of disability services while transitioning from active duty into the VA system. The U.S. Department of VA (2015b) states that, "from 2002 to 2009 one million

troops left active duty in Iraq or Afghanistan and became eligible for VA care and only 46% came in for VA services" (para. 12).

PTSD

Since WWI took place, numerous veterans, both men and women, have lived in combat zones (Eaton, 2013; Gilbert, 1994; Heinz, Makin-Byrd, Blonigen, Reilly, & Timko, 2015; Karairmak, & Guloglu, 2014; Stagner, 2014). Many of these veterans have been shot at and witnessed their own battle companions injured or killed. These are the sorts of occasions that can prompt combat PTSD. Countless historical data reveals the process of PTSD over time and the effects it has on veterans. In fact, more than one million veterans are suffering with PTSD related issues (Bateman, 2011; Costello, 2015; Chandrasekaren, 2014). Drug addiction, abuse, and suicide are all common side-effects of PTSD. With this, it can be stated that researchers have discovered numerous traumatic events that veterans suffer from and the negative effects that follow. These results show that further research is needed to better understand how to help veterans who suffer with combat PTSD.

Shell Shock. Shell shock was first defined after veterans of WWI came home with mental conditions resulting from war. The side effects of shell shock were intense, ranging from severe anxiety, fatigue, confusion, and extreme nightmares (Moore & Reger, 2007; Sherman, 2016; Stager, 2014). It was utilized to portray the psychological traumas that military men endured in consequence of the extreme battle common all through the European theater (Moore & Reger, 2007). Researchers reveal that many of the military members in WWI would be so overwhelmed in fear and in a panic that they would retreat their own battle zones putting their lives in danger (Binneveld, 1997;

Gilbert, 1994). The outcomes of this was unknown at the time, but now can be looked at as these military warriors suffering with severe combat mental disorders in relation to shell shock.

Later, medical doctors understood the side effects of shell shock, which were due to the anxiety of battle experiences (E. Jones et al., 2007; Stagner, 2014). Shell shock and symptoms of PTSD are similar, but PTSD had not yet been defined post-WWI. Though it is not known as such, the effects do not differ from one another at all. In fact, some studies regarding military medicine and mental health examine shell shock, the dramatic effects it has on the U.S. Military, and the association it has with PTSD (E. Jones et al., 2007). It is explained that exposure to violence, death, and war related injuries has been acknowledged as a momentous causes of shell shock and PTSD related issues among combat veterans (Binneveld, 1998; Gilbert, 1994).

Researchers have revealed how shell shock has even been mistaken for combat PTSD related issues among veterans (J. A. Jones, 2013; Moore & Reger, 2007; Sherman, 2016). Research has also made it clear that combat related injuries and exposure to war zones has major effects on veterans leading to a psychological diagnosis like shell shock. Combat mental disorders vary and many veterans suffer from them daily. However, researchers are convinced that combat PTSD is the most common among veterans in modern times (Betthauser, 2016; E. Jones et al., 2007; Stagner, 2014).

Combat Stress Reaction (CSR). Not to be mistaken with PTSD, combat stress reaction has many of the same traits. During WWI, year 1917, CSR was labeled as "war neurosis" and the war veterans returning with fatigue or other related illnesses, were described as "malingerers" (Moore & Reger, 2007). "Shell shock, and combat fatigue

were once commonly used to describe CSR" (Goldsmith, 2015, para. 1). Some of the traits described by researchers through CSR were fatigue, slowed response, difficulty making decisions, an inability to order decisions in terms of importance, and a seeming lack of presence in the current surroundings (Goldsmith, 2015; Moore & Reger, 2007). Sharing the same traits of PTSD, the negative psychological impacts from war on veterans can be observed. February 1999, CSR was acknowledged and mandated as a used term by the DOD (Department of Defense [DoD], 1999).

The psychological effects on war veterans have been happening for many years and research proves that here. No matter if it is PTSD, shell shock, or combat stress reaction, wars are tremendously changing veterans lifestyles, dating all the way back to WWI. Authors E. Cohen, Zerach, and Solomon (2011) states that "CSR also share some characteristics with acute stress disorder, such as the functional impairment and the predictive value for chronic psychopathology such as PTSD" (p. 689). Looking at the psychodynamics of this, CSR is an acute reaction that can lead to even more severe psychological issues such as PTSD. Researchers have concluded that veterans who keep experiencing traumatic events began to avoid incitements associated and become numb to everyday life awareness (E. Cohen et al., 2011; Goldsmith, 2015; Moore & Reger, 2007; Sherman, 2016).

OEF/OIF

Military veterans have been deployed to numerous of regions in support of the OEF/OIF wars (War Related Illness & Injury Study Center [WRIISC], 2014). October 2001, OEF commenced in response to the 9/11 attacks that occurred on United States soil. From here, the OIF wars took place March 2003, with the invasion of Iraq due to

the Islamic terrorist issues. Ground troops in Afghanistan and Iraq were measured by the War Related Illness & Injury Study Center (WRIISC) from 2002 to 2012, indicating that the number of military members deployed to OEF and OIF varied in this time frame. According to this study, OEF increased at average levels around 63,500 boots on ground from 2010 to 2012; and OIF averaged around 67,700 in 2003 (WRIISC, 2014). Research reveals that there are numerous military members being deployed in these war zones and an issue of supply and demand is at an all-time low (B. M. Anderson, 2013; E. Jones et al., 2007; WRIISC, 2014).

Political ramifications. Medical doctor Sterling S. Sherman (2016) goes over how military veterans are coming back from war redeployment complaining of new medical issues. The medical examination is not if there will be redeployment medical related issues, yet rather what types will be revealed, how they will be present, and how can they best be distinguished or overseen. On the off chance that history is any aide, the medicinal parts of redeployment will keep on being critical in future operations (Sherman, 2016). This is what is known as a political ramification. Dr. Sherman authored on the medical issues in a redeployment study, revealing several aspects of the recurring issues among military member's multiple deployments. In fact, he shares a recent example of political ramifications happening with veterans deploying and redeploying in OEF/OIF war zones; stating "how public policy goals can appear to be at odds with the science of the day when considering post deployment medical syndromes" (Sherman, 2016, p. 1428).

Based on redeployed war veterans and recurring medical issues from multiple deployments, side effects are surfacing from being in these war areas repeatedly. The

exposure to such a violent and life changing environment only extends the thoughts on what our government will do when more and more veterans come home with combat related medical issues. Researchers B. M. Anderson (2013); Sherman (2016); and WRIISC (2014) press this issue and reveal that if more veterans are deployed and redeployed time and time again, the ramifications of combat medical issues will be of great importance for future governance.

Transitioning from Active Duty to the Civilian Sector

Researcher Michele Flournoy (2014) argues that transitioning from active duty into the civilian sector is not just a change of a career, but it is a change in all aspects of life. Research tells us that combat PTSD is currently a major and growing concern for military and veterans today. Does this cause frustration and hurt to these veterans and their loved ones? Who do we blame? How can we help? When will this all end? And when will people understand that this is a serious topic that must be addressed immediately?

Further, looking at exact numbers, more than 100,000 combat veterans are either seeking help for mental illness related issues or suffering from some sort of substance abuse (AMITA Health, 2015; B. M. Anderson, 2013; Heinz et al., 2014; Mental Illnesses, 2015; Saxon, 2011). Of the 2.4 million who served in the OIF/OEF war zones, only 4% of this population are seeking help or are being reported as having some sort of serious war related issues. This is raising the eyebrows of many researchers and everyday people alike. Researchers Heinz et al. (2014) and Saxon (2011), shares that help, support, and the current transitional process is lacking for these veterans. They conclude that there is a major gap that needs to be filled.

Theoretical Framework

Dealing and coping with PTSD is a job on its own. To add to it, being an OEF/OIF war veteran going from combat to homeland; and from active duty into the civilian sector; are critical life changing events. Learning how to adjust by using different coping mechanisms that many veterans and those outsiders who do not understand themselves, can be understood, thoroughly, through a specific theoretical framework. The framework that will be discussed to give that understanding of transitioning is the Schlossberg Adult Transition Theory.

Schlossberg's Adult Transition theory. The Adult Transition theory is recognized as the ability to adapt to change. Many adults do not have the ability to conform nor understand the complexities that come with environmental change. This theory helps study the dynamics of how adult's transition into new networks and the behaviors associated (M. L. Anderson, Goodman, & Schlossberg, 2012; Arman, 2016; Diamond, 2012; Schlossberg, 1981). This theory is what many veterans are being challenged with in the three transitional stages: moving in, moving through, and moving out of going from active duty into the civilian sector. The phases of transition have been intense and veterans are not able to effectively adapt to their new environments due to the lack of support. This model will explore the experiences during transition and what impacted the veteran while moving through each phase (M. L. Anderson et al., 2012; Arman, 2016; Diamond, 2012; James, 2002; Schlossberg, 1981).

Being able to go into a new and unknown environment is life changing for anyone, but to live in two different worlds and quickly change it and manage that change, is something far more intense (Waters, Corcoran, & Anafarta, 2005). Preparing for such

a major transition is important in being effective in all aspects of the medical field in helping these veterans, because it could help save their life and someone else's. The role of the VA Medical System and DoD system, regarding veterans getting out with disabilities, is to take care of the member (Sherman, 2016). This begs the question, why is it that veterans are so afraid to get out of the military and why is there no true transitional system for them to rely on?

Statement of Research Problem

Though there are comprehensive studies on the effects of transitioning out of the military into the civilian sector among OEF/OIF PTSD veterans, there is absence of studies on the effectiveness of the DTAP. According to several researchers, the primary factor in mental health outcomes is the amount of social support the individual receives (Angermeyer, Matschinger, & Riedel-Heller, 1999; Asnaani, Reddy, & Shea, 2014; Berger, 2015; Bliese, Wright, Adler, Thomas, & Hoge, 2007; U.S. Government Accountability Office, 2011). As it is known, PTSD veterans transitioning out of the military, use about two-hours of their time in the DTAP briefings, which is just not enough. The amount of social support for these medically injured veterans needs to be re-examined. OEF/OIF veterans are accounting for the increased use of mental health medical services at the VA. The United States Government Accountability Office (2011) states that "each year the number of veterans receiving mental health care increased, from about 900,000 in fiscal year 2006 to about 1.2 million in fiscal year 2010" (p. 2).

To better understand the systematic issues these veterans face, the primary roles of both the DoD and VA needs to be understood. When it comes to the DoD concerning medical difficulties related with deployment, there are three major responsibilities. The

first responsibility is to provide healthcare and ensure their veterans are healthy enough to be a back in the work force (C. W. Hoge et al. (2004); C. W. Hoge, Terhakopian, Castro, Messer, & Engel, 2007; Sherman, 2016; U.S. Government Accountability Office, 2011). For example, doctors will treat veterans when they are ill/injured and return them back to active duty or determine if the member should be separated due to their service connected injuries. Their second responsibility is to report all medical lessons learned and future plans. This will in turn, help better prevent illnesses and injuries for future veterans.

The last responsibility is to publicize medical findings to all veterans nationwide. Knowing this, it can be said that the DoD plays a major role in OEF/OIF PTSD veterans transitioning out of the military. They are the first and last impression of these veterans' experiences. Based on many researchers, no matter what military branch of service was researched, they all have come to the same conclusion. The common conclusion revealed was that the DoD should deliberate and deliver a more effective transitional mental health system for these veterans (Brancu, Straits-Tröster, & Kudler, 2011; C. W. Hoge et al., 2004; Porcari, 2009). This in turn could help eliminate the common side effects; suicide, substance abuse, homelessness, excreta.

Looking at the role of the VA, they work in conjunction with DoD, regarding the medical problems of both active duty service members and veterans (Bass & Golding, 2012; B. E. Cohen et al., 2010; Seal et al., 2007; Schnurr et al., 2003; Sherman, 2016). The three main responsibilities of the VA are to first provide treatment for those members/veterans with service-connected injuries or illnesses. The second responsibility of the VA is conducting research on the veterans' health issues and providing depth on

care needed and possible causes of the health issues of these veterans. The VAs third responsibility is to accurately determine which benefits these service-connected veterans are entitled to and the interconnected disabilities they have obtained (Bass & Golding, 2012; B. E. Cohen et al., 2010; Schnurr et al., 2003; Seal et al., 2007; Sherman, 2016). It can be concluded that the DoD and VA are vital to all veterans while transitioning out of the military. If these two government agencies do not come up with a better plan to assist OEF/OIF PTSD veterans, researchers tell us that the issues these veterans face will only increase and a true epidemic can evolve.

Looking further, DTAP is a transitional program supported by the VA that is supposed to assist service-connected veterans transitioning out of the military. However, this program seems to be flawed, as it is only focusing on the vocational rehabilitation services; going back into the workforce and gaining a better education. It can be said that pushing the issue on these veterans to quickly get back into the workforce and obtaining an effective degree, can cause even more issues (Ostovary & Dapprich, 2011; T. Stecker, Fortney, Hamilton, & Ajzen, 2007; Stecker, Fortney, Hamilton, Sherbourne, & Ajzen, 2010; T. Stecker, Shiner, Watts, Jones, & Conner, 2013). Based on research and studies, the most ideal case would be focusing on their health above all else.

Westwood, McLean, Cave, Borgen and Slakoy (2010) states that "veterans with PTSD are 10 times more likely to be unemployed than other veterans" (p. 45). This proves the research problem, which is that there is no true effective system in place to support these veterans transitioning out of the military. Pushing employment and education on these veterans is just not enough, nor is the support they need when dealing with PTSD related issues. Authors conclude that effective treatment representations

should be developed and is needed to better support veterans with PTSD (Brunger, Serrato, & Ogden, 2013; E. Cohen et al., 2011; Westwood et al., 2010). This is where the DoD and VA would come into play, collaborating on effective ways to generate a system that would benefit these veterans more significantly.

Purpose Statement

The purpose of this phenomenological study was to describe the perceptions of OEF/OIF veterans with PTSD, who are transitioning from active duty to civilian life, regarding their participation in the DTAP.

Central Research Question

This study is guided by one central research question and three sub-questions: *What are the lived experiences of Operation Enduring and Iraqi Freedom veterans with PTSD, who participate in the Disabled Transition Assistance Program?*

Sub-Questions

1. How did the disabled transition program help or support Operation Enduring and Iraqi Freedom veterans with PTSD transition?
2. How could the disabled transition program be changed to better support Operation Enduring and Iraqi Freedom veterans with PTSD needs related to transition?
3. What challenges and issues do Operation Enduring and Iraqi Freedom veterans with PTSD face that may interfere with their abilities to fully transition into civilian life?

Significance of the Problem

The significance of this study is to better describe the perception of OEF/OIF veterans with PTSD, who are transitioning from active duty to civilian life, regarding their participation in the DTAP. Interviews will help reveal what these veterans go through while transitioning out of the military using the VA DTAP, identifying the following: (a) areas that lack in the program, (b) further programs that maybe needed, and (c) systems these veterans feel would be most beneficial. The literature tells us that the increase of veterans returning home from OEF/OIF war zones, being diagnosed with PTSD, are not utilizing the medical care available (Chase, 2014; Erbes, Curry, & Leskela, 2010; C. W. Hoge et al., 2006; Savitsky, Illingworth, & DuLaney, 2009). Per the Veterans Health Administration (2008), mental health disorders were placed at the second highest identified category among OEF/OIF veterans (musculoskeletal ailments are the number one category). This has lead the VA to increase their mental health staff to help accommodate these veterans (Chase, 2014; Erbes et al., 2010; Veterans Health Administration, 2008).

In general, everyday veterans battle with transitioning from active duty into civilian life. With the many complexities of their combat experiences, PTSD OEF/OIF veterans may experience more tremendous and perplexing experiences coming home from war (Card-Mina, 2011; MacGregor et al., 2009). Researchers tell us that PTSD can be so negative to the influenced veteran, that it regularly leads to a huge decline in work, expanded medical issues, and a higher comorbidity rate (Bolton et al., 2004; Wheeler, & Bragin, 2007). It is known that the frequency of PTSD is much higher among veterans and those who are exposed to war. Specifically, the highest rates of those exposed to

traumatic events range from one-third to one-half of these individuals (American Psychiatric Association, 2013). Further, OEF/OIF PTSD veterans who have sought related care have either dropped out or avoided it altogether. Chase (2014) states "timely post-deployment treatment mitigates long-term mental health problems with veterans who suffer from mental issues following deployment" (p. 2). Thus, this matter merits additional attention to help these veterans overcome possible barriers that restricts their use of the VA mental health services and programs.

An EBSCO and ProQuest electronic library search looking at several variables (e.g., transitioning, PTSD, OEF/OIF, veterans, VA) revealed numerous articles when these key terms were explored independently. Nevertheless, when the search criteria were done together, the search results came back with only related articles. Not one article or dissertation dealt exactly with PTSD OEF/OIF war veterans perceptions of DTAP while transitioning out of the military. The apparent gap in research and current data on the increase of veterans diagnosed with PTSD, transitioning from the military entering the civilian world, is firm evidence on the need for this study. This research can help assist these PTSD veterans transition and live more successfully in their new environments outside the military. In turn, it can help reveal a better medical system, program, or early intervention that assists the transition of these veterans more efficiently; understanding the changes that will occur overtime (Amstadter, McCart, & Ruggiero, 2007; Bartone, 2006; Sundin, Fear, Iversen, Rona, & Wessely, n.d). Further leading to the elimination of the common side effects with these veterans today (e.g., suicide, substance use disorders, homelessness).

Definitions of Terms

Active Duty. All individuals who are currently serving in the U.S. Military Armed Forces: Army, Navy, Air Force, Marines.

Civilian Sector. Non-combatant or military environments.

Combat. Conflict or battle between armed forces and their enemies.

Department of Veteran Affairs. An organization developed to help care, assist, and honor those who have served in the U.S. Armed Forces.

Disabled Transition Assistance Program. A 2-hour briefing developed by the Department of Veterans Affairs, to help disabled veterans who are exiting the active duty into the civilian sector.

Department of Defense. An executive branch department of the U.S. federal government, that is responsible to govern and organize all functions of both national security and U.S. Armed Forces (DoD, 2017).

Military. Consisting of the Armed Forces: Army, Navy, Air Force, and Marines. The military are forces that protect and defend the United States

Moving In. The first stage of the Adult Transition Model, OEF/OIF PTSD veterans began to adapt to their original environments. In this study, this stage is where the veteran starts to become familiar with the DTAP, VA Medical system, and new nonmilitant environments.

Moving Out. The final stage is described as the end or passing of a change or transition, and the start of a new moving phase (M. L. Anderson et al., 2012; Arman, 2016; Lopez, 2011). Once a veteran reaches this point in the model, they should be familiar with the new environments that they are in.

Moving Through. The second phase of the Adult Transition model requires sustaining and balancing the burdens of the transition. In this phase, OEF/OIF PTSD veterans are converting into the transition, but are not entirely transitioned.

Operation Enduring Freedom. A combat war that began October 7, 2001, in Afghanistan, and needed December 28, 2014.

Operation Iraqi Freedom. On March 20, 2003, OIF, also known as the invasion of Iraq, began and ended December 18, 2011.

Posttraumatic Stress Disorder. A mental health disorder that an individual acquires after encountering or observing life altering incidents, such as war, accidents, sexual assault and violence (U.S. Department of VA, 2017a).

Service-connected Disability. An identified disability that is military related, injury or illness that occurred during the service member's active duty time. This is determined by the U.S. Department of VA.

Transitional Assistance Program. Established in the 1990s by Congress, TAPs was generated and made mandatory for all separating veterans to attend this five-day program (U.S. Department of VA, 2016a). This program consists of assisting in job searches, constructing transitional plans, and other related services to help these vets transition back into the civilian workforce (Bascetta & General Accounting Office, 2002).

Transitioning. Going from active duty into the civilian sector, learning how to adapt from one environment into the next.

Veteran. Any individual who has served or is serving in the U.S. Armed Forces.

Vocational Rehabilitation and Employment Program. Sometimes referred as the Chapter 31 program, VR&E was developed to provide services to military members and veterans who have been diagnosed service-connected disabilities. These services entail appropriate employment and establishment of self-governing living for these military and veteran members' (U.S. Department of VA, Vocational Rehabilitation and Employment, 2016).

Delimitations

This study was delaminated to the U.S. Armed Forces veterans associated with local San Diego, California Veteran of Foreign Wars (VFW) nonprofit organization. In addition, this study focuses on veterans who are identified as having combat PTSD due to serving in the OEF/OIF war zones. Further, the study only focuses on those veterans who transitioned out of active duty using the DTAP program. Due to this, all findings from this study are solely particular to this veteran population.

Organization of the Study

This study explored the perceptions of OEF/OIF veterans with PTSD, who are transitioning from active duty to civilian life, regarding their participation in the DTAP. The findings from this study could help inform the government agencies involved on the gaps in the program. Revealing the needs of these veterans while transitioning out of military with their mental disorder.

Chapter II provides an extensive review of literature revealing the background of all critical variables of this research. The DTAP, PTSD, OEF/OIF wars, transitioning from active duty into the civilian sector, theoretical background, and gaps in research will all be expanded upon, supporting the relevance and urgency of this topic. Chapter III

provides and focuses on the methodology, research design, data collection, population, sample, and evaluation measures chosen for this study.

Chapter IV and V will provide and address the findings of the study. This will then lead to final summaries, conclusions, and recommendations for future actions and research. The study will close with an extensive reference list and related appendices.

CHAPTER II: REVIEW OF LITERATURE

This chapter will present a review of literature probing data pertaining to veterans returning from OEF/OIF war zones, transitioning with combat PTSD and the systematic issues they are steadily facing (B. M. Anderson, 2013; Bateman, 2011; Ho, 2015; Knetig, 2012). This review of literature will incorporate a broad scope of associated focuses: (a) PTSD veterans, (b) DTAP, (c) VA system, (d) OEF/OIF wars, and (e) transitioning vets from combat into the civilian sector. Historical data will be presented regarding each of these focuses and the related theory. In addition, this qualitative phenomenological study will describe the perception of OEF/OIF veterans with PTSD, who are transitioning from active duty to civilian life, regarding their participation in the DTAP.

Using the Chapman University Library, public libraries, military websites, and other online sources, the identified key terms were used for this literature review: Combat-Related PTSD, PTSD, combat, war zones, disabled veterans, veterans, OEF/OIF wars, disability, mental health, DoD/VA medical systems, DTAP/TAPS, disadvantages, active duty, transitioning from active duty into the civilian sector, psychology adjustments, psychology, receiving treatments, culture, civilian sector, relationships, social roles, combat stress, shell shock, political ramifications, and Schlossberg's Transition Theory. A synthesis matrix was created to help identify the common themes among the references used (see Appendix A). Chapter II closes with the gap in the literature, summary of the research problem, and overall significance of the study.

Background of TAP

Starting in the 1990s, congress created the TAP to help exiting service members adapt back into the civilian sector due to the downsizing of the military at that time

(Bascetta & General Accounting Office, 2002; Heflin, Hodges, & London, 2016; Hicks, Weiss, & Coll, 2017; National Defense Authorization Act for Fiscal Year, 1991; U.S. Department of VA, 2016a). This program was created to help assist these veterans make appropriate selections of both educational and occupational choices going from active duty into the civilian world. The Department of Labor (DOL), DoD and VAs were the identifying organizations to help structure and govern this program. From here, these agencies established their roles and responsibilities for the service members in active duty branches: Army, Air Force, Marines, Navy, and Coast Guard (DoD, 2014; Heflin et al., 2016; U.S. Department of Labor [DOL], TAP Workshop Participant Manual, 2002).

Later, it was then originated that each branch of the military, required by law, must offer pre-separation counseling entirely to service members 90 days before their military separation date. Further, service members are required to complete the pre-separation counseling checklist confirming they have been educated of all services offered to them, as well as choosing which services/workshops they would like to partake in (DD Form 2648, Pre-Separation Counseling Checklist for Active Component Service Members, 2005; U.S. DOL, TAP Workshop Participant Manual, 2002). Within these separation counseling's, it is mandatory that the military branches provide the following information to these separating veterans:

- Educational and vocational rehabilitations.
- Selective reserve options.
- Job counseling.
- Job search and placement information.
- Relocation assistance services.

- Medical and dental benefits.
- Counseling on the effects of career change.
- Financial planning (U.S. DOL, TAP Workshop Participant Manual, 2002).

In addition to this, the DOLs role is to provide transitional workshops that consist of three-days depending on the location and time allotted. These workshops are to include resume writing, job search strategies, and a manual with information that geared from the workshop (U.S. DOL, 1995; U.S. DOL, TAP Workshop Participant Manual, 2002). The intension of this workshop is to (a) reduce unemployment rates among separating veterans, (b) reduce unemployment benefits paid to veterans, and (c) help improve retention. Looking at exact expenses, according to the DOL, they spent about "$5 million in the fiscal year 2001 to provide about 3,200 workshops, in addition to the funding spent on transition assistance by the Military branches" (Bascetta & General Accounting Office, 2002, p. 4). Table 1 shows these expenses report by each branch in the year 2001 to the General Accounting Office.

Table 1

Transition Assistance Funding by Military Branch, Fiscal Year 2001

	Army	Air Force	Marine	Navy	Coast Guard	Total
Funding (in millions)[a]						
DOD	13.5	8.9	4.0	10.3	0.0	**36.7**
Other	5.3[b]	0.0	0.0	0.0	0.5[c]	**5.8**
Total	**18.8**	**8.9**	**4.0**	**10.3**	**0.5**	**42.5**
Transition Assistance Workshops[d]						
Number held	1,207	1,115	520	1,075	33	**3,950**
Length (in days)	2-3	3	3-4	4	4	**N/A**
Average class size	24	25	41	38	35	**N/A**

Note. Adapted from "Military and Veterans Benefits: Observations on the Transition Assistance Program. Testimony before the Subcommittee on Benefits, Committee on Veterans Affairs House of Representatives," by C. A. Bascetta, 2002, p. 4. Retrieved from ERIC database. (ED467626)

The TAP varies in significant ways throughout the military branches. All branches of the military provide the required pre-separation counseling and workshops that focus on the areas listed previously, however, not all active service members participate (Bascetta & General Accounting Office, 2002; Hicks et al., 2017; U.S DOL, 1995). In addition to these services, the disabled members are given comprehensive material on the services available for their disabilities, assistance in obtaining these services, and the overall benefits they are entitled to. It has been revealed that military branches can design their own transitional programs, allowing flexibility on how they present or deliver their programs (Hick et al., 2017; DoD, 2014; Hanssen, 2008). Meaning, that based on the mission needs of the branch, it can affect the delivery, access, and processes of the transitional assistance program.

Military Branches Design of TAPS

Due to mission needs and the differences of each branch of the military, some have devised, executed, and distributed TAPS in their own unique way. The Army, Navy, and Marines are the only branches that have added to or made TAP to fit the needs of their missions. While the Air Force and Coast Guard have kept the standards basic to what the DoD has stated to implement. Below are brief examples of the Army, Navy, and Marines unique ways in offering TAP to service members.

Army. The United States Army refers to TAP as the Army Career and Alumni Program (ACAP). The Army allows members who are retiring 24 months prior to separating to conduct the pre-counseling and regular separating members 12 months prior. Unlike most of the other branches, the Army has an ACAP on-line program that

provides job assistance information, transitional assistance information, employment lists, and other important associated links (Hanssen, 2008; United States Army, 2016).

ACAP encompasses three main sections: (a) pre-separation counseling, (b) transition assistance referral, and (c) employment assistance training (Hanssen, 2008; United States, Congress, House, Committee on Veterans Affairs, Subcommittee on Benefits, 2004; United States Army, 2016). The Army's focus is to aid and assist not only the soldiers, but their families as well. ACAP helps identify the transitional needs of the service member and provides the assistance for their own personal needs through the following: high quality guidance, training, resources, and support through their transitions (United States Army, 2016). Though attending these offered services are not required, the pre-counseling portion is.

Navy. The United States Navy signifies their TAP as a workshop that ensures a successful transition into the civilian sector. The Navy has adjusted their program to be used as a retention and recruiting utensil (Heflin et al., 2016; Navy Live, 2015; Navy Personnel Command, 2017). In addition to the standard TAP three-day workshop, the Navy created an additional day to help provide more concrete information about the military benefits offered to these members. Their intent is to provide a program that is concentrated on an occupational process that is extended throughout their career.

The Navy has now established two additional focuses within the TAP, the Transition GPS (goals, plans, and success) and DoD Career Readiness Standards (CSR). The transitions GPS is specifically designed to help Navy Sailors more in depth on finical planning, understanding the VA benefits, and employment workshops (Heflin et al., 2016; Navy Live, 2015; Navy Personnel Command, 2017. CSR was established by the

Navy to help sailors comprehend their proficiencies and resources required for their future careers. This updated transition program helps guarantee sailors are achieving the requirements and gathering the appropriate resources to transition out effectively (Heflin et al., 2016; Navy Live, 2015; Navy Personnel Command, 2017). Like the Army, though many of these services are offered, the pre-counseling is the only required aspect when transitioning out of the Navy.

Marines. The United States Marines has established their transition assistance program as The Marine Corps Transition Assistance Management Program (TAMP) and was officially recognized November 1990 (Forkin, 2015; Hanssen, 2008; United States Marine Corps, 2017). TAMP provides employment assistance, occupational assistance, and transitional material for all Marines who are separating out of the service. In addition to TAMP, the Marines created the Transition Readiness Seminar (TRS) that goes over in depth the education, entrepreneurship, post service budget, and future career options (Forkin, 2015; Hanssen, 2008; United States Marines, 2017). TRS is not only for service members, but for their significant others as well.

The Marines also highly encourage service members to attend the Spouse Transition and Readiness Seminar (STARS) to learn about all the transition changes and planning that will take place. Like the rest of the military branches presented previously, the Marines only makes it mandatory to attend the pre-separation counseling. Bascetta and General Accounting Office (2002) identified participation in the pre-counseling and the TAP workshops for the year 2001 for all military branches. This helps reveal how many service members are truly using the workshops that are provided versus the mandatory pre-separation counseling (see Table 2).

Table 2

Participation in Pre-Separation Counseling and Transition Assistance Workshops by Military Branch, Fiscal Year 2001

Participation	Air Force	Army	Marines	Navy	Coast Guard	Total or Average
Total Separated/Retired	**43,756**	**85,190**	**31,319**	**57,452**[a]	**4,037**	**221,754**
Number of pre-separation counselings	39,375	77,146	27,849	30,508	N/A[b]	**174,878**
Percent receiving pre-separation counseling	90%[c]	91%	89%	53%	N/A[b]	**81%**
Number attending transition assistance workshop[d]	27,815	28,464	21,397	41,181	1,155[e]	**120,012**
Percent attending workshop	64%	33%	68%	72%	29%	**53%**

Note. Adapted from "Military and Veterans Benefits: Observations on the Transition Assistance Program. Testimony before the Subcommittee on Benefits, Committee on Veterans Affairs House of Representatives," by C. A. Bascetta, 2002, p. 5. Retrieved from ERIC database. (ED467626)

Background of DTAP

As a fundamental portion of TAP, DTAP was established for those service members who are qualified and are being released from active duty, due to a service connected disability or feel that they have a disability (Transition Assistance Program, 2016; U.S. Department of VA, Vocational Rehabilitation and Employment, 2016). When this is determined, the service member will be deemed qualified for the VA's VR&E, also known as Chapter 31. The primary goal of DTAP is to inform and help service members on the benefits of the VR&E program and urge them to take advantage of the program. Though an optional program, DTAP is supposed to benefit those whom have more specific needs regarding their service-connected disabilities.

Research reveals that DTAP is a two-hour briefing that gives a more modified provisional disposition to those exiting out of the military with service-connected disabilities (Transition Assistance Program, 2016; U.S. Department of VA, Vocational Rehabilitation and Employment, 2016; Veterans Authority, 2016). Looking further, the data surrounding the TAP, reveals that the DTAP program is simply just an extension of

TAP and a way to get veterans to go into the VA's VR&E program. According to the U.S. Department of VA (2016a), the VR&E is required to provide a rehabilitation plan that includes the following:

- Quick employment services for new employment.
- Independent living services.
- Long term services through employment.
- Reemployment with an earlier employer.

Though these services seem promising, research is revealing that many of these veterans are not using the services or finishing the programs altogether.

According to the U.S. Department of VA Inspector General (2007), an audit was conducted, stating the following:

> Our review of 1,377 case files for veterans who were rehabilitated or discontinued during the first 11 months of FY 2006, showed that 1,136 (82 percent) had discontinued their participation without being rehabilitated. The results also showed that 983 (87 percent) of the 1,136 discontinued veterans were eligible and entitled to Chapter 31 benefits but did not complete the program. The remaining 13 percent were either ineligible or not entitled to benefits after applying for the Chapter 31 program and were not included in the methodology used to calculate the rehabilitation rate. VA spent about $3.7 million, an average cost of $3,218 per veteran, on discontinued veterans in our sample. The factors that caused many veterans to discontinue the program were unknown to VR&E management. (p. 8)

This audit reveals key aspects of the VR&E and possible downfalls of the program. Trying to help rehabilitate disabled veterans is the key focus of these programs and it

seems that the success rates show otherwise. Due to these rates, the VR&E Task Force Report advocated that the VR&E Service start a nationwide inquiry on why it is these veterans cease involvement in the program (U.S. Department of VA Office Inspector General, 2007).

Following, the VA Office of Policy, Planning, and Preparedness began the VR&E study October 2005. Through focus groups with these veterans and VR&E staff, it was identified why these veterans had withdrawn their involvement in the platform. The U.S. Department of VA Office of Inspector General (2007) revealed that 33 (57%) responses were received of 58 participants who withdrew from the program; revealing the following:

- Veterans did not understand the program, and some lost interest after learning of the time commitment or the amount of subsidy they would receive.
- Travel distances to the VAROs discouraged veterans from completing the program.
- Veterans with learning disabilities needed extra time to complete assignments, and the course work seemed too difficult to successfully complete.
- Veterans perceived that VR&E staff had specific professions and jobs that they wanted veterans to pursue and disregarded the veteran's personal goals and interests.
- Veterans wanted to acquire an education but did not necessarily want to find a job.
- Personal and family problems, including financial and health issues, created barriers to completing the program.

- One veteran stated that he had relapsed into substance abuse. (pp. 8-9)

Looking at this data alone raises concern for the VR&E, VA, DoD, DOL, and military branches. Research concludes that veterans who quit the program are not fully rehabilitated in the VR&E program. The U.S. Department of VA Office of Inspector General (2007) shares how they would recommend that under the secretary for benefits, a well-developed methodology must be established, as well as procedures to better understand why it is these disabled veterans are discontinuing their participation in the DTAP/VR&E programs.

Table 3 shows the U.S. Department of VA Office Inspector General (2007) findings of the VR&E participants and rehabilitated veterans from 1998 to 2006. Comparing the program participants versus the rehabilitated veterans is clear that of the overall total of veterans who have participated, 783,799, only 95,311 have been fully rehabilitated. Making it clear that there is an apparent gap in the program and these medically disabled veterans are not actively engaging in the programs available to them.

Table 3

Chapter 31 Program Participants and Rehabilitated Veterans- FY 1998 through FY 2006

Fiscal Year	Program Participants	Rehabilitated Veterans	Obtained Suitable Employment (Percent of Rehabilitated)	Met IL Goals (Percent of Rehabilitated)
1998	80,665	9,289	9,038 (97.3)	251 (2.7)
1999	79,569	10,281	9,841 (95.7)	440 (4.3)
2000	77,920	10,603	9,837 (92.8)	766 (7.2)
2001	81,103	10,116	8,559 (84.6)	1,557 (15.4)
2002	90,039	10,209	7,799 (76.4)	2,410 (23.6)
2003	97,158	9,554	7,520 (78.7)	2,034 (21.3)
2004	94,851	11,129	8,392 (75.4)	2,737 (24.6)
2005	92,703	12,013	9,279 (77.2)	2,734 (22.8)
2006	89,791	12,117	9,225 (76.1)	2,892 (23.9)
Total	783,799	95,331	79,490(83.4)	15,821(16.6)

Note. Adapted from "Audit of Vocational Rehabilitation and Employment Program Operations (Report No. 06-00493-42)," by Department of Veterans Affairs Office of Inspector General, 2007, p. 15. Retrieved from https://www.va.gov/oig/52/reports/2008/VAOIG-06-00493-42.pdf

Department of VA

Executive order 5378, establishing the Veterans Administration, was started July 21, 1930, by President Herbert Hoover. According to the U.S. Department of VA (2015b), the purpose of the order was the following:

> An Act to authorize the President to consolidate and coordinate government activities affecting war veterans. The President is authorized, by Executive order, to consolidate hospitals and executive and administrative bureaus, for the relief of veterans, into an establishment to be known as the Veterans Administration. (p. 1)

History tells us that the government has had the interest of our veteran's wellbeing for many years. Over time, the VA medical system has changed tremendously. Dating back to 1636, Plymouth help disabled veterans in the colony's defense versus the Indians, by giving money compensation. Moving into the Civil War 1861, more than 80,000 war veterans were initiated, ending with 1.9 million veterans who served altogether in this

war. Under President Lincoln 1862, The General Pension Act was established to help afford disability compensation centered on the level of the veteran's disability. Also, providing slight benefits for those veterans' dependents/relatives (U.S. Department of VA, 2017b).

Research reveals that in the United States 1812, medical care for disabled veterans was first afforded at a Naval home in Philadelphia, Pennsylvania. Leading to the establishment of two more medical facilities in Washington, D.C., "The Soldiers' Home" 1853 and "St. Elizabeth's Hospital" 1855 (U.S. Department of VA, 2017b). Moving further into history, The Disabled Veterans Rehabilitation Act in 1943 was approved, leading to the establishment of the vocational rehabilitation program for all disabled war veterans from WWII serving after December 6, 1941. This lead to more than 621,000 disabled WWII veterans seeking job training who were returning home (U.S. Department of VA, 2017b).

As time has passed and many wars have developed, the VA system has changed repeatedly, and the government has sought out on how to help these war veterans. Today, the VA's medical system has expanded from 54 hospitals in 1930 to 157 medical facilities in 2005. Around 5.3 million veterans have received care through the VA medical system in 2005 (Hicks et al., 2017; U.S. Department of VA, 2017b). Though services are available and veterans are using the system, research tells us that in 2012, there were 3,536,802 disability compensation recipients and only 121,236 of them used the VR&E program (U.S. Department of VA, 2012). The efforts to support war veterans has been tremendously progressive, however statistics tells us there is a missing

piece, as only 3.4% of veterans receiving medical compensation are using the rehabilitation services offered.

Responsibilities and Roles

Knowing now the purpose of the VA, the responsibilities and roles must be identified. This is where much confusion takes place and many veterans are lost on where to go or who to turn to. The overall responsibility of the VA is to provide adequate services to U.S. veterans. These services include (a) health care, (b) benefit programs, and (c) national cemetery access.

The mission statement: "To care for him who shall have borne the battle, and for his widow, and his orphan by serving and honoring the men and women who are America's veterans" (Department of VA, 2017b, Mission Statement section).

Core values (I CARE). The VA core values are all-inclusive throughout the VA organization. To have a foundation in the VA system, these values were established to help support the culture, mission, and provide the greatest services to veterans and their families today.

- Integrity: Act with high moral principle. Adhere to the highest professional standards. Maintain the trust and confidence of all with whom I engage.
- Commitment: Work diligently to serve veterans and other beneficiaries. Be driven by an earnest belief in VA's mission. Fulfill my individual responsibilities and organizational responsibilities.
- Advocacy: Be truly veteran-centric by identifying, fully considering, and appropriately advancing the interests of veterans and other beneficiaries.

- Respect: Treat all those I serve and with whom I work with dignity and respect. Show respect to earn it.
- Excellence: Strive for the highest quality and continuous improvement. Be thoughtful and decisive in leadership, accountable for my actions, willing to admit mistakes, and rigorous in correcting them. (U.S. Department of VA, 2014, p. 8)

It can be concluded that the VA's responsibilities and roles is to ensure the best quality of care for veterans, and advocate for them at all possible causes, especially to those whom have been injured at war. However, data and statistics show that the veteran services are not being used by all veterans.

Reported from the Department of VA from fiscal year 2000 to fiscal year 2012, Table 4 discloses a summary of veteran benefits and the differences of disability compensation veterans versus how many are partaking in the VA benefit programs. To point out a few, in year 2012, 3,536,802 veterans were receiving disability compensation and of this amount only 121,236 were using the VR&E services. Which leaves 3,415,566 not utilizing the VR&E program altogether. If we compare years between VR&E services used, it has increased significantly. Disability compensation veterans totaled 2,308,186 for in the year 2000; of this amount only 50,281 were utilizing the VR&E services. Comparing that to the year 2012 numbers that is a 70,955-veteran increase in the program. Though there has been increased improvement, there is still an issue with all veterans not using these benefit services. Numbers prove an underlying issue and the gap is still yet hard to determine on why veterans are not utilizing the services. Which is why the VA is still trying to research to fix these gaps and issues.

Table 4

Summary of Veteran Benefits: Fiscal Year 2000 to Fiscal Year 2012

Fiscal Year	Disability Compensation Recipients (DCR)	% Change in DCR From Previous Year	Disability Pension Recipients (DPR)	% Change in DPR From Previous Year	Education Beneficiaries (EB)	% Change in EB From Previous Year	Home Loans Guaranteed (HLG) During Fiscal Year	% Change in HLG From Previous Year	Life Insurance Policies[1] (LIP)	% Change in LIP From Previous Year	Vocational Rehabilitation and Employment (VR&E) Participants	% Change in VR&E Partisipants From Previous Year
2000	2,308,186	-	364,220	-	397,589	-	199,160	-	2,206,834	-	50,281	-
2001	2,321,103	0.56	348,052	-4.44	420,651	5.80	250,009	25.53	2,079,163	-5.79	52,402	4.22
2002	2,398,287	3.33	346,579	-0.42	464,159	10.34	317,251	26.90	1,962,525	-5.61	53,605	2.30
2003	2,485,229	3.63	346,555	-0.01	472,970	1.90	489,418	54.27	1,853,872	-5.54	55,589	3.70
2004	2,555,696	2.84	342,903	-1.05	490,397	3.68	335,788	-31.39	1,750,372	-5.58	55,805	0.39
2005	2,636,979	3.18	335,787	-2.08	498,498	1.65	165,854	-50.61	1,648,195	-5.84	55,228	-1.03
2006	2,725,824	3.37	329,856	-1.77	498,123	-0.08	142,708	-13.96	1,545,436	-6.23	52,982	-4.07
2007	2,844,178	4.34	322,875	-2.12	523,344	5.06	133,313	-6.58	1,446,004	-6.43	98,548	86.00
2008	2,952,282	3.80	315,763	-2.20	541,439	3.46	179,670	34.77	1,347,563	-6.81	103,126	4.65
2009	3,069,652	3.98	314,245	-0.48	564,487	4.26	325,690	81.27	1,254,059	-6.94	110,750	7.39
2010	3,210,261	4.58	313,563	-0.22	800,369	41.79	314,011	-3.59	1,167,081	-6.94	117,130	5.76
2011	3,354,741	4.50	313,665	0.03	923,836	15.43	357,594	13.88	1,085,004	-7.03	116,295	-0.71
2012	3,536,802	5.43	314,790	0.36	945,052	2.30	539,884	50.98	1,006,235	-7.26	121,236	4.25

Note. Adapted from "Summary of Veterans Benefits: FY 2000 to FY 2012," by Department of Veterans Affairs, Veterans Benefits Administration, Annual Benefits Reports, 2000 to 2012. Retrieved from https://www.va.gov/vetdata/docs/ Utilization /Summary_of_Veterans_Benefits_2012.pdf

Advantages and Disadvantages

As it was revealed previously, the VA offers many services to disabled veterans affording several advantages for these members. Some of the known advantages of the VA for qualified veterans are the following:

- Unlimited use of VA facilities and services.
- Multiple resources (health, employment, rehabilitation, education).
- Assisted living/Home healthcare.
- Prescription coverage.

Looking at just these advantages alone, it can be said that the qualified veterans are fortunate to be able to have these services available to them always. It can also be said that the services provided are helping these veterans transition back into the civilian sector. The VA does in fact help many veterans through the services they offer.

According to Hicks et al. (2017), healthcare alone at the VA provides 9.1 million veterans medical and dental care at the multiple clinics around the United States. This is a positive look for the VA, as it shows that the services they offer are being used by veterans and they are obtaining the services that they truly need. It also tells us when they transition from active duty into the civilian sector, these veterans are being given the tools needed about the VA services available. It can be concluded that there are services offered to these qualified veterans through the VA and they just should seek out to retrieve them.

Though there are advantages of the VA, there are also disadvantages. Some of the disadvantages are the following:

- Effective treatments.
- Time.
- Serious transitional side effects (suicide, depression, drug additions, and homelessness).
- Too many veterans and not enough help.

Looking at just these few disadvantages, it can raise some attention to these matters. Researchers tell us that effective treatments are not happening, revealing how many disabled veterans are seeking the care they need, but are not able to get the care they need nor in a sufficient amount of time (Ahern et al., 2015; Buckley, 2013; Gaudet, 2014; Hyatt et al., 2014; Kelley, 2012; Lazaro-Munoz & Juengst, 2015). These researchers explain how this is happening due to lack of medical doctors and availability in the VA clinics. This has lead these veterans, particularly those with PTSD, to serious side effects, such as homelessness, depression, suicide, drug addictions etc.

Costello (2015) cites data from the Department of Veterans Affairs, sharing that "80% of veterans diagnosed with PTSD are given psychiatric drugs. Of them, 89% are given anti- depressants" (p. 1). This is where drug abuse has settled in due to lack of attention, care, and access to effective care in a proficient timeframe. Research also demonstrates that there are 950 suicide attempts occurring each month among veterans receiving services through the VA (Mental Illness, 2015). This proves that there are major issues with communication and support within the mental health clinics at the VA. According to Author Debra Draper (2014), "4 of the 10-physical therapy consults GAO reviewed for one VAMC, between 108 and 152 days elapsed with no apparent actions taken to schedule an appointment for the veteran" (p. 2). It can be said that treatment is not accessible to these veterans at the mental health clinics and VA altogether. Reported by the U.S. Department of VA (2016b), it was revealed that the number of veterans who take their own life is due to the struggle of coping with going from the war zone into the civilian environment. There data shared that suicide numbers are increasing to 20 suicides per day among these veterans, to almost 22.5 a day.

As it was previously stated in Chapter I, from 2002 to 2009 more than one million troops have transition out of active duty from Iraq and Afghanistan war zones and 46% became eligible for VA services (U.S. Department of VA, 2015b). These numbers tell us that not only does the VA not have enough hands to attend to these veterans, but too many are returning at the same time causing major delays with system availability. Proper education and information from the transitional system in place has been beneficial on some levels, however, veterans are unable to take advantage of them due to the shortage of help. The perceptions among veterans has been voice vocally and around

the United States, sharing that the VA is less interested in their care and more interested in supporting research on medical research programs and the organizations survival (Gaudet, 2014; Hicks et al., 2017; Panangala, 2016). This has fed fuel to the ongoing issues already happening in the VA medical system and has now affected these disabled veterans personally.

PTSD

PTSD is defined by the American Psychiatric Association, (2013) as a psychiatric disorder that transpires among people who have either faced or observed a harrowing event such as a severe accident, terrorist act, war/combat, natural disaster, rape, or other violent attacks. Those who suffer significantly with PTSD, bear the extreme, troubling feelings and moods in relation to their experiences years after the traumatic event(s) has occurred. Symptoms of PTSD are expressed through the American Psychiatric Association to help identify the criteria for this disorder. The American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* diagnostic criteria are broken down into eight criterions and they are the following:

- Criterion A: Stressor- The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows: (1 required) 1. Direct exposure. 2. Witnessing, in person. 3. Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental. 4. Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details

of child abuse). This does not include indirect nonprofessional exposure through electronic media, television, movies, or pictures.

- Criterion B: Intrusion Symptoms- The traumatic event is persistently re-experienced in the following way(s): (1 required) 1. Recurrent, involuntary, and intrusive memories. Note: Children older than 6 may express this symptom in repetitive play. 2. Traumatic nightmares. Note: Children may have frightening dreams without content related to the trauma(s). 3. Dissociative reactions (e.g., flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness. Note: Children may reenact the event in play. 4. Intense or prolonged distress after exposure to traumatic reminders. 5. Marked physiologic reactivity after exposure to trauma-related stimuli.
- Criterion C: Avoidance- Persistent effortful avoidance of distressing trauma-related stimuli after the event: (1 required). 1. Trauma-related thoughts or feelings. 2. Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations).
- Criterion D: Negative Alterations in Cognitions and Mood- Negative alterations in cognitions and mood that began or worsened after the traumatic event: (2 required). 1. Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol or drugs). 2. Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world is completely dangerous."). 3. Persistent distorted blame of self or others for causing the traumatic event or

for resulting consequences. 4. Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt or shame). 5. Markedly diminished interest in (pre-traumatic) significant activities. 6. Feeling alienated from others (e.g., detachment or estrangement). 7. Constricted affect: persistent inability to experience positive emotions.

- Criterion E: Alterations in Arousal and Reactivity- Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event: (2 required). 1. Irritable or aggressive behavior. 2. Self-destructive or reckless behavior. 3. Hypervigilance. 4. Exaggerated startle response. 5. Problems in concentration. 6. Sleep disturbance.
- Criterion F: Duration- Persistence of symptoms (in Criteria B, C, D and E) for more than one month.
- Criterion G: Functional Significance- Significant symptom-related distress or functional impairment (e.g., social, occupational).
- Criterion H: Attribution- Disturbance is not due to medication, substance use, or other illness. (pp. 271-271)

PTSD symptoms can be short lived or everlasting. Those who suffer with PTSD can develop serious issues in addition to those defined. The American Psychiatric Association (2013) further discusses additional criteria for diagnoses in the areas of depersonalization and de-realization. Depression, detachment, substance abuse, retention difficulties, and other physical or mental issues are all examples of dissociative symptoms with PTSD diagnoses. This disorder has gained great attention among war veterans since the beginning if WWI and is still a surfacing issue today.

U.S. service men and women have operated in combat zones around the world, returning with many medical issues since the beginning of WWI (Eaton, 2013; Gilbert, 1994; Heinz et al., 2015; Karairmak & Guloglu, 2014; Stagner, 2014). Witnessing severe violence, death, and even being injured themselves, has provoked the diagnoses of PTSD. Historical data has revealed the evolution of PTSD over several decades and how it has effected veterans due to combat related issues. According to research, more than one million veterans suffer with PTSD problems. It can be expressed that experts have found various traumatic incidents that veterans experience the ill effects of and the negative impacts that take after (Arman, 2016; Halligan & Yehuda, 2000). These outcomes alone, demonstrate that further research is expected to better see how to help veterans who endure combat PTSD.

The effects of extended exposure in combat zones can unquestionably bring about many combat related disorders. The most identified disorder has been PTSD. Tanielian et al. (2008), goes over the psychological and physical distress that OEF and OIF veterans face, who have been deployed in these areas. Researchers reveal that around 50% of veterans who served in OEF/OIF wars have personally known (friends or family) a veteran who has been killed or injured in these wars. While 10% have conveyed being injured so severely that they were hospitalized and 45% of these veterans reported that they have witnessed veterans being seriously injured or death altogether (B. M. Anderson, 2013; Tanielian et al., 2008). Further, nearly 20% who have served in OEF/OIF war zones have been found or met the criteria in having PTSD related symptoms (C. W. Hoge, Auchterloine et al., 2006; C. W. Hoge, Castro et al., 2004). It is

no secret that being in war zones can be a traumatic event and the historical definitions have changed over time because of this.

Shell Shock

Discovered in WWI, shell shock was an expression used to portray the physiological suffering that veterans experienced from this war. Many researchers conveyed that shell shock was a term used to identify the long-term effects that war had on veterans (E. Jones et al., 2007; Stagner, 2014; Winter, 2000). Some of the common side effects that were identified in diagnosing a war veteran were severe. These included but were not limited to anxiety, fatigue, confusion, extreme nightmares, loss concentration, and mood swings (Moore & Reger, 2007; Sherman, 2016; Stagner, 2014). During the time of WWI, a hefty portion of the warriors would escape the war zones because of the fear feeling of severe anxiety or they would end up noticeably incapacitated and unequipped for development. Thus, huge numbers of these veterans were marked as "weaklings" or "malingerers." The results of this was obscure at the time, yet now can be looked at, as these military warriors are enduring extreme battle mental disarranges in connection to shell stock.

Eventually medical doctors could better understand the effects of war and the diagnoses/side effects of shell shock. It was understood that shell shock occurred due to the exposer of the war and experiences that took place on the battle field. The actual definition of shell shock was presented by the British medical committee whom was tasked with the investigation of this medical term and it was the following (Bateman, 2011):

> Emotional shock, either acute in men with a neuropathic predisposition, or developing because of prolonged strain and terrifying experience, the final breakdown being sometimes brought about by some relatively trivial cause. [Or] nervous and mental exhaustion, the result of prolonged strain and hardship. (p. 14)

Once this definition was produced and officially confirmed by the British medical committee it was better understood the reasoning behind the psychiatric disorder. At the end of WWI, the military data and statistics revealed that 69,394 war veterans suffered with neurological and psychological disabilities that fell under the diagnosis of shell shock (Bogacz, n.d.; Stagner, 2014).

Experts have additionally uncovered how shell shock has even been mixed up for combat PTSD related issues among veterans (J. A. Jones, 2013; Moore & Reger, 2007; Sherman, 2016). Scholars have also made it clear that battle related wounds and introduction to combat areas disturbs veterans, prompting a mental analysis like shell shock. Battle psychological disorders fluctuate and numerous veterans experience the ill effects of them every day. In any case, specialists have been persuaded that combat PTSD is the most widely recognized among veterans today (Betthauser, 2016; Halligan & Yehuda, 2000; E. Jones et al., 2007; Stagner, 2014). PTSD has been identified as many designations over the years and shell shock is just one to name a few.

CSR

Often confused as PTSD, CSR is a combat disorder that was acknowledged during WWI, in the year 1917. Originally it was identified as war neurosis, and like shell shock, these war veterans were coming back with weakness or other related sicknesses

and were portrayed as malingers (Goldsmith, 2015; Moore & Reger, 2007). Some traits of CSR include the following: (a) weakness, (b) hindered reaction, (c) trouble deciding, (d) unable to make sound decisions in terms of significance, and (e) an appearing absence of nearness in the current encompassing's (Goldsmith, 2015). Having similar attributes of PTSD, the negative mental effects from war on veterans can be examined. February 1999, CSR was recognized and ordered as a utilized term by the DoD. CSR is a temporary effect, while PTSD and other persistent mental disorders are long-lasting. Though CSR is not PTSD or shell shock, it can in fact foretell the future advances of PTSD (Goldsmith, 2015; Moor & Reger, 2007).

The mental consequences for war veterans have been going on for a long time and research demonstrates that here. "CSR is also considered a major risk factor for PTSD which is the most common and conspicuous war-induced chronic psychopathology" (E. Cohen et al., 2011, p. 689). Taking a glimpse at the psychodynamics of CSR, it is an intense effect that can prompt much more serious mental issues, like PTSD. Researchers have revealed that over time, CSR among veterans have sustained the difficulties associated with this reaction. Example, having the capacity to confide in their abilities as a spouse or father because of the shattering of their manly personality amid battle (E. Cohen et al., 2011; Ruscio, Weathers, King, & King, 2002; Solomon, 1993).

Regardless of if it is PTSD, shell shock, or combat stress reaction, wars are hugely changing a veteran's way of life, dating the distance back to WWI. Clinicians and researchers devise that the challenges experienced by the damaged veterans is parental functioning stemmed from hyperarousal, evasion, and particularly emotional desensitizing indications (E. Cohen et al., 2011; Ruscio et al., 2002). It has additionally

been found that since the military has not been able to viably build up a capable framework to move out veterans who have been distinguished as expanded hazard for CSR, these medical specialists must be more mindful to limit this war related issue. Analysts have reasoned that veterans who continue encountering traumatic occasions, start to maintain a strategic distance from actuations related or end up noticeably numb to regular day to day existence mindfulness (E. Cohen et al., 2011; Goldsmith, 2015; Moore & Reger, 2007; Sherman, 2016).

Prevalence of PTSD among OEF/OIF Veterans

Understanding PTSD and the history surrounding it is imperative, but understanding the prevalence of this disorder among OEF/OIF veterans is even more substantial. Research tells us that the estimate popularity of OEF/OIF post deployment PTSD ranges from 4% to 20%, with the associated effects of 5% to 37% depression and 4.7% to 39% of problematic alcohol abuse (Eber et al., 2013; Erbes et al., 2010; C. W. Hodge et al., 2004; C. W. Hoge et al., 2006; Military Medicine, 2014; SAMHSA, 2013). In 2010, over 300 service members committed suicide, and of this number, around 50% have been veterans who served in OEF/OIF wars (Military Medicine, 2014). With over 2.5 million service members being deployed to OEF/OIF war zones, some serving multiple times or being exposed to these combat atmospheres over and over, it unquestionably raises their possibility for long-term mental health distresses (Berglass, 2010; Eber et al., 2013; Nicholson, 2015; Spelman, Hunt, Seal, & Burgo-Black, 2012).

Early studies from the U.S. Department of VA (2015b), goes over how they looked at the mental health of veterans who served in both OEF/OIF wars. In this study, soldiers and Marines were questioned about their war experiences and their indications of

distress. In a chart developed by the U.S. Department of VA (2015b) they shared how the outcomes of their study revealed that those soldiers and Marines who served in Iraq, reported more combat stressors than in Afghanistan. Table 5 provides these stressors that these veterans faced in OEF/OIF war zones 2003.

Table 5

Combat Stressors of OEF/OIF war veterans from 2002 to 2005

Combat Stressors		Seeing dead bodies	Being shot at	Being attacked/ ambushed	Receiving rocket or mortar fire	Know someone killed/ seriously injured
Iraq	Army	95%	93%	89%	86%	86%
Iraq	Marines	94%	97%	95%	92%	87%
Afghanistan	Army	39%	66%	58%	84%	43%

Note. Adapted from "Mental Health Effects of Serving in Afghanistan and Iraq," by U.S. Department of Veteran Affairs, 2015, para. 5. Retrieved from Retrieved from https://www.ptsd.va.gov/public/PTSD-overview/reintegration/overview-mental-health-effects.asp

It is no question that PTSD among OEF/OIF vets is dominant, studies and data show that unemployment rates have increased to around 58% from the year 2002 to 2005 among these war veterans (Loughran & Klerman, 2008). OEF/OIF veterans struggle with many transitional issues going from active duty into the civilian workforce. Which brings reasoning as to why the VA offers vocational and rehabilitations programs to help smooth the process of these transitioning war veterans. However, statistics and studies disclose that OEF/OIF veterans suffering with PTSD, are less prone to stay in treatment or programs for prolonged periods of time and or drop out altogether (Erbes et al., 2010; Fontana & Rosenheck, 2008; Ramchand, Karney, Osilla, Burns, & Caldarone, 2008).

The war in Afghanistan and Iraq have been the lengthiest military wars in the United States around 10 years and counting. Researchers tell us that since these wars

started, approximately 40% of men and women have been activated from the reserve component, becoming fully active and deployed more than once to these wars zones (Institute of Medicine, 2010; Ostovary & Dapprich, 2011). The stressors of these deployments and the side effects associated have been genuine signs of the pervasiveness of this topic. Analysts reveal that drawn out battle exposure can diminish the capability in continued attention and memory, bringing on issues in business and instructive settings (Church, 2009; Ostovary & Dapprich, 2011; Vasterling, 2006). Hypervigilance, invasive thoughts, anxiety, moodiness, concentration issues, and sensitivity to noise/crowds are all side effects that hinder the successions of the PTSD veterans. Eventually, these PTSD veterans will encounter expanded detachment, prompting intensified barriers, for example, social, instructive, and job-related issues (Burnett & Segoria, 2009; Kim, 2010).

OEF/OIF

Over time, service men and women have been deployed to various regions in support of OEF/OIF operations. The origination of OEF began 2001 after the 9/11 attacks that happened in the United States. Following the OIF war began in 2003, with the invasion of Iraq due to the Islamic extremist problems (Miller, 2015; VA, 2015; WRIISC, 2014). Around 37,000 American citizens have deployed over five times and 400,000 military members have finished more than three deployments. With more than 2.5 million serving in support of these wars, research tells us that around 4,500 Americans have been killed in the war in Iraq and increasing to 6,600 when Afghanistan was added with it (Adams, 2016; DoD, 2013; Nicholson, 2015). Veterans serving in these wars come home learning how to cope with what they experienced and readjusting back into their “normal” lifestyles.

Life changing events can bare many effects on one's life, veterans who have served in OEF/OIF wars are returning with much needed attention. As of September 2013, around 1,724,058 have separated from the military service and around 998,004 (58%) have requested medical care from the VA (WRIISC, 2014). Whether it is short or long-term care, the effects of these wars are putting a major burden on our veterans today. Authors Avery and McDevitt-Murphy (2014), shares how OEF/OIF combat exposure does in fact affect veterans who have been in an out of deployments several times. These life changing events can affect the thinking process and ability to see what is real. These authors close with how combat veterans need great assessment to see how much the combat exposure has affected them and how much social support is needed. The long-term effects of these wars on veterans is increasing with about 670,000 veterans of the one million who have served in these wars and 100,000 have initiated VA medical claims and are pending decision (Adams, 2016).

Deployments/War Zones

Knowing what it is like to live in foreign countries is unimaginable when it is dealing with deployments and wars among service members. A whole new culture, environment, guns, and bombs become the new life style for many military members. Research tells us that military members are now developing Post-Deployment Syndrome (PDS), which is a signature injury of the OEF/OIF wars that includes various injuries in one. PDS can include PTSD, depression, chronic pain, anxiety disorders, and concussions. PSD, known as the illness of these wars, has caused many veterans to want to return to their deployment areas because it gives them a sense of feeling, strength, need, and honor (Cifu & Blake, 2011; Lewis et al., 2012; Walker, Clark, & Sanders, n.d).

But on the other hand, these war veterans are dealing with hurt, pain, anxiety, depression, and detachment from the real world. OEF/OIF have been the longest wars in 240-years of America's history. In fact, these wars have been the main impetus behind enormous advances in the modernizations of military strategies, weaponry, leaps forward in medical procedures and innovation, improved appreciation for civilizations in Afghanistan and Iraq, and advancement of an overall framework in war healthcare transportation (Cifu & Blake, 2011).

Medical doctor David Cifu and certified movement specialist/therapist Cory Blake (2011), give depth on how OEF/OIF war veterans feel dealing with war and the many symptoms they obtain. They share how these veterans are coping with these issues and how deployment has truly changed their mindsets returning home. An example of what a veteran with PTSD revealed to authors Cifu and Blake was the following:

> I wish I was back in Iraq. People don't understand, but it's just what we do. I'm a marine, not a patient. I remember when I first got there. I was so strong. It was intense…I had no idea it would be this hard when I got back…As hard as the 15 months in Iraq where they don't compare with how hard it is to be back here…The way I feel now…everything's a pain. My back is killing me. I wonder if I'm ever gonna really walk right again. These headaches won't let up. Everywhere I go the lights are way too bright; and I can't stand being around people, they're constantly staring at me. (p. 1)

Every wound has a need and every need must have the support to back them. These researchers show that in every traumatic event, a side effect can take place and how is medical help healing these wounds if they are put back into the same situations over and

over before fully healing. OEF/OIF wars are putting major hurt on American people whom give their life to protect and serve, however, 400,000 veterans have been impacted with multiple symptoms and disables. One in five U.S. service members that have been to OEF/OIF war zones, suffer with an array of signs and symptoms from deployment (Cifu & Blake, 2011 Lewis et al., 2012; Walker et al., n.d).

Another example that Cifu and Blake (2011) share was from the perspective of a Vietnam War veteran by the name of John Wolfe:

> Few things in this world are as unforgiving, pitiless, ungovernable, and irrecoverable as lead and steel loosed from a weapon. The transfigurations they effect on the bodies of friend and foe alike form a permanent backdrop to all a man's future visions. While others experience intervals of silence between thoughts, a combat veteran's intervals will be filled with rubbery Halloween mask heads housing skulls shattered into tiny shards, schemeless mutilations, and shocked, pained expressions that violent and premature death casts on a dead boy's face. These images are war's graffiti. They are scrawled across the veterans' mind defacing the silence and peace that others enjoy. At times the images may seem to fade, but an unguarded glance into the gloom is sufficient to exhume them. (p. 4)

The hidden wounds of OEF/OIF war vets is indescribable and unsettling when trying to understand their personal experiences and trauma from combat. Redeployments have been a prime factor in multiple medical side effects among these veterans and is increasing as these wars persist. Studies, data, and specialist convey that redeployment medical plans must be thoroughly developed for these veterans to help classify

disabilities among these returning members and help repair their issues (DoD, 1997; Joint Chiefs of Staff, 1998; Mazzucchi, 1997; Sherman, 2016).

Political Ramifications

In view of redeployed war veterans and repeating health issues from redeployment, symptoms from various arrangements in a battle region are surfacing. The presentation to such a rough and groundbreaking condition just amplifies the contemplations on what our legislature will do when an ever-increasing number of veterans return home with battle related health issues. Authors B. M. Anderson (2013), Sherman (2016), and WRIISC (2014), squeeze this issue and uncover that if more veterans are conveyed and redeployed on numerous occasions, the repercussions of battle health issues will be of extraordinary significance for future administration. As new developments surface on returning veterans, questions gear towards on how the attention of these redeploying veterans will be handled. Whether it is how they will be cared for, what types of side effects will surface from these wars among veterans, how they will be extant, how they can be distinguished, and how they will be managed effectively; what we need to know is how to address the redeployment medical plan and goals (B. M. Anderson, 2013; Sherman, 2016; WRIISC, 2014).

Sterling S. Sherman (2016), the U.S. Navy Commander of Threat Assessment Department, Naval Environmental and Preventive Medicine Unit, revels that military veterans are returning from war redeployment upset of new restorative issues. The restorative examination gets the chance to be not if there will be redeployment medicinal related issues, yet rather what sorts will be uncovered, how they will be available, and how they can best be recognized or regulated. In case history is any aid, the restorative

parts of redeployment will continue being basic in future operations (Sherman, 2016). This is what is known as a political repercussion. Sherman composed on the restorative issue in a redeployment difficulties, uncovering a few parts of the repeating issues in military individuals and arrangement. Truth be told, he shares a current case of political consequences occurring with veterans conveying and redeploying in OEF/OIF combat areas; sharing "how public policy goals can appear to be at odds with the science of the day when considering post deployment medical syndromes" (Sherman, 2016, p. 1428).

From this research alone, it can be concluded that redeployment plans and goals are a key player in these veterans' lives. The redeployment medical plans help classify diseases and disabilities among returning service men and women (DoD, 1997; Joint Chiefs of Staff, 1998; Mazzucchi, 1997; Sherman, 2016). From here, medical examiners through both active duty and the VA system, can help rapidly, in trying to fix the identified medical issues among these veterans, or compensate them by returning them home or back to active duty depending on the outcomes (DoD, 1997; Joint Chiefs of Staff, 1998; Mazzucchi, 1997; Sherman, 2016). It is no surprise that OEF/OIF veterans are returning with medical disabilities, however the transitional effects and the system in place seems to have missing gaps.

The redeployment plan has three primary purposes and they are identified as the following by DoD, 1997; Joint Chiefs of Staff, 1998; Joint Chiefs of Staff, 2007; Sherman, 2016:

- Distinguish the transmittable illnesses present in the military branches and to avoid the increase of these disorders to other militaries or to the noncombatant populace.

- Averting or decreasing the medical effects of military work-related exposure on militants.
- Determine the military's/veterans medical qualification for ensuing duty.

Looking at these identified purposes of the redeployment plan, it can be concluded that medical screening is proficient, it is just a matter of the process once the veteran returns home and their transition into the local VA system. Though taken care of in the best way possible while active duty and during deployments, there is no set standard of a redeployment plan and it varies depending on the military branch, service member, and medical examiners. Data tells us that DoD has made increased efforts since numbers of redeploying veterans are surfacing with many combat related disabilities, in hopes that they can convey the health changes among military members before, during, and after the wars they have served (B. M. Anderson, 2013; DoD, 1997; Joint Chiefs of Staff, 1998; Joint Chiefs of Staff, 2007; Mazzucchi, 1997; Sherman, 2016).

Transitioning from Active Duty into the Civilian Sector

Making life transitions can differ from person to person, however, when it consists of a whole new life style and environment change, this can be traumatic for any individual, especially active duty service members. In fact, it is explained by author Flournoy (2014) that: "the transition from uniform duty to civilian status is not just a change of jobs, it's a change in virtually every aspect of life: their careers, responsibilities, jobs, homes, communities, lifestyle, health care, training, and more" (p. 2).

Service men and women who transition from active duty into the civilian sector have a lot weighing on them. For example: if they have families, their transition involves

major changes for their significant other and children. Readjustment involves all who are associated with the service member and takes great effort to ensure the transitional process is smooth (Flournoy, 2015). These veterans are only dealing with the transition from active duty into the civilian world, but also health, medical, education, and employment. Trying to decide on what life is supposed to be like outside the military or what your next move will be is no easy task when you become accustomed to daily rituals and leadership dictating your every move. In fact, due to readjustment and health issues, around 300 service members committed suicide, while half of them were those who had deployed to OEF/OIF war zones. In addition, the unemployment rates among these OEF/OIF veterans aged 18 to 24 was 30.2% versus 16.1% of similar aged nonveterans (Institute of Medicine, 2010).

It is no surprise that OEF/OIF war vets are having many readjustment issues, research discloses to us that battle PTSD is as of now a noteworthy and developing worry for military veterans today (Hyatt et al., 2014). As previously shared, more than 100,000 combat veterans seeking help for mental illness issues or are suffering from substance abuse issues, is bringing attention to the government parties involved and answers are wanted on how to fix these underlying war related matters. The Mental Illnesses (2015) reports that the drug and alcohol dependency percentage went from 63,767 in 2006 to 100,580 in 2007 per the VA reporting records. Furthermore, these researchers share similar ideas and go into depth on how better support is needed for these transition processes that combat veterans go through, because the current processes in place seem to be failing them based of statistics alone.

To make matters worse, not only is the transitional process difficult among these war veterans, but now they are having to chase the care they need. Authors Hyatt et al. (2014) conducted a study on another common injury OEF/OIF veterans obtain besides PTSD, mild traumatic brain injury (mTBI). The research goes over the rehabilitation processes and experiences of nine military soldiers and their spouses who suffer with mTBI. The main factor in this research is the amount of care and effectiveness of care they receive. These findings were similar to those who are seen for PTSD and is relevant to share in comparing the care these OEF/OIF members are truly receiving. The first example that was given on the transitional care received based on the pre-diagnosis from the VA was shared by one of the participants in the study. The participant shares the following from the Hyatt et al. (2014) study:

> I wasn't aware at the time---- I just didn't know I had a TBI incident until I actually got back. I just dealt with the symptoms downrange. Moodiness, headaches, sensitivity to the eyes, and I just dealt with those on a daily basis and my co-workers had to deal with it [my lash- outs] on a daily basis.... I guess if you don't lose a limb, or if you're not bleeding out the ears or the eyes, you don't think anything's wrong. (p. 851)

In conjunction with this interview, two more interviews revealed the lack of empathy from healthcare providers and perception of being looked at as malingerers. The first interview on the lack of empathy from healthcare providers shared the following:

> Lack of empathy from providers, my biggest issues with mental health… I've actually had a mental health professional up there tell me to stop being a pussy

> and suck it up. It was his exact words to me, and after that, I kind of just stopped dealing with them. (Hyatt et al., 2014, p. 852)

The second interview on being looked at as a malingerer shared the following:

> I was worried that people are going to start thinking I'm making it up. But luckily, there was objective data from my neuro-psych testing, which proved that I am not making it up. So, once I find that out and they sent that to me, it's been a lot easier to deal with, because I know I'm not making it up. (Hyatt et al., 2014, p. 852)

These interviews and research from these authors was so impetrative for this study in deploying this section as it is pertaining to transitioning OEF/OIF veterans. No matter if these veterans are suffering with medical issues or not, the care they receive should never be questioned as they have the records sharing that they have severed once or even several times in these war zones. This should be an indicator that they deserve the right to be seen and taken seriously when presenting issues, they feel they have obtained due to war. Why make the transition process even more difficult or a fear factor in these veterans life, when it can be made so much simpler for them by just actively listening and making the effort to help them at all measures possible. Research reveals this and obtaining the care they need should never be a factor in their transitional processes.

Theoretical Framework

The theoretical framework of this study is based on one framework and it is the Adult Transition theory. As it was discussed previously, managing and adjusting to PTSD is a profession by itself. In addition to this, being an OEF/OIF war veteran going from war back home and from active duty military into the non-military personnel

division; are basic groundbreaking occasions. Figuring out how to modify by utilizing distinctive methods for dealing with stress that numerous veterans and those outsiders who do not comprehend themselves, can be completely understood, carefully, through this theoretical framework.

Schlossberg's Adult Transition Theory

In 1981, expert Nancy Schlossberg, established a transition model that was compiled of three phases, moving in, moving through, and moving out. Her model was created to help explain the factors of influence that effect an individual's aptitude to handle each phase and how the individual assimilates their transition into their everyday life (M. L. Anderson et al., 2012; Arman, 2016; Diamond, 2012; Schlossberg, 1981). The Adult Transition theory is perceived on the capacity to adjust to change. Numerous adults are unable to adjust or comprehend the complexities that accompany natural change. As it was shared previously, this theory is what numerous veterans are being tested with in the three transitional stages: moving in, moving through, and moving out of going from active duty into the civilian world. The periods of interchange are extremely intense for these veterans and they are not fully prepared to successfully adjust to their new surroundings because of the absence of support. This model will investigate the encounters amid transition and what affected the veteran while traveling through each stage (M. L. Anderson et al., 2012; Arman, 2016; Diamond, 2012; Schlossberg, 1981). Which is why this model is most appropriate in helping describe OEF/OIF PTSD veterans transition from active duty into the civilian sector.

Moving in. The first stage of the transition process, OEF/OIF PTSD veterans began to adapt to their original environments. In this study, this stage is where the

veteran starts to become familiar with the DTAP, VA Medical system, and new nonmilitant environments. Goodman, Schlossberg, and Anderson (1997) share that the first phase is where the individual begins to navigate and "learn the ropes" (p. 167) of the new environment. Schlossberg (1984) goes on to further state that

> [F]or veterans, this not only includes learning the ropes of the transition to civilian but also learning the ropes of using VA benefits and the VA system. This phase can be overwhelming and challenging; and, these stressors may contribute to a crisis of identity in which the individual attempts to combine knowledge of past environments with information from the new environment. (p. 17)

Based on literature, it can be concluded that this stage is the beginning for these veterans as they learn new social cues and interfaces. Learning to cultivate different affairs, study new principles, adapt into their new civilian roles, and understand what they need to do to obtain proper care, help, and gain the appropriate benefits they are entitled to (M. L. Anderson et al., 2012; Arman, 2016). Though it can be a difficult process for OEF/OIF veterans with PTSD as they transition back into the civilian sector, understanding how to cope and get the proper care they need is key in this process.

Moving through. The second phase of this model requires sustaining and balancing the burdens of the transition. In this phase, OEF/OIF PTSD veterans are converting into the transition, but are not entirely transitioned. In fact, this stage of the model can take time and even be very drawn-out, leading the OEF/OIF PTSD veteran to be undoubtedly muddled. M. L. Anderson et al. (2012) stated that "moving through a transition requires letting go of aspects of the self, letting go of former roles, and learning new roles. People moving through transitions inevitably must take stock as they

renegotiate these roles" (p. 45). Letting go of the past is no easy task, especially for medically injured war veterans who must create a whole new life outside of the military. Going from their active duty title to just a regular civilian title with disabilities obtained from war, is traumatic for these vets. The second phase of this model requires "letting go of aspects of self, letting go of former roles, and learning new roles" (Goodman et al., 1997, p. 23). Lopez (2011) goes on to further state that:

> During this phase, the veteran will begin to understand the new role of becoming a civilian and should be able to balance life within the new environment. VA benefits may play a critical role in these first two phases depending on what resources have been used to aid with the transition. (p. 17)

The requirements to successfully complete this phase can be very demanding for these veterans, however, researchers tell us it can be done. It is no surprise that "letting go" of the past can be a struggle for anyone, especially when it became your everyday lifestyle. For these war veterans to understand their new roles, they must take the times and effort to engage with their VA representatives. This will allow them to understand their ins and outs of their new disabilities, how to go about gaining proper care, and get the attention they need for their medical needs. Acceptance and understanding is the primary factor in this phase for these veterans.

Moving out. The final stage is described as the end or passing of a change or transition, and the start of a new moving phase (Arman, 2016; M. L. Anderson et al., 2012; Lopez, 2011). Once a veteran reaches this point in the model, they should be familiar with the new environments that they are in. In addition, the OEF/OIF PTSD veteran should be knowledgeable of the VA system and the benefits entitled to help

assistance their transition back into the civilian sector (Arman, 2016; Lopez, 2011). This moving-out stage for OEF/OIF PTSD veterans signifies the complete achievement of transitioning fully into the civilian lifestyle and obtaining the care they need through the VA system. Lopez (2011) stated that:

> During this phase, the veteran should also have a good idea of how the VA benefits used aided in the transition to civilian. Unfortunately, this phase can be one of the most challenging as it signifies the ending of one chapter, which may indicate that more changes may soon be in store. This offers the potential of going back to the uncertainty of a new transition and the challenges and setbacks that accompany it as the process begins anew. As a result, feelings of grief have been noted during this phase. (p. 17)

Closing out this phase, OEF/OIF PTSD veterans should be transitioned enough that they are able to understand what it is they need to do to take care of themselves and live a healthy life outside the military.

Summary

The review of literature in this chapter demonstrated a wealth of research about OEF/OIF PTSD veterans transitioning from active duty into the civilian sector, and the systematic issues they face. Hawkins (2009) believes that it is often expected that veterans deserve more support than their civilian counterparts. Lopez (2011) argues that "…most contemporary arguments about veterans' benefits take a positive tone" (p. 7) and many believe "that our veterans of Iraq and Afghanistan deserve all the benefits we can give them" (Frydl, 2009, p. xii).

In addition, this chapter also explores OEF/OIF PTSD veterans and the many challenges they endure transitioning through DTAP and the VA system, as well as statistical data on the effects of these transitional programs among these veterans.

Some of the common effects discovered among these transitioning veterans included health problems due to serving in combat zones, problems finding suitable employment, trouble adapting to new environments, and the lasting results of facing disturbing occurrences (M. L. Anderson et al., 2012; B. M. Anderson, 2013; Avery & McDevitt-Murphy, 2014; Burnett & Segoria, 2009; Cifu & Blake, 2011; Kim, 2010; Lewis et al., 2012; Lopez, 2011; Ostovary et al., 2009; Sherman, 2016; Walker et al., n.d; WRIISC, 2014). However, current studies on OEF/OIF PTSD veterans transitioning out of active duty into the civilian sector and their insights of the overall systems in place were limited. Further, there were no studies on the perceptions of OEF/OIF veterans with PTSD, who are transitioning from active duty to civilian life, regarding their participation in the DTAP. Thus, study magnified the intense challenges these OEF/OIF PTSD veterans face transitioning out of the military and the systematic issues that occur using the VA programs.

This analysis proves that a change needs to happen within the VA System, particularly DTAP. The lines of communication are not clear among OEF/OIF PTSD veterans and it is leading these veterans to feel alone and they turn to other means to fill their hurt and pain. Flouncy (2014) closes her argument with:

> are we doing enough to ease this transition for those who have served and

> sacrificed so much on our behalf? While there have certainly been some important initiatives, our honest answer must be no. There is much more we can and should be doing. (p. 1)

Transitioning with a medical disability is already hard, but going from active duty to the civilian sector is even more challenging and the research here proves that.

Furthermore, the research revealed that suicides have steadily increased over the years among veterans, drug addictions have become a means of numbing the pain, and coping with PTSD has made veterans into something they never thought they would be, such as monsters in their own environment (Bateman, 2011; Chandrasekaren, 2014; Costello, 2015; Hicks et al., 2017; Military Medicine, 2014; Seal et al., 2007; SAMHSA, 2013; Tanielian et al., 2008; U.S. Department of VA, 2015b; U.S. Department of VA, 2016b). It is time to bring to light the issues associated with transitioning OEF/OIF PTSD veterans, and how the VA system can help support in making increased breakthroughs by focusing in on DTAP. This in turn, may help distinguish possible areas that are deficient and where expansions are necessary.

Schlossberg's (1981) three-phase model of the Adult Transition theory served as the theoretical framework of the study. This theory helped give depth and understanding of OEF/OIF PTSD veteran's process of transition, going from active duty into the civilian sector, and the challenges they endure personally and professionally.

CHAPTER III: METHODOLOGY

This chapter will present the methodology for this research study, which will be qualitative from a phenomenological perspective. When thinking of research as it pertains to qualitative methods, it is appropriate to use when a researcher is trying to study the lived experiences of individuals (Flipp, 2014; Patton, 2015). This method will describe perceptions of OEF/OIF veterans with PTSD, who are transitioning from active duty to civilian life, regarding their participation in the DTAP. Thus, the collected data related to the reduction of problems among these war veterans transitioning with PTSD, as the leading mechanism to affect this transformation will be assessed. The following parts will be presented in this chapter: purpose statement, research question, research design, population sample, instrumentation, validity and reliability, data collection, data analysis, and limitations. This chapter will then finish with a closing summary.

Purpose Statement

The purpose of this phenomenological study was to describe the perceptions of OEF/OIF veterans with PTSD, who are transitioning from active duty to civilian life, regarding their participation in the DTAP.

Central Research Question

This study is guided by one central research question and three sub-questions: *What are the lived experiences of Operation Enduring and Iraqi Freedom veterans with PTSD, who participate in the Disabled Transition Assistance Program?*

Sub-Questions

1. How did the disabled transition program help or support Operation Enduring and Iraqi Freedom veterans with PTSD transition?

2. How could the disabled transition program be changed to better support Operation Enduring and Iraqi Freedom veterans with PTSD needs related to transition?
3. What challenges and issues do Operation Enduring and Iraqi Freedom veterans with PTSD face that may interfere with their abilities to fully transition into civilian life?

Research Design

The methodology was qualitative research, and the research design was phenomenological. The qualitative phenomenological approach was most appropriate for this study for a few purposes. The first purpose, interviews for this study were intended to "help researchers understand people and what they say and do, as well as help researchers understand the social and cultural context within which people live" (Myers, 2009, p. 5). Qualitative research is used to help understand a phenomenon from the perspective of the study partakers (Arman, 2016; Bloomberg & Volpe, 2008; Nicholson, 2015). Furthermore, McMillan and Schumacher (2010) expressed nine essential key characteristics qualitative research should consist of:

- Natural setting.
- Context sensitivity.
- Direct data collection.
- Rich narrative description.
- Process orientation.
- Inductive data analysis.
- Participant perspectives.

- Emergent design.
- Complexity of understanding an explanation (p. 321).

Each of these characteristics will add to the improvement and execution of this phenomenological study, though some were more major than others for this analysis.

Phenomenology pursues to recognize, understand, and describe singular or collective experiences of people (Arman, 2016; Creswell, 2013; McMillian & Schumacher, 2010; Patton, 2015). Yates and Leggett (2016) brought to light that:

> Phenomenological studies focus on a shared human experience, such as surviving breast cancer, experiencing the death of a child, or winning the lottery. The researcher collects data from participants (usually a small number) who have experienced the phenomenon, and through the process of analysis and interpretation, generates a description of the participants' meaning, structure, and essence of the lived experience. Qualitative data can be collected in the form of in-depth interviews (often multiple interviews with each participant), open-ended survey questions, diaries, journals, art forms, and other media in which the participant describes or depicts his or her experience. (p. 229)

This study inquired the lived experiences of OEF/OIF veterans with PTSD, who participated in the DTAP. The interviews created for this study included particulars of the interviewees lived experiences to the observers in the interviewee's personal disputes. Narratives provided by the OEF/OIF PTSD veterans can help future researchers in gathering further analyses on this understudied topic.

A qualitative approach was appropriate for this study because it pursued to assess the perceptions of OEF/OIF veterans with PTSD, who are transitioning from active duty

to civilian life, regarding their participation in the DTAP. Researchers reveal that "closed instruments such as surveys do not capture the feeling and experiences of participants, which are essential in completing a comprehensive assessment" (Nicholson, 2015; Patton, 2002). Face-to-face in person interviews for this review gave openness and point by point data not bolstered by surveys. Nicholson (2015) further states that:

> Interviews are also ideal for subjects who are illiterate, speak a foreign language, or cannot write due to physical or mental disability. The combination of structured and unstructured questions during interviews provides depth and richness to a research study. (p. 64)

Understanding the perception of individuals through interviews are most ideal based off many researchers. Moreover, Yates and Leggett (2016) shares that "phenomenological studies frequently are used in the context of medicine and the descriptions they provide might inform the development of policies and practices" (p. 229). This study is based on a transitional program, DTAP, to try and help veterans whom separate out of the military with a disability. Focusing in on this further, OEF/OIF PTSD veterans perceptions of the DTAP through interviews, gave substance on the effectiveness of the program, its relevance, and purpose based on their own perspectives/experiences.

Population

This study will depend on the impairment prototypical of PTSD. Defined by McMillan and Schumacher (2010), a population is "a group of individuals or events from which a sample is drawn into which results can be generalized" (p. 129). The population focus will be on OEF/OIF PTSD war veterans in the United States. Many combat veterans are coming back from war and transitioning with PTSD with no programs to

truly help them transition. Author Carol Roberts (2010) shares "when you don't have an opportunity to study a total group, select a sample as representative as possible of the total group in which you are interested" (p. 149). The population of OEF/OIF PTSD veterans has become exceedingly large, in fact, approximately 2.6 million veterans served in the Iraq and Afghanistan wars (U.S. Department of VA, 2015b), while nearly 20%, which is 520,000, who have served in these war zones have been found or met the criteria in having PTSD related symptoms (C. W. Hoge et al.., 2006; C. W. Hoge et al., 2004). This provoked the researcher to select a smaller group of OEF/OIF PTSD veterans to represent the studies populace.

This population of 520,000 veterans was too large to sample every possible respondent in the target population. When it is not feasible to include all members from a large target population, it is necessary to identify an accessible population that is practical for the researcher to interview. It was identified that the research would be concentrated on approximately 681 U.S. Armed Forces veterans associated with local San Diego, California VFW 3788 nonprofit organization.

Target Population

Of the overall population, the targeted populace, was approximately 136 (19.97%) Afghanistan and Iraq veterans who were diagnosed with PTSD due to serving in combat and went through the DTAP while transitioning out of the military for better assistance (Veterans of Foreign Wars Department of California, 2017). Focusing in on this selected population will allow the researcher to narrow down what will help in understanding transitioning OEF/OIF PTSD veterans and their experiences using the systems in place. A target population is known as an assortment of persons whom are compatible with a

definite criteria; where the research can also be furthered simplified to the subject (McMillan & Schumacher, 2010).

Sample

The sample is known as a group of participants in a research study selected from the population from which the researcher indents to generalize. According to McMillan and Schumacher (2010) sampling is selecting a "group of individuals from whom data are collected" (p. 129). Purposeful random sampling was appropriate for this study, as it represents a group of different non-probability sampling techniques. These sampling techniques are known as judgmental, selective or subjective sampling, relying on the judgments of the researcher when it comes to selecting the units. McMillan and Schumacher shared that this sampling, "will provide the best chance that every member of the target population will be represented in the research study to yield unbiased results" (p. 131).

Using this sample strategy was ideal for this research as it allows the researcher to use strong preferences for the random selection samples (Patton, 2015; McMillian & Schumacher, 2010). This type of sampling also helped reduce any possible bias, as it eliminates using just one branch of service among these veterans. Patton (2015) states "random sampling, even of small samples, will subsequently increase the creditability of the results" (p. 286). Well knowledgeable, random, experienced OEF/OIF war veterans, will be selected for this sample from the San Diego, California VFW 3788 organization. This will allow a more current and diverse selection of samples in the research.

Conducting purposeful random sampling, Patton (2015) shares "there are no rules for sample size in qualitative inquiry. Validity, meaningfulness, and insights generated

from qualitative inquiry have more to do with the information richness of the cases selected" (pp. 244-245). Which is why the researcher agreed that selecting 20 OEF/OIF PTSD veterans to interview was sufficient enough for this study, as it helped provide meaningful, valid data, and insights of this inquiry. In fact, Creswell (2013) suggested that five to 25 interviews is sufficient enough for this type of study. The following measures were followed in selecting the 12 OEF/OIF PTSD veterans:

- OEF/OIF veteran.
- Diagnosed with PTSD.
- Discharged from the U.S. Armed Forces (separation, retirement, or medical).
- Went through the DTAP while transitioning out of the military service.
- Receiving mental health care through VA system and associated transitional programs at the time of the study.

Creswell (2013) goes over how this sort of sampling enhances validity towards the identified sample when the potential intentional example is greater than the researcher can deal with. In fact, Creswell (2013) as well as McMillan and Schumacher (2010) share the same views on though this type of random sampling seeks to use small sample sizes, and the main focus and goal is credibility, not the representativeness or the capability to simplify.

Instrumentation

When piloting qualitative research, the researcher is known as the instrument (Patten, 2009; Patton, 2015). The researcher has an abundant background working with the U.S. Armed Forces veteran population. Her knowledge encompasses working for both the U.S. Army and U.S. Navy, both activity duty and as a civilian, providing Human

Resources administration functions, as well as separation processing for all members exiting the military. The researcher also has experience working with one of the local nonprofits VFW 3788 in San Diego, California; where the researcher helps all war veterans and the organization with transitional and health needs. Currently, the researcher is a full-time volunteer for this organization, working as the Webmaster, helping veterans understand the resources available to them and where to obtain the care they need.

Due to the researcher being the instrument in a qualitative study, Pezalla, Pettigrew, and Miller-Day (2012) contended that the unique personalities, characteristics, and interview techniques of the researcher may influence how the data is collected. As a result, the study may contain some biases based on how the researcher influenced the interviewee during the qualitative interview sessions. For this study, the researcher was the primary instrument in the methodology process (Creswell, 2013). This study involved inclusive, phenomenological, semi-structured interviews as the primary method of data collection. Authors Gill, Stewart, Treasure, and Chadwick (2008) stated:

> Semi-structured interviews consist of several key questions that help to define the areas to be explored, but also allows the interviewer or interviewee to diverge in order to pursue an idea or response in more detail. This interview format is used most frequently in healthcare, as it provides participants with some guidance on what to talk about, which many find helpful. (p. 291)

That said, the researcher piloted a similar request of institutionalization, unrestricted queries for each of the affiliates to give consistency of information. In addition to this, participants were forwarded the opportunity to specify supplementary confirmation

during the interview as each question was answered (Nicolson, 2015; Patton, 2015). The interviews were conducted face-to-face in a location that was remote, suitable, and easy for all participants.

Interview Procedure

Conducting interviews helps researchers in investigating the phenomena in which they cannot openly perceive. Patton (2015) explained the purpose and focus of qualitative phenomenological interviewing as a process in which the interview focuses on capturing lived experiences. That "the phenomenological interview involves an informal, interactive process… aimed at evoking a comprehensive account of the person's experience of the phenomenon" (Moustakas, 1994, p. 114). That

> by capturing a personal description of a lived experience, the researcher aims to describe a phenomenon as much as possible to concrete and lived-through terms. In other words, the focus is on the direct description of a particular situation or event as it is lived through without offering casual explanations or interpretive generalizations. (Patton, 2015, p. 433)

In conjunction with the researcher as the instrument, empathic neutrality grounded in mindfulness is required. Being mindful "involves being focused in the moment, being attentive to what's going on, without distracting, and maintaining attentiveness on a moment-to-moment basis" (Patton, 2015, p. 60). This helped enhance the focused interaction with the individuals being interviewed in this study and avoid bias, leading to empathic neutrality. Which also guarantees the interview method is not one-sided.

To ensure the effectiveness of the interviews with this study's participants, an interview procedure was developed using uniform, unrestricted questions that were

aligned with the studies research question. Interview questions were developed and adapted from Nicholson (2015) interview questions presented in his study. In order, 10 questions were presented to the participants to ensure that they were uniform and consist each time (see Appendix B). Combining these approaches allowed for the interviewer to be engaged in the process and make a sympathetic connection with the participants.

Pilot Interview

Before conducting the official interviews, a pilot interview was completed to confirm the effectiveness of the interview method, queries, and help distinguish any study insufficiencies. Selecting an OEF/OIF PTSD veteran for this pilot testing was done randomly and was not a participant in this study. The research protocol was followed and all steps were gone over like it would for the official interview. Once the interview was complete, the researcher, observer, and pilot interview participant evaluated the interview process and questions associated. An interview critique and interview observer feedback questionnaire was given to the participant, U.S. Navy Veteran Samuel Scaifeii III, and observer, U.S. Air Force Veteran Dr. Felicia Haecker, once the interview concluded. Mr. Scaifeii met all aspects of the criteria for this study and agreed to be part of the pilot testing. Dr. Haecker, whom is a Brandman University Ed.D. graduate, has an extensive background in this research field and agreed to be the observer for this pilot testing to provide her professional research views.

The questions for this pilot testing was generalized for the researcher to ensure the effectiveness, quality, and process was appropriate for future participants (see Appendix C & D). This process helped reassure that the official interviews were as effective and suitable for this study. Once the questions were gone over, Mr. Scaifeii and Dr. Haecker

provided feedback on the interview process. Each shared that it was smooth, clear, and overall excellent research questions. The only change they agreed upon was interview question number four. The question read as the following: *How would you describe the care provided to other OEF/OIF PTSD veterans by the DTAP at the VA?* Since it would be hard to tell whom is an OEF/OIF PTSD veteran going through DTAP, they both suggested to just put veteran instead. The interview question was changed to the following: *How would you describe the care provided to other veterans by the DTAP at the VA?* This question will still be effective as only medically injured veterans go through DTAP. All in all, the pilot testing was productive in understanding the effectiveness and accurateness of the interview process.

Background of Researcher

As it was previously discussed, the researcher has an abundant background working with the U.S. Armed Forces veteran population. Her knowledge encompasses working for both the U.S. Army and U.S. Navy, both activity duty and as a civilian, providing Human Resources administration functions, as well as separation processing for all members exiting the military. The researcher also has experience working with one of the local nonprofits VFW 3788 in San Diego, California, where the researcher helps all war veterans and the organization with transitional and health needs. Currently, the researcher is a full-time volunteer for this organization, working as the Webmaster, helping veterans understand the resources available to them and where to obtain the care they need.

The researcher obtained her degree Master's degree in Organizational Leadership with a minor in Human Resources Development. Obtaining her degree was the first step

in trying to understand the many issues within the VA system and processes for medically injured veterans. Wanting to further her studies to help war veterans through their transitional phases, she began to peruse her doctoral degree, volunteered for a local veteran nonprofit, and learned how to take the steps to engage with these veterans and understand their needs. Her experiences in both the academic and military fields, has made her exceedingly skilled to peruse this study.

Validity and Reliability

Validity and reliability was established in this study and are known critical elements in establishing creditability and dependability. Validity is clarified by McMillan and Schumacher (2010), "validity is the degree to which scientific explanations of phenomena match reality" (p. 104). External validity gave generalizability of the gathered results and outcomes from the views of the selected veteran participants. The pilot interview permitted the researcher to recognize queries plus responses that were not associated with the research questions.

To address validity and creditability, the analysis exploited specific strategies proposed by McMillan and Schumacher (2010): "(1) Triangulation in data collection and analysis, (2) Use of voice recordings to accurately document statements made by the participants, and (3) Participants' review of researcher's synthesis of interview data" (p. 330). To further measure the validity of this study, participants were asked to review the transcriptions to validate the accuracy. Empathic neutrality grounded in mindfulness, helped enhance the focused interaction with the individuals being interviewed in this study and avoid bias, leading to empathic neutrality. Which also reassured the interview method was not one-sided.

Reliability is an important element in qualitative research and should be concentrated on during the study development. Creswell (2013) shares how reflexivity in qualitative research "the inquirer reflects about how their role in the study and their personal background, culture, and experiences hold potential for shaping their interpretations, such as the themes they advance and the meaning they ascribe to the data" (p. 186). The intent of the researcher was that the statistics presented in this analysis would be beneficial in aiding the OEF/OIF PTSD veteran population. Credibility requires emphasizes on the criteria in which have priority within the tradition (Patton, 2015). Reflexivity in this area was also applied in this study to help further enhance the creditability and reliability. This was done through recording the researcher's bias in a reflective journal and the dissertation itself. "One way to increase the credibility and legitimacy of qualitative inquiry among those who place priority on traditional scientific research criteria is to emphasize those criteria that have priority within that tradition" (Patton, 2002, p. 544).

Data Collection

The initial step in conducting the research was contacting the San Diego, California VFW 3788 to confirm it was acceptable to do a research study at their organizational posts, in order to collect official data (see Appendix E). To further safeguard the confidentiality of these PTSD war veterans, the researcher solicited the San Diego VFW 3788 representatives to promote the study to the OEF/OIF PTSD veteran population via email and newsletters, followed with the public study flyer (see Appendix F). The email and newsletter announcement to each San Diego VFW 3788 representative, clarified the purpose, the criteria, and contact information to participate in

the study (see Appendix G). It was highlighted that the study was voluntary, all names would not be shared to other veterans at the VFW posts in this study, and there are no consequences if the participants did not want to proceed with the study if they developed felt any sort of uneasiness.

Due to VFW 3788 being a nonprofit organization that helps support veterans in their transitions and conducts morale based events, they do not have access to personnel records nor medical descriptions of the veterans involved in this study. These probed questions if an advocate would be needed for this study. However, it was identified that because the VFW does not have direct access to medical records or history of the veterans with possible war related issues, an advocate would not be needed. Though, if required per the university, there was a Surgeon Service Officer available at the organization that would be the advocate for these participants. The Surgeon Service Officer is the only advocate at the VFW whom can obtain such access from the VA and from the veterans for medical benefit related cases. Overall, this study relied solely on an honor system and word of the veterans that they were in fact OEF/OIF PTSD war veterans, whom transitioned through the DTAP program.

Upon completion of the necessary training to conduct research on human participants (see Appendix H) approval to collect data by Brandman University Instructional Review Board (BUIRB) was obtained (see Appendix I). The researcher then began the process of collection. An informed consent form (see Appendix J), demographic data sheet (see Appendix K), and interview protocol were all tools used for the interview process. The informed consent was explained to all interviewees and the importance, followed by the bill of rights (see Appendix L). The researcher's

demographic data sheet was used to gather data regarding age, gender, ethnicity, date of diagnosed PTSD, discharge date from the military, and reasoning for separation (retirement, medical, expiration term of service/ETS).

An announcement flyer was promoted on the VFW 3788 Facebook page, including the researchers, forwarding the opportunity to participate in this study. If the participants responded to the flyer about conducting an interview it was set up with the time that worked best. The announcement had the exact same information as the flyer emailed out to the VFW 3788 representatives. The VFW 3788 Facebook group encompassed veterans from each branch of the military and OEF/OIF PTSD veterans. In addition, an interview sheet was given to the all interested participants to sign up for a suitable time slot. Finishing this process, follow up emails were sent to the veterans whom were interested in participating in the study. Emails were set to remind the participants of the location, times, and dates for their selected interview.

The researcher began interviewing each of the veteran participants using the interview procedure developed. The interviews were consistent, unrestricted questions that were associated with the research question. All interviews were recorded auditory, per the permission from the veteran participant, aimed to assist the data collection and examination. The interview questions were asked in the same manor and order for each participant. Interviews concluded, once fulfillment of the questions were achieved.

Closing the interviews, participants were given gratitude for their participation, assurance of their confidentiality, and a summary of the recorded interview. Following the interview procedure, collection of data was also conducted through field notes and a personal researcher's journal. The personal journal increased reflexivity of study bias,

while the field notes recorded the interview observations from the perspective of the researcher during the interview process with each participant. Effective and beneficial, the interview procedure, researchers personal journal, field notes, and overall observations gave great substance to the study.

Data Analysis

Once all interviews were completed, the data analysis was conducted for this study. McMillian and Schumacher (2010) stated that "qualitative analysis is a relatively systematic process of coding, categorizing, and interpreting data to provide explanations of a single phenomenon of interest" (p. 367). In this part of the study, it was imperative to the researcher to organize the data to make sure the coding was consistent. Using the general process of inductive data analysis as a guide, presented by McMillian and Schumacher (2010), the researcher made sure no aspects were left untouched in the data analysis process. Once the transcription process was complete, the data was examined and put in the appropriate categories (see Figure 1).

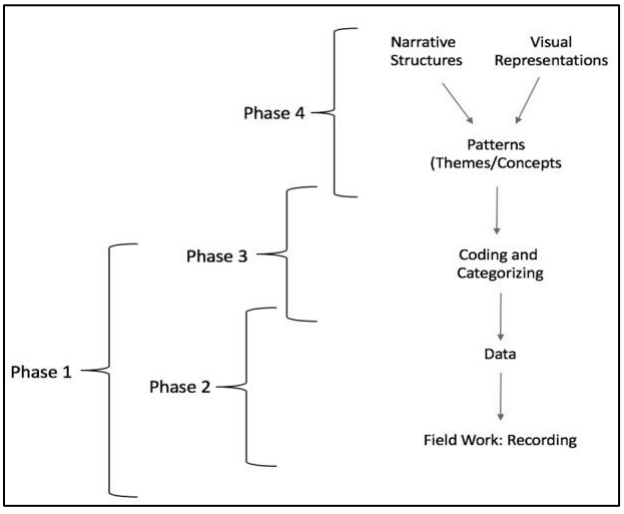

Figure 1. The General Process of Induction Data Analysis that shows a range of ideal analytical styles, such as anticipated procedural to evolving styles. Adapted from "Research in Education: Evidence-Based Inquiry" (7th ed.)" by J. H. McMillan and S. Schumacher, 2010, p. 368. Upper Saddle River, NJ: Pearson.

The researcher used NVivo, a qualitative research software, that helped assist with the coding process and transcriptions of the interviews. An expert in qualitative research methodology was also selected to help code interview testimonials into pinpointed themes, classify repetitions and constant themes, followed by concluding a statistical assessment. According to McMillian and Schumacher (2010) "inductive analysis is the process through which qualitative researcher's synthesis and make meaning from the data, starting with specific data and ending with categories and patterns" (p. 367). Helping in this process, NVivo assumed a critical part in sorting codes into nodes, speaking to the substantive essentialness of the discoveries. The researcher also followed the steps in the qualitative analysis illustrated by McMillian and Schumacher (2010), which helped reassure the data analysis process quality and effectiveness. Figure 2 shows each step in analyzing qualitative data per McMillian and Schumacher.

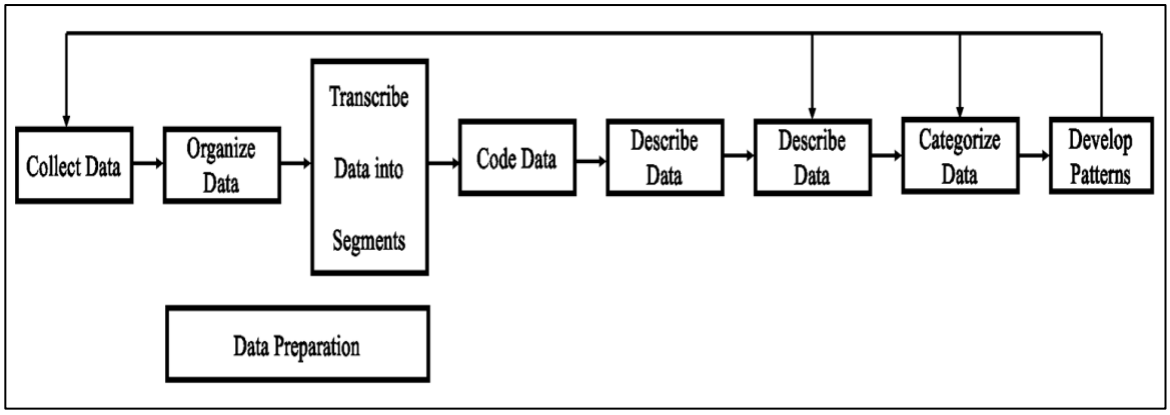

Figure 2. The Steps in Analyzing Qualitative Data shows the iterative, inductive process which researcher's survey, to ensure the qualitative analysis is monitored accordingly. Adapted from "Research in Education: Evidence-Based Inquiry (7th ed.)," by J. H. McMillan and S. Schumacher, 2010, p. 369. Upper Saddle River, NJ: Pearson.

Theoretical Framework Application

Analyzing the data through the Adult Transition model help investigate the encounters amid transition and what affected the veteran while traveling through each stage (M. L. Anderson et al., 2012; Arman, 2016; Diamond, 2012; Schlossberg, 1981). Which is why this model was selected as most appropriate, as it helped describe OEF/OIF PTSD veterans transition from active duty into the civilian sector. Compiled of three phases of transition, moving in, moving through, and moving out will be accessed based on the feedback from the interviews with the OEF/OIF PTSD veterans.

***Moving in*.** The first stage of the transition process is where OEF/OIF PTSD veterans began to adapt to their original environments. In this study analysis, the researcher will be looking for examples of where the veteran starts to become familiar with the DTAP, VA Medical system, and new nonmilitant environments. Based on the data received, the research will be able to compare the adaption to their new environments process versus their original military environments.

***Moving through*.** The second phase of this model is where a veteran will be sustaining and balancing the burdens of their transition. It should be clear where OEF/OIF PTSD veterans are converting into their transition, but are still not fully transitioned, based on the interview feedback. In fact, in this stage of the model, it can be identified that it can take some time and even be very drawn-out, leading the OEF/OIF PTSD veterans to be undeniably scrambled.

Moving out. The final stage will be identified as the end or passing of a change or transition, and the start of a new moving phase (Arman, 2016; M. L. Anderson et al., 2012; Lopez, 2011). Once a veteran reaches this point in the model, the researcher will

be able to compare how familiar veterans are with their new environments versus their old environments. In addition, the researcher should be able to collect data from the interviews on how the OEF/OIF PTSD veteran's knowledge of the VA system and the benefits entitled to help assistance their transition back into the civilian sector (Arman, 2016; Lopez, 2011). Overall, the researcher will be able to make final conclusions through this final stage, on whether or not the OEF/OIF PTSD veterans have been transitioning fully into the civilian lifestyle, and obtaining the care they need through the VA system effectively. Figure 3 shows the M. L. Andersons et al. (2012) Adult Transition model and the phases of transition these veterans were measured through based on the collected data and analysis.

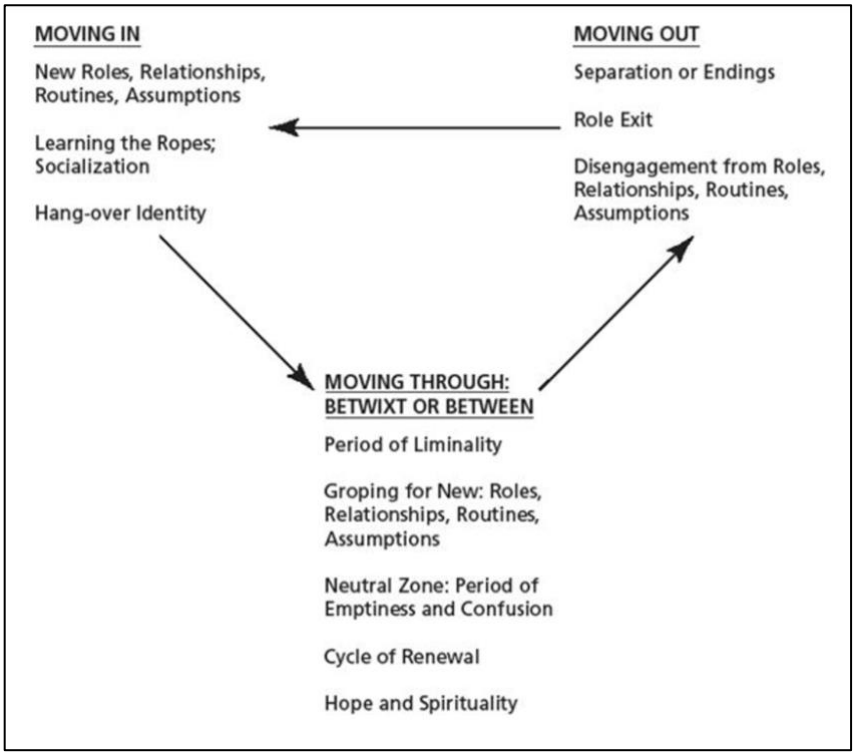

Figure 3. Integrative Model of the Transition Process. Cyclical Adult Transition Model demonstrating the three phases of transitions adults go through. Adapted from "Counseling Adults in Transition: Linking Schlossberg's Theory with Practice in a Diverse World (4th ed.)," by M. L. Anderson, J. Goodman, and N. K. Schlossberg, 2012, p. 56. Copyright by Springer Publishing Company.

Limitations

Roberts (2010) explains limitations as "features in your study that you know may negatively affect the results or your ability to generalize" (p. 162). Limitations are known to the researcher as areas in which one has no control over nor can avoid altogether. Roberts also makes it clear that all limitations in a study must be directly and truthfully stated for the readers to decide for themselves, on possible limitations. The major limitations of this study are stressed below and they were the following:

- The size of the sample used was a limitation of the study. It only focused on OEF/OIF PTSD veterans whom are part of the San Diego VFW 3788. Which can present issues when attempting to hypothesis simplifications concerning this population.
- Researcher bias is a possible limitation for this study due to the researcher's background. Inadvertently, the researcher could affect the study results by taking it in the direction desired, influenced by personal feelings and experiences.
- Relying on responses from participants is a possible limitation of this study. During the interviews, the researcher asked each question hoping that the veterans responded 100% truthfully and honorably. This can present limitation issues as the level truthfulness and honesty during the interview could not be dignified.
- Participants having PTSD in this study, is also a possible limitation. This disorder could affect their interview responses, triggering emotional or

psychological issues with the probing interview questions; reflecting on their life-changing experiences.

The researcher procured certain safeguards to eliminate or decrease the possible outcomes surfaced from the limitations of the study. Reducing researcher bias was done by having uniform, unrestricted questions that were aligned with the studies research questions, to guarantee that nothing was out of line or would trigger anything towards participants. Constraints for the analysis were also unveiled to enable readers to make individual resolve about the discoveries of the research. Furthermore, reassuring to the participants that all information was confidential and they could at any time withdraw from the interview, was also an essential part of the safeguards in the study.

Summary

The purpose of Chapter III was to investigate lived experiences of San Diego, California VFW 3788 OEF/OIF PTSD veterans, regarding their participation in the DTAP. Qualitative, phenomenological research was revealed as a method appropriate for this study. The research questions were aligned with the purpose statement. Purposeful random sampling was used to select 12 OEF/OIF PTSD veterans based on the four identified measures:

- Diagnosed with PTSD.
- Discharged from the U.S. Armed Forces (separation, retirement, or medical).
- Went through the DTAP while transitioning out of the military service, receiving mental health care through VA system.
- Associated transitional programs at the time of the study.

The background of the researcher was articulated to provide depth on her experiences working both with the Army and Navy, both activity duty and as a civilian, providing Human Resources administration functions, as well as separation processing for all members exiting the military; as well as working with one of the local nonprofits VFW 3788, in San Diego, California. The data collection measures and analysis were clarified. Lastly, the restrictions and limitations were acknowledged and examined. Following, Chapters IV and V will expose the data discoveries, explanations of the discoveries, suggestions of the discoveries, and final conclusions and future research recommendations.

CHAPTER IV: RESEARCH, DATA COLLECTION, AND FINDINGS

Chapter IV will expose the major findings of the study. It will first begin with a review of the purpose statement, research questions, and a summary of the research design, population, sample, and interviewee demographics. From here, the presentation of findings for the central research question and three sub-questions will be addressed thoroughly. Closing with a chapter summary of the findings.

Purpose Statement

The purpose of this phenomenological study was to describe the perceptions of OEF/OIF veterans with PTSD, who are transitioning from active duty to civilian life, regarding their participation in the DTAP.

Central Research Question

This study is guided by one central research question and three sub-questions: *What are the lived experiences of Operation Enduring and Iraqi Freedom veterans with PTSD, who participate in the Disabled Transition Assistance Program?*

Sub-Questions

1. How did the disabled transition program help or support Operation Enduring and Iraqi Freedom veterans with PTSD transition?
2. How could the disabled transition program be changed to better support Operation Enduring and Iraqi Freedom veterans with PTSD needs related to transition?
3. What challenges and issues do Operation Enduring and Iraqi Freedom veterans with PTSD face that may interfere with their abilities to fully transition into civilian life?

Research Methods and Data Collection Processes

Phenomenology pursues to recognize, understand, and describe singular or collective experiences of people (Arman, 2016; Creswell, 2013; McMillian & Schumacher, 2010; Patton, 2015). This study inquired the lived experiences of OEF/OIF veterans with PTSD, who participated in the DTAP. The interviews created for this study included particulars of the interviewees lived experiences to the observers in the interviewee's personal disputes. Narratives provided by the OEF/OIF PTSD veterans can help future researchers in gathering further analyses on this understudied topic. A qualitative approach was appropriate for this study because it pursued to assess the perceptions of OEF/OIF veterans with PTSD, who are transitioning from active duty to civilian life, regarding their participation in the DTAP.

Researchers reveal that "closed instruments such as surveys do not capture the feeling and experiences of participants, which are essential in completing a comprehensive assessment" (Nicholson, 2015). Face-to-face in person and video interviews for this review gave openness and point by point data not bolstered by surveys. Understanding the perception of individuals through interviews are most ideal based off many researchers. This study is based on a transitional program, DTAP, to try and help veterans whom separate out of the military with a disability. Focusing in on this further, OEF/OIF PTSD veteran's perceptions of the DTAP through interviews, gave substance on the effectiveness of the program, its relevance, and purpose based on their own perspectives/experiences.

Interview Procedure

Before conducting the official interviews, a pilot interview was completed to confirm the effectiveness of the interview method, queries, and help distinguish any study insufficiencies. Selecting an OEF/OIF PTSD veteran for this pilot testing was done randomly and was not a participant in this study. The research protocol was followed and all steps were gone over like it would for the official interview. Once the interview was complete, the researcher, observer, and pilot interview participant evaluated the interview process and questions associated. An interview critique and interview observer feedback questionnaire was given to the participant, U.S. Navy Veteran Samuel Scaifeii III, and observer, U.S. Air Force Veteran Dr. Felicia Haecker, once the interview concluded. Mr. Scaifeii met all aspects of the criteria for this study and agreed to be part of the pilot testing. Dr. Haecker, whom is a Brandman University Ed.D. graduate, has an extensive background in this research field and agreed to be the observer for this pilot testing to provide her professional research views. The questions for this pilot testing was generalized for the researcher to ensure the effectiveness, quality, and process was appropriate for future participants. This process helped reassure that the official interviews were as effective and suitable for this study.

To ensure the effectiveness of the interviews with this study's participants, an interview procedure was developed using uniform, unrestricted questions that were aligned with the studies research questions. Interview questions were developed and adapted from Nicholson (2015) interview questions presented in his study. Ten questions were presented to the participants to ensure that they were uniform and consist each time. Combining these approaches allowed for the interviewer to be engaged in the process and

make a sympathetic connection with the participants. Following the interview procedure, collection of data was also conducted through field notes and a personal researcher's journal. The personal journal increased reflexivity of study bias, while the field notes recorded the interview observations from the perspective of the researcher during the interview process with each participant. Effective and beneficial, the interview procedure, researchers personal journal, field notes, and overall observations gave great substance to the study.

Population

The population focus was on OEF/OIF PTSD war veterans in San Diego, CA 2017. Defined by McMillan and Schumacher (2010), a population is "a group of individuals or events from which a sample is drawn into which results can be generalized" (p. 129). Many combat veterans are coming back from war and transitioning with PTSD with no programs to truly help them transition. Author Carol Roberts (2010) shares "when you don't have an opportunity to study a total group, select a sample as representative as possible of the total group in which you are interested" (p. 149). The population of OEF/OIF PTSD veterans has become exceedingly large, in fact, approximately 2.6 million veterans served in the Iraq and Afghanistan wars (U.S. Department of VA, 2015b), while nearly 20%, which is 520,000, who have served in these war zones have been found or met the criteria in having PTSD related symptoms (C. W. Hoge, Auchterlonie et al., 2006; C. W. Hoge, Castro et al., 2004). This provoked the researcher to select a smaller group of OEF/OIF PTSD veterans to represent the studies populace.

This population of 520,000 veterans was too large to sample every possible respondent in the target population. When it is not feasible to include all members from a large target population, it is necessary to identify an accessible population that is practical for the researcher to interview. It was identified that the research would be concentrated on approximately 681 U.S. Armed Forces veterans associated with local San Diego, California VFW 3788 nonprofit organization. Of this overall population, the targeted populace, was approximately 136 (19.97%) Afghanistan and Iraq veterans who were diagnosed with PTSD due to serving in combat and went through the DTAP while transitioning out of the military for better assistance (Veterans of Foreign Wars Department of California, 2017). Focusing in on this selected population allowed the researcher to narrow down what will help in understanding transitioning OEF/OIF PTSD veterans and their experiences using the systems in place.

Sample

Using the purposeful random sampling strategy was ideal for this research as it allowed the researcher to use strong preferences for the random selection samples (McMillian & Schumacher, 2010; Patton, 2015). This type of sampling also helped reduce any possible bias, as it eliminates using just one branch of service among these veterans. Patton (2015) states "random sampling, even of small samples, will subsequently increase the creditability of the results" (p. 286). Well knowledgeable, random, experienced OEF/OIF war veterans, will be selected for this sample from the San Diego, California VFW 3788 organization. This will allow a more current and diverse selection of samples in the research.

The researcher agreed that selecting 12 OEF/OIF PTSD veterans to interview was enough for this study, as it helped provide meaningful, valid data, and insights of this inquiry. In fact, Creswell (2013) suggests that five to 25 interviews are sufficient enough for this type of study. The following measures were followed in selecting the 12 OEF/OIF PTSD veterans:

- Diagnosed with PTSD.
- Discharged from the U.S. Armed Forces (separation, retirement, or medical).
- Went through the DTAP while transitioning out of the military service.
- Receiving mental health care through VA system and associated transitional programs at the time of the study.

Demographic Data

The researcher's demographic data sheet was used to gather data regarding the following: (a) age, (b) gender, (c) ethnicity, (d) date of diagnosed PTSD, (e) discharge date from the military, (f) reasoning for separation (retirement, medical, expiration term of service/ETS), and (g) current employment status. The study consisted of 12 veterans all diagnosed with PTSD. All participants were discharged out of the military and went through DTAP between the years 2003-2015. Nine of the participants were male and three were female. Looking at the age range, three fell into the 18 to 30 years old range, seven were in the 31 to 40 years old range, one was in the 41 to 50 years old range, and one was in the 50+ years old range. Further, eight were of African American decent, three were Caucasian, and 1 identified as other. Five participants were in the Army, four were in the Navy, one was in the Air Force, and two were in the Marines. The summary of the participant's demographics is specified in Table 6.

Table 6

Participant Demographics

	n	Percent
Gender		
Male	9	75.0
Female	3	25.0
Age Range		
18 to 30	3	25.0
31 to 40	7	58.3
41 to 50	1	8.3
50+	1	8.3
Ethnicity		
African America	8	66.7
Caucasian	3	25.0
Other	1	8.3
Military Branch		
Army	5	41.7
Navy	4	33.3
Air Force	1	8.3
Marines	2	16.7

Note. n = 12.

Presentation of Data

The collection of data began October 2017 and consisted of 12 interviews of OEF/OIF veterans with PTSD, whom served in the Army, Marines, Navy, and Air Force. The one-on-one interviews allowed these veterans to share more personal experiences, while transitioning out of the military through DTAP. Rather than doing group interviews, it was ideal to conduct face-to-face interviews to collect more rich and authentic data from these participants. This also allowed the veterans to feel more comfortable in sharing their experiences with researcher. To ensure the effectiveness of the interviews with participants, an interview procedure was developed using uniform, unrestricted questions that were aligned with the studies research questions.

In sequence, 10 interview questions were presented to the participants to ensure that they were uniform and consist each time. With the permission of each participant,

the interviews were recorded and transcribed. The transcripts were then evaluated once completed for accuracy and related information was added from the field notes that were conducted during the interviews. Analyzing the data, codes were generated based on the related literature and initial review of data. When the data was coded, the researcher and the data analyst, then reviewed all the codes and searched for collective themes and patterns that were identified among various study participants. The themes were then translated into major findings of the study, which were exhibited by considering the central research question and sub-questions in the accompanying segments.

The Lived Experiences of OEF/OIF PTSD Veterans Participation in DTAP

The central research question directing this study was: *What are the lived experiences of Operation Enduring and Iraqi Freedom veterans with PTSD, who participate in the Disabled Transition Assistance Program?* Interview questions 1-6, addressed this research question. These interview questions targeted this research question by providing the reasons given for their separation from the military, experiences with the transitional process through the VA, experiences with the information and process through DTAP, description of care provided to others through DTAP, description of information about DTAP provided by TAP, and types of issues faced during the transition process.

Reasons for separation from the military. Of the veterans interviewed, all reported very similar reasons as to why they were separated from the military. Five themes were developed based on the respondent's answers and their multiple reasoning's for separating from the military. The most shared reason was due to mental health/PTSD, trailed by retirement, substance abuse, family/personal reasons, and physical injury.

Mental health/PTSD. Looking closely at dominate major theme found, nine of the veteran participants (Veteran 1, 2, 4, 5, 6, 8, 10, 11, and 12) shared that mental health/PTSD was their reasoning for separation. All respondents shared a sense of frustration while being separated of the military due to having mental health issue or PTSD. Their body language shared many things: stress, anxiety, flash back, and tense body movements. All indicating their relived experiences were emotional events in their life time.

Veteran 5 shared an extensive reflection on his change in career and diagnoses of PTSD while active duty, before being medically separated by stating the following:

> The events leading to my transition from active duty to the civilian sector was due to me being out of country and deployed for a great portion of my 10-year Naval career. I was a flight deck plane captain and trouble shooter for the first six years of service working the majority of my time on the flight deck. Due to the constant adrenaline and stress of being exposed to that type of environment for so long I was diagnosed with PTSD and anxiety. This diagnosis occurred while still on active duty and my last deployment even though I was no longer on the flight deck my anxiety seemed to peak which caused me to look at other than active duty options.

Retirement. Two veteran participants, Veteran 7 and 9, shared that they were retiring out of the military, but they knew that they were possibility suffering with PTSD related issues, and never reported them until after they separated into the VA system. They each received the diagnoses and are being compensated through the VA currently.

Substance abuse. Two veteran participants, Veteran 1 and 2, in conjunction with their mental health/PTSD reason for separating, also shared that they suffered with substance abuse issues which was the main reason for them separating, as well as their mental health/PTSD related issues.

Family/personal reasons. Another theme that immerged was family/personal reasons for separation. Veteran 3 shared how she thought it would be better for her family to separate out, as the military takes a lot of time and sacrifice away from them. Though she was diagnosed with PTSD through the VA after her separation, she shared how she does not regret voluntarily separating out of the military. Veteran 12 shared that she was put out due to PTSD related issues and due to sexual harassment issues throughout her Army career. Veteran 12 felt as though it was just her time to separate out.

Personal injury. Finally, the last theme was personal injury. Only one respondent reported this theme which was Veteran 4. He shared how he was separated out due to PTSD and a physical injury which is the reason why he elected to use both as the reason why he separated out. This Veteran 4 shared the following:

> I was injured during training in the Marines. It was a sad event because as soon as I was injured they wanted to separate me. I tried to fight it but they were not feeling it. I felt like I was used and abused.

Table 7 presents the sample findings for the five major themes found.

Table 7

Reasons Given for Separation from the Military

Major Themes	Number of Respondents	Percent of Respondents
Mental Health/PTSD	9	75.0
Retirement	2	16.7
Substance Abuse	2	16.7
Family/Personal Reasons	2	16.7
Physical Injury	1	8.3

Note. Respondents could give more than one answer; Number of Respondents controlled the sort in descending order.
[a]n = 12.

Experiences with the Transitional Process Through the VA

The veteran respondents could all give more than one answer to this interview question in defining the transitional process through the VA. Eight out of 12 (66.7%) respondents shared how their process was generally negative, sharing how it was simply not enough information and how it was a confusing/overwhelming process. Four of the 12 (33.3%) veteran participants shared how it was generally a positive process saying it was quick and simple. Seven common themes emerged from two or more of the participants: (a) generally positive, (b) quick process, (c) simple and smooth, (d) generally negative, (e) not enough information provided, (f) confusing/overwhelming, and (g) general difficulties.

Generally positive. Looking at the generally positive themes, four veteran respondents 1, 2, 3, and 12 shared how the process was easy, simple, and quick. These themes all emerged from their responses stating it was generally a positive process, but did agree it was a bit fast or done quickly, which messed their compensation up. In fact, Veteran 12 shared that: "*In one word - easy. When out processing, the Army almost*

forces you to make an appointment with the VA to review your medical records. But it was too fast."

Veteran 2 stated: "*I would say it went by smooth and it was very quick to be rated for my disability, but it was not done or rated correctly*."

It was evident by the respondents, that their process was unlike the other eight veterans and had a total different experience.

Quick process. Three of the 12 veteran participants reported that they believed that the process needs an overhaul. Veteran 7 explained how the process was all a blur and so fast explaining that: "*It was a blur. A fast pace timeline for the establishment to meet their requirement. Almost like herding old/useless cattle out to pasture.*"

Veteran 9 then explained differently how: "My transition through the VA was slow, customer service was not helpful at all. The VA process was crazy and needs to be changes. I felt so lost."

Simple and smooth. Two of the 12 veteran participants reported the process as being simple and smooth. For example, Veteran 1 explained how the process was easy and had no issues expressing that: "*The VA process was a step by step process and I did not have any issues.*" While Veteran 12 shared: "*In one word - easy. When out processing, the Army almost forces you to make an appointment with the VA to review your medical records. But it was too fast.*"

Generally negative. Generally negative was reported by more than half of the veteran respondents. Veterans 4, 5, 6, 7, 8, 9, 10, and 11 all shared similar general negative responses on the transitional process though the VA.

These respondents shared how the process was rushed, the information given was very basic, and altogether confusing. In fact, Veteran 6 shared:

> I did not even know the TAPS or DTAP was a VA program. I thought it was an active duty program. My experience, was a group experience it was not individual. I could not get into much detail on my particular medical situation due to sensitivity of the information.

Not enough information provided. Four of the 12 veteran participants shared that not enough information was provided to them in this process, especially in the medical areas that they needed most. In fact, Veteran 5 shared that:

> The VA process was not very informative. The only information that was given was during the five-day transition class knows as TAP. This was less than a half of day. The VA website does have a lot of information on it and it was hard to navigate. I was able to network with a lot of people who have got out before me and get a better understanding of the process.

Confusing/overwhelming experience. Three of the 12 veteran participants shared that the information was confusing and they were overwhelmed by the amount of information that was given all at once. Veteran 4 shared:

> Going through the VA it is not at all clear on where to go or who to contact. When you are put out of the service they just say okay here is all this VA packets figure it out. The briefings are so loaded of information you do not know which applies to you. It is just overwhelming and unclear.

General difficulties. Three of the 12 veteran participants shared how they suffered with general difficulties such as their PTSD, anxiety, other associated mental health issues, and the feeling of being hopeless and lost. Veteran 8 shared that:

> It was challenging dealing with anxiety that comes with post-traumatic stress. I was always on edge and felt like I could never relax. It was hard to focus and the last thing I cared about was trying to find other employment or transitioning. I also had some difficulties with the VA. Once you go through all the military evaluations for mental health you have to do the same exact thing with the VA. This added additional anxiety to the whole process.

Veteran 10 shared: "*Going from active duty transitioning into civilian was all confusing and I felt so alone. I felt like everything went to fast, way too fast on top of dealing with PTSD and anxiety*."

Table 8 displays the statistical analysis and major themes associated with the veteran experiences with the transitional process through the VA.

Table 8

Experiences with the Transitional Process through the VA

Major Themes	Number of Respondents	Percent of Respondents
Generally Positive	4	33.3
Quick Process	3	25.0
Simple and Smooth	2	16.7
Generally Negative	8	66.7
Not Enough Information Provided	4	33.3
Confusing/Overwhelming	3	25.0
General Difficulties	3	25.0

Note. Respondents could give more than one answer; Number of Respondents controlled the sort in descending order.
[a]n = 12.

Experiences with the Information and Process through DTAP

Ten of the 12 respondents indicated that DTAP failed to provide a lot of information about the program overall and its purpose. Many explained how they were confused and did not understand purpose of DTAP, as it seemed to be the same as TAP.

Due to this study finding the lived experiences of these PTSD veterans going through DTAP and their own perceptions of the program, this question was ideal in understanding how these veterans would explain the information and process established through the DTAP. From here four common themes emerged and they were: (a) lacked information about the DTAP program, (b) information too basic to be useful, (c) no difference between VA TAP and DTAP, and (d) too much information at once/ overwhelming.

Lacked information. Lacked information about the DTAP program was reported by 10 of the 12 (83.3%) participants. Many gave detailed information on their experiences and could give me more than one explanation on their personal views on the processes in place through DTAP. For example, Veteran 4 shared:

> Going through DTAP I was not even sure what it was as while in TAPs they just said here is another part of our program for those with medical injuries. I was not understanding what the point was as they just focused on the Voc Rehab portion of the VA. I was under the assumption it would be more focused on the health aspects. Until this day, I do not understand the point of DTAP when TAP's covers the same information.

Many of these veterans shared their frustrations during the DTAP program and the information given to them through TAP. Some explained themselves through anger,

frustration, and fear that they would never get the appropriate treatments they are entitled to. It was clear that Veteran 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, and 12 were on the same page and were not even interviewed at the same time, locations, or together. Recording and noting these responses it was found that these veterans felt it was all unclear and progressed their PTSD symptoms even further.

Information was too basic. Eight of the 12 respondents shared how the information was way too basic through DTAP for it to even be useful. Respondents shared how they had to ask other veteran counterparts who have been through the program, to get proper answers and adequate help. Many respondents gave more than one answer and fell into the same themes. Veterans 4, 5, 6, 8, 9, 10, 11, and 12 were all in the theme previously stated, as well as in this theme. Veteran 9 shared that:

> Being informed about DTAP through TAP was a little confusing. There are too many names and acronyms for the transitional program that you do not know what the difference is. They just say if you have a disability or feel you have one to attend the DTAP. Once attending, it was just the same information TAP gave me on the vocational rehab and employment help. Seems kind of useless if you ask me. I thought I was going to get information on how to file a claim on PTSD and so forth.

No difference between VA and DTAP. Looking further into the themes, half of the respondents shared how they see no difference between the VA, TAP, and DTAP. They are simply all the same. Veterans 2, 4, 5, 6, 9, and 10 shared how they did not even know DTAP was not TAP, or that they felt it made no sense to have it separate when it was all the same information. As illustrated by Veteran 10:

DTAP made no sense to me. I do not get the point of it. It provided all the same information as TAP. I thought it would be more focused on my medical transition and how to go about getting the help needed but it was not. It focused again on employment and education benefits.

Too much information/overwhelming. The last theme presented was too much information being shared at once causing many to be overwhelmed about everything in the program. Four of the 12 veteran participants shared that it was a lot given to them all at once, causing countless emotions to arise. Veterans 7, 9, 11, and 12 gave very high emotional responses and did not want their emotional happenings to be recorded. It was like a bad nightmare that came back to haunt them and they hated to relive it. Veteran 11 shared: "*For me personally it was not good experience at all. Everything was unclear and rushed. I really do not even want to relive that experience it brings back a horrible past*."

In this interview, it was clear the veteran was hurt and suffering from having trust in the system in place. This war veteran suffered a lot in his time in the military and he showed that through his answers in the interview, much could not be revealed per his discretion. This vet had high hopes in the system until he went through it. Suffering with PTSD and having to get out of the Army was an event for him altogether. He was enraged and hurt by the way he was treated. His entire demeanor was aggressive and physically broken.

These veterans all expressed themselves voluntarily and gave substance to their answers by sharing their personal experiences. It was recorded in researcher's personal

journal how each responded to this interview question. Anger, anxiety, depression, frustration, and hopelessness were all common reflections noted (see Table 9).

Table 9

Experiences with the Information and Process through DTAP

Major Themes	Number of Respondents	Percent of Respondents
Lacked Information about the DTAP Program	10	83.3
Information too Basic to be Useful	8	66.7
No Difference between VA TAP and DTAP	6	50.0
Too Much Information at Once; Overwhelming	4	33.3

Note. Respondents could give more than one answer; Number of Respondents controlled the sort in descending order.
[a]n = 12.

Care Provided to Others Through DTAP

The responses from the veteran participants on the care provided to other veterans through the DTAP program seemed to all be geared towards insufficient or lack of effective care. Some shared that they are just trying to numb the pain with medication, some shared that there is simply not enough staffing at the VA medical facilities, and others said it was altogether it is just a lack of treatment all around. All participants could give more than one answer to this question and it showed in the themes that emerged. That said, the four common themes that emerged were shared by all 12 veteran participants: (a) insufficient or lack of effective care, (b) mixed experiences (good and bad), (c) too focused on pharmaceuticals, and (d) good/sufficient care.

Insufficient or lack of care. Insufficient or lack of effective care/support was reported by 75% of the veteran respondents. The majority of these respondents shared the same responses or ideas on the care provided through DTAP. Some shared how

drugs are pushed on them, while others shared the lack of trained staff and attention to detail on their medical needs was minimal to none. For example, Veteran 5 shared:

> I would say that the initial fix seems to be medication and it is hard to manage. There have been accounts where medications are not filled on time resulting in increased anxiety. Not enough staffing and/or time to effectively treat all personnel appropriately upon separation.

While Veteran 7 shared similarly:

> Spiritless and drained, under-trained staff not qualified to handle traumatic stress. Issuing pharmaceutical drugs by the handful as the only answer to all problems. I felt they were overwhelmed daily by the sheer number of veterans I see during my visits. They were treading water/drowning in quick sand seeing a fast fix to relieve the bottle neck of precious souls they had to see.

Veterans 4, 5, 6, 7, 8, 9, 10, 11, and 12 were not too pleased with the medical treatments they received through DTAP or VA altogether. These responses are just examples of the few that made it quite clear about the medical treatment and their views on the care/support they received or others receive.

Mixed experiences. The second theme: mixed experiences- some good and some bad, Veteran 2, 8, and 12 shared how they have also had both good and bad experiences. They shared how either they received both good and bad treatments or heard about other veteran's experiences that affected them. Veteran 2 shared that: "*It is hit and miss. Some I see are taking great care and depending on the worker's mood they get crappy service. I have also heard any stories that I was upset to hear about other veterans*."

Veterans 8 and 12 also shared the care was insufficient and lacked support based off the first theme. Veteran 8 shared "No *real care was provided to other veterans*", while Veterans 12 shared how "*I have heard bad stories and a lot complain that the system is horrible and did not help them*." These veterans made it very clear that they had mixed feelings about the medical system and care in place through DTAP.

Focus on pharmaceuticals. The third theme, too focused on pharmaceuticals, was expressed by Veterans 5, 7, and 10. They each felt that rather than fixing the issues at hand, the medical providers would just push drugs on them and other fellow comrades. This in their eyes was a bad concept as it brings on other issues, rather than fixing the problem. Veteran 10 shared:

> It is the same treatment I got, confusing!! Everyone I speak to say the same thing. I know so many veterans who are close friends and family and they all have nothing nice to say. Everything is rushed, the medical providers question your disability consistently, and they always want to give your prescription medicine.

These veterans felt as though the medical providers through DTAP/VA are just trying to drown veteran's injuries in medicine, making their injuries worse, and making them avoid care altogether.

Good/sufficient care. The fourth theme, good sufficient care, was reported by Veterans 1 and 3. These veterans shared how the care provide was clear and consistent. Veteran 1 shared how "*the care provided to us OEF/OIF PTSD veterans is separate and more focused on our needs with certified professionals that understand and know how to deal with our issues*." While Veteran 3 shared "*I got the care I needed from the VA, and*

I never had a problem." Though only two veteran respondents shared their experiences were good, it was clear that not all veterans have bad experiences, but in this study 9 of the 12 veteran participants expressed their negative experiences (see Table 10).

Table 10

Description of Care Provided to Others through DTAP

Major Themes	Number of Respondents	Percentage of Respondents
Insufficient or Lack of Effective Care/Support	9	75.0
Mixed Experiences; Some Good and Some Bad	3	25.0
Too Focused on Pharmaceuticals	3	25.0
Good/ Sufficient Care	2	16.7

Note. Respondents could give more than one answer; Number of Respondents controlled the sort in descending order.
[a]n = 12.

Shared Information about DTAP provided by TAP

This question was combined with question 6, because the themes that immerged were parallel. Question 6 asked "*How would you describe the information shared with other OEF/OIF PTSD veterans by the DTAP?"*

Almost all veterans shared that the information given to them was insufficient or that no information was provided to them about DTAP through TAP. It is important to note that all of themes that emerged were negative as it pertained to information shared by TAP about DTAP. Five themes emerged from this question and they were: (a) insufficient to no information provided, (b) too broad/needed information for injured veterans, (c) too basic/general to be useful, (d) unable to differentiate TAP/DTAP, (e) too much information provided too fast.

Insufficient/no information provided. Eleven of 12 participants (91.7%) shared that the information was either slim-to-none or insufficient. Many shared that the information is lacking about the purpose of DTAP and its unclear what exactly the point is of the program is. Some even felt it was pointless and TAP could give the same information to help injured veterans. Veteran 4 shared: "*The information was basic. Not very informative and lacked attention to those with medical disabilities. There needs to be more pinpointed information or a different separation process for injured veterans getting out.*" While Veteran 9 shared:

> The information was very dry and basic. They give you a lot of paper work and flyers on where to go but it is so generalized that it is confusing. I am not sure what to say but the process sucks and they need to have more people who actually care do these programs.

Veterans 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, and 12 had consistent and common responses to this question. It was evident that confusion, lack of attention, and frustration were all emotions these veterans expressed in their responses. There was only one veteran, Veteran 1, who shared that:

> The information was spot on. I believe that if you follow the instructions given and ask questions to issues you don't understand anyone would be successful in this transition. Not everything pertains to every Soldier so you have to be able to distinguish what is relevant to you.

Though the majority of the veteran respondents shared otherwise, this veterans experience seemed to be exactly what he felt it was supposed to be, and it was successful in his eyes.

Too broad, basic, similar, and extensive. Themes 2, 3, 4, and 5 were identified by all of the veteran participants except Veteran 1. The responses: (a) too broad - needed information for injured veterans, (b) too basic/general to be useful, and (c) unable to differentiate, and (d) too much information/too fast TAP/DTAP were the themes identified. Some veterans expressed their concerns in multiple responses and shared their personal events. One that was most detailed and personal was shared from Veteran 2 (Note: Due to the high emotional state of the participant, explicit language was used to express some thoughts and reactions to questions. Those explicit swear words have been omitted and replaced by "cussword" indicating that a swear word was used):

> I never had anyone to reach out to me about the program. So, what is DTAP is my response?! It was like 'hey we know you're injured so you go through TAP they will help you.' When people see my discharged it's embarrassing to get the look that I get. I feel that there is more information out there for me. But being black and the city I came from I honestly feel like another "nigger" to them and it hurts my feelings. So, I go into silent depression. I'm diagnosed with mood disorder/PTSD. However, I don't feel 100 percent compensated for it because I got in trouble one time and I get kick out the *"cussword"* service.

Followed by Veteran 5 who shared:

> There was not a lot of information shared- if any. Though I did not know I was eligible to attend, I went anyways because I knew I had a disability. It was all done the same day. DTAP is not really discussed or explained. It is really a lot of confusion on what the difference is or what the point of the program is.

While Veteran 10 shared:

> The information shared through TAP on the DTAP is minimal. The way it is introduced is like "oh hey, here is this if you want to try this program to. Like I am getting out on medical why is this not mandatory? It is just really upsetting how even TAP is all rushed, just to hurry up and get you out of active duty. They really do not care about us when we are injured and just want us out because we are a liability- waste of money and time.

These responses made it clear that the information provided about DTAP from TAP was minimal to none. These veterans had multiple answers to this question and some shared stories that they did not want to be shared. What can be shared is their attention to detail on their experiences and how they all individually expressed themselves physically and emotionally. Each of these respondents were aggressive, upset, enraged, and emotional, because they were left hanging on a ledge while transitioning. Lack of support and communication is what made them feel as such, while transitioning through these programs. The fear of the unknown was fully present and acknowledged multiple times by these veterans (see Table 11).

Table 11

Description of Information about DTAP provided by TAP

Major Themes	Number of Respondents	Percentage of Respondents
Insufficient/ No Information Provided	11	91.7
Too Broad/ Needed Information for Injured Veterans	6	50.0
Too Basic/General to be Useful	5	41.7
Unable to Differentiate TAP/DTAP	4	33.3
Too Much Information/ Provided too Fast	3	25.0

Note. Respondents could give more than one answer; Number of Respondents controlled the sort in descending order.
[a]n = 12.

Issues Faced During the Transition Process

This interview question brought it altogether by asking: *What types of issues have you as a OEF/OIF PTSD veteran been faced with while transitioning through this program?* Helping better define the overall experiences these participants have experienced over time going through DTAP.

Almost all veteran respondents shared that trying to obtain proper care through the VA has been a true struggle. Six themes unfolded from this interview question and many of the veterans could give more than one answer like the rest of the questions asked. The six themes revealed were: (a) obtaining proper care, (b) mental health challenges, (c) future uncertainty, (d) too fast of a transition, (e) limited compensation, and (f) miscommunication.

Obtaining proper care. Eleven of the 12 veterans revealed that this was one of the major issues they faced through the transitional process and are even still seeking the care they need. The veterans shared their many intensifying irritations and their transitional needs. Some revealed that they are just giving up and others said they expected more from the program. In fact, Veteran 4 shared (Note: Due to the high emotional state of the participant, explicit language was used to express some thoughts and reactions to questions. Those explicit swear words have been omitted and replaced by "cussword" indicating that a swear word was used):

> Going through the program I have been faced with many obstacles. The major obstacle is proper care. Dealing with PTSD alone, I have seen over five different providers and have been misled or given so many different medications, that it has caused even more frustrations. The VAs medical system is the worst based off

> my experiences. I have made reports after reports and nothing changes. The medical system needs to be redone. The care we get and the treatment we received is horrible, in fact it is *"cussword"* Our treatments and care should be the best!!
>
> While Veteran 12 shared that:
>
> Again, no time to understand my options and take advantage of my benefits. Also, information was gained along the way, instead of being provided all up front in a way that is easy to process and understand. The entire process was stressful and caused a lot of anxiety. I just thought I would have better support, especially dealing with PTSD.

Mental health and uncertain future. Themes 2 and 3 went hand in hand. Revealing the mental health challenges and uncertainties about the future after the military. Veterans 3, 4, 5, 6, 7, 8, 9, 10, 11, and 12 shared their overall experiences and what came along with them transitioning out of the military with a service connected disability. Veteran 6 shared:

> I was faced many issues such as not knowing where to go or who to ask for help. Even feeling alone and frustrated on the process altogether. It was already hard knowing that I was no longer going to be the same with PTSD. Questions like how am I going to adjust with my family, how will I communicate to my loved ones, and who can I talk to when I feeling depressed and all alone? These were issues I was dealing with at the time of my transition. I still encounter them, but I have a system in place to help me cope.
>
> While Veteran 8 shared his future uncertainties stating:

> Some unexpected challenges were financials. I was so use to making a certain amount of money for the last 12 years that when that stopped it was very hard. I was not prepared for this. I thought I was tough enough to overcome these challenges but having anxiety was also affecting me. I felt like I didn't have the necessary civilian experience to get a job that would pay as much as I was making in the military. There is still struggles that I deal with until this very day, on top of deal with my war related injuries.

Too fast of a transition. Nine of the 12 veteran participants shared experiences where transitioning too fast had a negative impact on their physical, mental, and emotional well-being. Veteran 10 shared his emotional state during transition by sharing:

> Working with others, adapting to new environments, stress, anxiety, depression, insomnia, and family matters. My whole world felt like it crumbled and I truly felt alone. I am still working on a lot of these, but as time has passed and many medical appointments, it is slowly getting better. I have my days where I am depressed or even think about how life would be if I was gone, but I have other veterans who help support and family. I really hope that something changes because I am so saddened by the way veterans are treated and my own Marines killing themselves due to PTSD. We really need a change.

Compensation. Six of the 12 veterans interviewed, reported that limited compensation has been a struggle and an ongoing fight. Many shared that the wait times, appropriate compensation, and process of receiving compensation is all ineffective; all making no sense to these veterans, when they have proof of their injuries. Veteran 1, 4, 5, 7, 8, and 12 shared these similarities. Veteran 1 shared: "*The biggest issue I faced*

while transitioning was waiting for compensation. Compensation took about nine months initially; I had to resubmit for my PTSD compensation as it was not awarded initially."

Miscommunication. Veterans 1, 2, 4, 5, and 12 shared that miscommunication was for sure one of the multiple issues while transitioning. Their responses revealed just that. Not getting proper compensation and being given the run around, not knowing what DTAP was or that they are entitled to the program, going through the program and facing medical obstacles in which the program could have helped with, the feeling of being interrogated and not supported, and not properly understanding the options they are entitled to were surfacing issues among these respondents. This interview question helped reveal all of these themes and the many issues these veterans face transitioning out of the military into the civilian world through DTAP (see Table 12).

Table 12

Types of Issues Faced During the Transition Process

Major Themes	Number of Respondents	Percent of Respondents
Obtaining Proper Care	11	91.7
Mental Health Challenges	10	83.3
Future Uncertainty	10	83.3
Too Fast of a Transition	9	75.0
Limited Compensation	6	50.0
Miscommunication	5	41.7

Note. Respondents could give more than one answer; Number of Respondents controlled the sort in descending order.
[a]n = 12.

How DTAP Helped or Supported the Transition Process

The first sub-question of the study was: *How did the disabled transition program help or support Operation Enduring and Iraqi Freedom veterans with PTSD transition?*

The interview question that answered this was question seven: *How did the DTAP help or support with your transition process?* This question helped give depth on how the veteran perceived the program helped or supported their traditional processes.

Four themes emerged from this interview question and they were: (a) unhelpful: it failed, (b) a better structure is needed, (c) information was too general to be useful, and (d) only education and employment services were useful.

Unhelpful. All but one respondent, 11 of 12, shared that DTAP was unhelpful or it failed them altogether. In other words, veterans expressed that the time was to short and the information is such a quick overview it is not easy to remember. While others shared that the content and information provided was just general information, not knowing what DTAP was. Most interviewees further stated that the same info was provided in TAP. Many veterans also shared how they are still fighting for the benefits they are entitled to, the medical support is slim to none, the medical representatives are not trained well or uneducated on what is entitled to them, support systems are lacking, many found support from their peers, and how the system needs to be changed to meet the needs of those transitioning with medical issues like PTSD. Veteran 5 shared:

> It did not help or support with the transition process. DTAP class was just another check in the block for me and I did not really see much value. Everything was broad in nature and there was not really one-on-one time to individualize the process and not sure if that is even feasible. The instructors were knowledgeable however it was information overload and broad like mentioned above. Dealing with the stress of getting out without any idea of what the future holds is in itself a very anxious situation. Add to that trying to navigate the VA medical process,

claims process, and VA educational benefits process is very stressful. The BAH from the post 911 GI Bill did help the financial situation and offset not being able to work for the first few months post service.

A better structure is needed. Looking at theme two, 8 out of 12 veteran respondents shared that the DTAP needs to better structure their system to meet the needs of all medically injured veteran, especially PTSD veterans. In fact, Veteran 10 shared:

> It did not. The program makes no sense like I shared before and really needs to be revamped. I am still confused on the point of DTAP when TAP explains the same exact information. I was expecting DTAP to help us disabled vets more in depth.

Many of these respondents shared the same concerns on how the program does not even focus on their needs as medically injured veterans, it looks more at educational and employment services; which in their eyes is useless because they need to funnel in on their medical issues to get a job they can keep or meets their needs. Then they can focus in on school. This is when the last two themes emerged.

Education and Employment. Four of the 12 veteran participants identified education services and 3 of the 12 veterans identified employment services as the only helpful options through DTAP. It was to the understanding of the veteran participants that DTAP was supposed to provide better support for their medical injures and in fact it did not, it was just an extension of TAP. Veteran 4 shared:

> The only good part of DTAP is the education and employment services they offer. Other than that, the medical support is minimal to none. The representative's half of the time are uneducated themselves and give misleading information.

While Veteran 9 shared how "*DTAP is useless. They give basic information just like TAP. The system needs to be change to fit the needs of those with disabilities not for all separating out of the military."*

Table 13 shows the statistical data on how DTAP helped or supported the transition process for the veteran participants.

Table 13

Description of How DTAP Helped or Supported the Transition Process

Major Themes	Number of Respondents	Percent of Respondents
Unhelpful; It Failed	11	91.7
A Better Structure is Needed	8	66.7
Information was too General to be Useful	4	33.3
Only Education and Employment Services were Useful	3	25.0

Note. Respondents could give more than one answer; Number of Respondents controlled the sort in descending order.
[a]n = 12.

Improvements to Better Support Transitional Needs for Those with PTSD

The second sub-question of this study was: *How could the disabled transition program be changed to better support Operation Enduring and Iraqi Freedom veterans with PTSD needs related to transition?* The interview question was addressed just the same. It was ideal to keep the sub-question as is for the interview question. It was straight to the point and clear to the respondents.

Five themes emerged from this interview question and they were: (a) individualized/customized supports, (b) separate briefings specific to those with PTSD (c) mental health counseling, (d) longer and more extensive process, (e) information provided to all veterans.

Individual support. Individualized/customized supports was a theme emerged from 10 of 12 veteran respondents. Many of the veterans shared that DTAP should be more detailed to those medically injured, including making the program longer not just two hours out of the day. Some shared that it should be more individualized to support OEF/OIF PTSD veterans. While others said one-on-one counseling is needed to better understand what the veteran needs or would be best for them. Example, Veteran 5 shared a very extensive response stating:

> One way to better support OEF/OIF veterans is to make as individualized as possible. When suffering from PTSD you can have very specific symptoms that can cause trouble remembering, paying attention, being around large groups of people, and trouble concentrating. If it was more individualized it might be able to better help each person suffering with PTSD from service connection. PTSD comes in many forms and it doesn't need to be from direct combat. People often discredit having a traumatic experience that might not have happened with boots on ground while the symptoms could be just as harsh. Another recommendation is to have a possible representative assigned to each person who can assist them for the first couple of years' post service. There are case workers that do help advocate for you when it comes to VA matters but I mean more in the depth assistance that could help with employment, managing relationships, talking about your issues with family and friends so they may better understand some of the things the veteran with PTSD deals with on a daily basis. Someone who may talk to employers of personnel with PTSD so they may to also have a better

understanding of some of the symptoms and possible situations that may cause stress to a person suffering from PTSD.

Separate and specific benefits. From here other themes started to unfold. Veteran participants 1, 4, 5, 6, 8, 9, 10, 11, and 12 revealed in themes 2 and 3, separate briefings need to happen for PTSD veterans through DTAP and mental health counselors need to advise all mental health veterans to better understand their medical needs. Veteran 12 shared:

> One-on-one counseling should be offered to all Veterans transitioning out of the military with PTSD. A counselor should make sure the vet knows their treatment options. Most importantly, most vets don't stay at the location they transitioned from. The VA hospital at the vets final destination should be contacted or the vet should be given references on who to contact at the other hospital.

Improved process. Looking further to theme 4, 8 of the 12 veteran participants shared that longer and more extensive process is needed through DTAP. Many veterans shared that the two hour program is just not long enough and goes too quickly. Veteran 10 shared:

> Honestly, the program needs to be changed to explain how to process medical claims, the different medical facilities and contacts, what all is offered to disabled veterans, and how to go about obtaining medical proof of the service connected disabilities. I think this should be a whole separate program, not a 1-2 hour briefing that gives info on education and employment. Maybe a few days or week of this. I think even offering medical transitioning counselors to help with understanding the many effects transitioning can have on us would be helpful as

well. It can help reveal how to cope, understand, and deal with issues that will arise.

It was evident in many of the responses from these veterans that they all feel the program is too short and needs to be more structured to fit the needs of their mental health injures, rather than making it all the same for everyone. Some even shared that the information should be shared with all war veterans, so that they can be informed about what programs maybe be available to them in case they feel they do in fact have an injury. Which this then led into Theme 4.

Information provided to all. The last theme of these responses, it was identified that all veterans should be given the information on DTAP, not just those who know they are medically injured or know they are getting out due to an injury. Not just generic information given, but extensive enough so that they understand the purpose of DTAP and how it benefits them to partake. Five of 12 veterans shared this was needed in this last theme. Veteran 7 shared:

> Maybe make sure the information gets disseminated to all veterans no matter their current separation state of transitioning. It should not matter if you're disabled or not, it should be given to all exiting the military. Down the line, they may find they have a service connected disability and need to go through the same processes.

While Veteran 11 shared his personal feelings:

> They need to do a better job with veterans who suffer from any mental condition, I felt like I was set up for failure. All information about DTAP needs to upfront

and clear articulated to all. I was kicked out and lost for so many years unit finally another veteran told me about programs available to me.

Table 14 displays the suggested improvements to better assist the transition needs for those with PTSD as shared by the veteran participants.

Table 14

Suggested Improvements to Better Support Transitions Needs for those with PTSD

Major Themes	Number of Respondents	Percent of Respondents
Individualized/Customized Supports	10	83.3
Separate Briefings Specific to those with PTSD	9	75.0
Mental Health Counseling	9	75.0
Longer and More Extensive Process	8	66.7
Information Provided to all Veterans	5	41.7

Note. Respondents could give more than one answer; Number of Respondents controlled the sort in descending order.
[a]n = 12.

Challenges Obstructing the Transition Process

The final sub-question of this study was: *What challenges and issues do Operation Enduring and Iraqi Freedom veterans with PTSD face that may interfere with their abilities to fully transition into civilian life?* The interview question that was slightly altered was asked to the veteran participants was: *What challenges can you describe as a OEF/OIF PTSD veteran, that may have obstructed your ability to fully transition into the civilian life?* This question was another critical part in understanding what it is that these veterans are faced with and the many challenges they endure that prohibit them from fully transitioning.

The five themes that emerged from this question were from the critical responses: (a) psychological repercussions, (b) poor treatment of veterans, (c) access to proper care, (d) dealing with civilians (including family/friends), and (e) finding employment.

Psychological repercussions. Psychological repercussions was the most prominent and first theme revealed in the veteran responses. Ten of the 12 respondents shared that they are faced with many challenges and the most common has been associated with their PTSD related injuries. Stress, anxiety, support systems, insecurities, and depression were all commonly mention as some of the psychological repercussions that occurred. Veteran 1 shared "*Paranoia, the fear of failing my team, and high levels of anxiety at times makes it difficult to concentrate. Even on simple tasks*."

While Veteran 8 shared:

> Transitioning from the military to the civilian sector has psychological repercussions in itself. So, adding a condition such as Post Traumatic Stress Disorder to the equation can make things even more difficult. It was hard, I felt alone, and insecure. I felt like even though I knew there were resources for me, I was almost scared to use them because I secluded myself. I didn't like talking about my issues to strangers or in group settings, so I never got the help or assistance I needed.

Treatment of veterans and proper care. Examining further into themes, themes 2 and 3 revealed poor treatment of veterans through the VA medical system and obtaining access to proper care. Veterans 2, 4, 5, 6, 9, 10, and 11 gave in-depth statements on how they received poor treatment and it caused many underlying issues personally and professionally. Veteran 6 shared:

> I felt like an outcast, on edge, and mad at the world. It was hard to transition knowing that my plans in the Air Force were changing and I had to get out. Also, the DTAP program was so confusing that I felt like I would never be able to get the help that I needed. It was already bad enough I had to deal with all the madness when my active duty unit found out I had a medical condition. It was just all very stressful.

From severe anxiety to aggressive behavior, lashing out on close friends and loved ones; these veterans expressed their many challenges during their transition and it showed in their body language while expressing their experiences. Their voices changed constantly going from high peached to very low depressing tones. It was evident that this was a touchy topic and they share how obtaining proper care has not been feasible. Veteran 5 shared:

> The amount of time that is provided to prepare for separation. The access to care and the stigmas that surround a military member with a mental health disorder is alarming. If I was open to employers regarding my disabilities I am not sure I would be hired in the civilian sector. Additionally, access to care. To get in a see a medical professional can take a very long time and to minimize the wait time they have implemented the VA choice program that allows you to go out and see a civilian doctor. The problem with that is you have to start the whole process over and if the contract expires you will not receive care or prescriptions until the contract is recertified.

Civilians. Dealing with civilians (family and friends) was strongly identified. Five of the 12 veteran respondents shared that dealing with people who were not military,

has been a true struggle. While family and friends do not understand what exactly it is they are going through while transitioning and even today. Many share that arguments break out, anger is then increased, and they tend to say or lash out in a manner they dislike. Some veterans did not want the personal stories they shared recorded because they were too intense and private. However, what can be shared is that a common theme developed and that was dealing with others while transitioning is just difficult for these veterans to bare at times. Veteran 2 shared a very personal story in which he wanted to reveal to all (Note: Due to the high emotional state of the participant, explicit language was used to express some thoughts and reactions to questions. Those explicit swear words have been omitted and replaced by "cussword" indicating that a swear word was used):

> My challenge is dealing with people that put me in a category as crazy. I hate how when I need to vent to people and at times when I'm with my primary care provider I feel like *"cussword."* It hurts really bad. I smile to hide the pain and I cry myself to sleep just to hope for a better day. My little brother doesn't do much with me nor do we talk like we use to. I hate how I better myself in being a personal trainer and going to school now to be a cop my family just *"cussword"* on me. I can't breathe at times because I know I will lose it. I have an issue with the state with a child that don't give a damn about me being in the military. I almost regret being in the service, but at least I was noticed and people saw me. Now they just see through me.

Employment. From here the last theme, finding suitable employment, was identified by Veteran 3, 5, and 12. Sharing that it has been truly a frustrating process to

find employment and or adjusting to these new environments. These veterans reveal how they feel like they are just thrown out into these new environments without any real help and making them professionally prepared. This caused many of them to feel scared and uneasy about their future. Veteran 3 shared "*As I was starting to look for a job I found it very difficult, I feel like they just throw you out in the civilian world an expect you to know what to do.*"

While Veteran 12 shared:

> First, the time to actually take care of myself. When I transitioned, I had to get a job right away. This left little time to attend appointments. A solution - Veterans should be given a grace period, maybe 3-6 months where the military will provide financial support to allow vets to attend appointments. A lot of anxiety and stress for sure.

These responses were endless and unwavering. It was evident that these veterans not only had transitional issues they were dealing with and still are until this day, but they felt a sense of emptiness and loneliness. Their body language spoke volumes to the researcher showing that they were in fact hurt, emotionally disconnected, empty during this process, and are still trying to cope.

These major themes with the number of respondents/the associated percentages are revealed in Table 15.

Table 15

Challenges Obstructing the Transition Process into Civilian Life

Major Themes	Number of Respondents	Percent of Respondents
Psychological Repercussions	10	83.3
Poor Treatment of Veterans	7	58.3
Access to Proper Care	5	41.7
Dealing with Civilians (including family/friends)	5	41.7
Finding Employment	3	25.0

Note. Respondents could give more than one answer; Number of Respondents controlled the sort in descending order.
[a]n = 12.

Analysis of Reflective Journal and Field Notes

The researcher maintained a personal journal and field notes to enhance the reflexivity of researcher bias. Forgoing each interview, the researcher made sure to be casual both physically and verbally to all veteran participants in each interview. The researcher made the environment carefree and relaxed enough so that the veteran felt comfortable to address each question. The researcher ensured to be present and in the moment to let the participant know that they have the researchers' utmost respect/attention while interviewing. This allowed the researcher to be mindful of the interviewees' body language, demeanor, tone and voice while speaking. In the journal the researcher gave depth on what she saw and her personal views on what the participant was conveying. This will further be addressed and explained in Chapter V.

The field notes were used to help document observations made from the participants speaking in the interview. The field notes focused more on identifying the three phases of the Adult Transition theory, in which the veteran was currently in or has been through. These phases are addressed in the Adult Theory as: moving in, moving

through, and moving out. Though not discussed in this chapter, it will be thoroughly addressed in Chapter V and its purpose to this study.

Summary

The purpose of Chapter IV was to explore this phenomenological study to help describe the perceptions of OEF/OIF veterans with PTSD, who are transitioning from active duty to civilian life, regarding their participation in the DTAP. It began, first, with a review of the purpose statement, research questions, and a summary of the research design, population, sample, and interviewee demographics. Following, the presentation of the major findings for the central research question and three sub-questions was addressed thoroughly through the themes found in the veteran's responses. The most dominant themes that were identified were the following:

- Reasons given for separation from the military: Mental health/PTSD.
- Experiences with the transitional process through the VA: Generally negative.
- Experiences with the information and process through DTAP: Lacked information about the DTAP Program.
- Description of care provided to others through DTAP: Insufficient or lack of effective care/support.
- Description of information about DTAP provided by TAP: Insufficient; no information provided.
- Types of issues faced during the transition process: Obtaining proper care and mental health challenges.
- Description of how DTAP helped or supported the transition process: Unhelpful; It Failed.

- Suggested improvements to better support transitions needs for those with PTSD: Individualized/customized supports.
- Challenges obstructing the transition process into civilian life: Psychological repercussions.

A narrative discussion was used to help explain the veteran participant's responses and themes identified. Chapter V includes a thorough examination of the findings as it related to the review of literature, conclusions, implications for actions, recommendations for further research, and concluding remarks and reflections.

CHAPTER V: FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

Chapter V is the final summary of this study that provides detailed descriptions of the findings reported in Chapter IV, conclusions, and recommendations of this research. The following is included in this chapter: purpose statement, research questions, methodology, population and sample, major findings, unexpected findings, conclusions, implications for action, recommendations for further research, and concluding remarks and reflections.

Purpose statement

The purpose of this phenomenological study was to describe the perceptions of OEF/OIF veterans with PTSD, who are transitioning from active duty to civilian life, regarding their participation in the DTAP.

Central Research Question

This study was guided by one central research question and three sub-questions: *What are the lived experiences of Operation Enduring and Iraqi Freedom veterans with PTSD, who participate in the Disabled Transition Assistance Program?*

Sub-Questions:

1. How did the disabled transition program help or support Operation Enduring and Iraqi Freedom veterans with PTSD transition?
2. How could the disabled transition program be changed to better support Operation Enduring and Iraqi Freedom veterans with PTSD needs related to transition?

3. What challenges and issues do Operation Enduring and Iraqi Freedom veterans with PTSD face that may interfere with their abilities to fully transition into civilian life?

Research Methods and Data Collection Processes

This study inquired about the lived experiences of OEF/OIF veterans with PTSD, who participated in the DTAP. The interviews created for this study included examples of the veteran participants lived experiences, provided to the researcher/observers, revealing their personal disputes with the transitional processes. Narratives provided by the OEF/OIF PTSD veterans can help future researchers in gathering further analyses on this understudied topic. Phenomenology pursues to recognize, understand, and describe singular or collective experiences of people (Arman, 2016; Creswell, 2013; McMillian & Schumacher, 2010; Patton, 2015). A qualitative approach was appropriate for this study because it pursued to assess the perceptions of OEF/OIF veterans with PTSD, who are transitioning from active duty to civilian life, regarding their participation in the DTAP.

Face-to-Face in person and video interviews for this review gave openness and point by point data not bolstered by surveys. Understanding the perception of individuals through interviews are most ideal based off many researchers. Researchers reveal that "closed instruments such as surveys do not capture the feeling and experiences of participants, which are essential in completing a comprehensive assessment" (Nicholson, 2015; Patton, 2002). This study is based on a transitional program, DTAP, to try and help veterans whom separate out of the military with a disability. Focusing in on this further, OEF/OIF PTSD veteran's perceptions of the DTAP through interviews, gave

substance on the effectiveness of the program, its relevance, and purpose based on their own perspectives/experiences.

Population and Sample

The population for this study was identified as approximately 681 U.S. Armed Forces veterans associated with local San Diego, California VFW 3788 nonprofit organization. Of this overall population, the targeted populace, was approximately 136 (19.97%) Afghanistan and Iraq veterans who were diagnosed with PTSD due to serving in combat and went through the DTAP while transitioning out of the military for better assistance (Veterans of Foreign Wars Department of California, 2017). Focusing in on this selected population allowed the researcher to narrow down what helped in understanding transitioning OEF/OIF PTSD veterans and their experiences using the systems in place.

Purposeful random sampling strategy was ideal for this research as it allowed the researcher to use strong preferences for the random selection samples (Patton, 2015; McMillian & Schumacher, 2010). This type of sampling also helped reduce any possible bias, as it eliminates using just one branch of service among these veterans. Patton (2015) states "random sampling, even of small samples, will subsequently increase the creditability of the results" (p. 286). Well knowledgeable, random, experienced OEF/OIF war veterans, was selected for this sample from the San Diego, California VFW 3788 organization. This allowed a more current and diverse selection of samples in the research.

A sample of 12 OEF/OIF PTSD veterans were interviewed and was enough for this study. It helped provide meaningful, valid data, and insights of this inquiry. In fact,

Creswell (2013) suggests that five to 25 interviews are enough for this type of study. The following measures were followed in selecting the 12 OEF/OIF PTSD veterans:

- OEF/OIF veteran.
- Diagnosed with PTSD.
- Discharged from the U.S. Armed Forces (separation, retirement, or medical).
- Went through the DTAP while transitioning out of the military service.
- Receiving mental health care through VA system and associated transitional programs at the time of the study.

Major Findings

The major findings of this study are described coinciding to the research questions. The most dominant themes that were identified were based on each interview question:

- Reasons given for separation from the military: Mental health/PTSD.
- Experiences with the transitional process through the VA: Generally negative.
- Experiences with the information and process through DTAP: Lacked information about the DTAP Program.
- Description of care provided to others through DTAP: Insufficient or lack of effective care/support.
- Description of information about DTAP provided by TAP: Insufficient; no information provided.
- Types of issues faced during the transition process: Obtaining proper care and mental health challenges.

- Description of how DTAP helped or supported the transition process: Unhelpful; It Failed.
- Suggested improvements to better support transitions needs for those with PTSD: Individualized/customized supports.
- Challenges obstructing the transition process into civilian life: Psychological repercussions.

Moving In

The theoretical framework of this study was based the Adult Transition theory. Controlling and regulating PTSD is an occupation alone, being an OEF/OIF war veteran going from war back home and from active duty military into the civilian world is a basic groundbreaking event. Understanding in what way to adapt by exploiting individual methods for dealing with stress that many veterans and those outsiders who do not realize themselves, can be fully understood through this theoretical framework.

Nancy Schlossberg (1981) developed the Adult Transition theory in 1981 which consists of three phases: moving in, moving through, and moving out. Schlossberg's model was created to help explain the factors of influence that effect an individual's aptitude to handle each phase and how the individual assimilates their transition into their everyday life (M. L. Anderson et al., 2012; Arman, 2016; Diamond, 2012; Schlossberg, 1981). This model helped examine the combats between transition and what affected each veteran while going through each stage (M. L. Anderson et al., 2012; Arman, 2016; Diamond, 2012; Schlossberg, 1981). This framework was most appropriate to help describe OEF/OIF PTSD veteran's transition from active duty into the civilian sector.

Moving in is the first stage of this transition model. This stage is when OEF/OIF PTSD veterans began to adapt to their original environments. Leona Lopez (2011) shares that:

> The first phase, "Moving In," is where an individual begins to navigate and "learn the ropes" of the new environment (Goodman, Schlossberg, & Anderson, 1997, p. 167). For veterans, this not only includes learning the ropes of the transition to civilian but also learning the ropes of using VA benefits and the VA system. (p. 17)

Responses from the veterans in this study helped reveal when the veteran started to become familiar with DTAP, the VA Medical system, their new environments, and the effects it had on them. Findings 1 through 3 helped identify these aspects based on the responses from the veteran participants.

Finding 1: Mental health/PTSD. To help answer the research question of this research the first interview question was focused on the reasons for the veteran participant's separation from the military. Through the interview responses, observations, and field notes finding the reason for the veteran participant's separation from the military helped reveal the starting phases of transition. Reasons for separating the military was defined clearly by all veterans. Nine out of 12 respondents stated that they were separated out due to mental or PTSD related issues. Looking closely at this major finding, these veterans shared how they were lost, confused, expressions of how miscommunication was frequent, and the care they received initially entering the process was a hit or miss type of deal. To illustrate this finding Veteran 1 shared:

> After 14 years of active service, I violated the substance abuse policy by smoking

marijuana while serving in the Army. I found marijuana to be a great vice to deal with my anxiety/PTSD. I was separated as General under Honorable conditions. The care I received was unclear, confusing, and just a losing fight.

Many of the veterans shared in their responses that they felt so hurt by the way they were treated transitioning out of active duty that they wanted to just be done. The researcher reflected through her field notes and personal journal, making firm notation of the veteran's expressions and tones. In fact, based off this phase of the transition model, the researcher reflected on Veteran 5, stating that the veteran replicated stress, anxiety, and separation from all. This Navy veteran was very broken by the way he was separated out of the Navy. It seemed that the veteran felt once he was diagnosed with PTSD that his whole career changed in active duty and as a veteran. His discomfort put him in a place where he is unsure about trusting the people around him and in the VA. He stressed how the accuracy of care is lacking and more time and effort needs to be put into veterans and their care. As a PTSD veteran, he sees that better care is needed for not only him but his fellow veterans as well.

Finding 2: Generally negative. Experiences with the transitional process through the VA, was the question asked to these veteran respondents. The findings revealed how many of the veterans were moving into a new phase in their life and did not understand why the processes in places were lacking so much. Eight of the 12 respondents shared how they felt like they were being rushed, the information given was very basic, and altogether confusing. These were all identified themes these veterans were relying. Researchers reveal how learning to cultivate different affairs, study new principles, adapt into their new civilian roles, and understand what they need to do to obtain proper care,

help, and gain the appropriate benefits they are entitled to (M. L. Anderson et al., 2012; Arman, 2016) is all a part of the moving in stage. Veteran 5 shared:

> The VA process was not very informative. The only information that was given was during the five-day transition class knows as TAP. This was less than a half of day. The VA website does have a lot of information on it and it was hard to navigate. I was able to network with a lot of people who have got out before me and get a better understanding of the process.

Looking at these findings and how these veterans felt going into this stage of transitioning, it was clear how emotionally impacted they were and still are today. As an example, the researcher notated in her personal journal and field notes how Veteran 3 was upset about the process information, but was very happy she was out of the service and able to spend time with her family. She expressed in her responses concerns about not enough information being given to veterans when they out-process altogether. She expressed her frustrations about how the transitional programs are just basic and many vets are unware of their entitlements from the start. Though the process was aggravating to her, she expressed that she is much happier now being out.

Finding 3: Lacked information about the DTAP program. Experiences with the information and process through DTAP, was the third question asked to the veteran participants. The dominate response was that the program lacked information about DTAP. Ten out of 12 veteran participants made it clear that more explanation of the program and its overall purpose would have been more beneficial to their process. Leona Lopez (2011) shared that this moving in phase it can be overwhelming and challenging and these stressors may contribute to a crisis of identity in which the individual attempts

to combine knowledge of past environments with information from the new environment (Schlossberg, 1984). Based on the responses from these 10 veterans, it was identified that they were expressing their initial frustrations about the program, their anger on how everything was unclear, and the fear of going into a new environment that was inefficient by itself. To illustrate this point Veteran 12 shared:

> I would say it was confusing. I didn't know exactly who to call for certain things. I just waited for someone to call me. Information was explained during out processing, but it was hard to understand it all because it was all just dumped on me in one hour.

This particular veteran expressed many concerns about her future in the civilian world and if she would ever be able to even begin her transition effectively and fully. It can be said that these 10 veterans were all trying to cope with the process of transitioning, on top of their personal medical diagnoses. To further share how difficult this process was to begin, the researcher explained in here journal how Veteran 10 was very quiet and had no emotion while answering the interview question. You could tell the veteran was drained, over the process, and dealing with her own issues on top of it all. She was expressive in her answers and it really made her think about how the transitional process really did not help her at all. She expressed many times how she never truly thought about the process in place and now thinking about it all, how upset she is knowing the transitional program failed her. The veteran then shared how she was stressed, depressed, and had major anxiety transitioning with PTSD. The research notated how the veteran expressed all the issues she still faces and wished that the transitional process was more helpful and

supported her. It was evident that these veteran respondents moved out of the first phase, into the moving through stage with some underlining issues.

Moving Through

Moving into this second phase of the Adult Transition theory, this model requires sustaining and balancing the burdens of the transition. M. L. Anderson et al. (2012) states "moving through a transition requires letting go of aspects of the self, letting go of former roles, and learning new roles. People moving through transitions inevitably must take stock as they renegotiate these roles" (p. 45). It is known that this phase of the transitional process can take some time before moving out. Moving through this phase, letting go of the past and moving into the present, is presented through many of the veteran respondents. In fact, these medically injured veterans even realize that they must create a whole new lifestyle outside of the military and that is what made many of them uncertain in their new environments.

Presented below, are findings 4 through 6, each presenting examples of how theses veterans are moving through their new transitions. It will also be noted if they are still presently in this second phase, or if they have progressed into the final phase. It is known, based off the finding that going from active duty into the civilian world with war injuries is a traumatic event for these vets. Live examples from the veteran respondents will give depth and proof of this aspect of the study.

Finding 4: Insufficient or lack of effective care/support. Description of care provided to others through DTAP, was the fourth question asked to these veterans. The major theme revealed was that the care provided was insufficient or lacked effective care/support. Nine of the 12 veteran participants made it perfectly clear that the attention

they needed regarding their medical needs, was lacking severely. "The second phase of this model is the "Moving Through" phase. This requires "letting go of aspects of self, letting go of former roles, and learning new roles" (Lopez, 2011, p. 17). It is revealed in this finding that these veterans are dealing with many physical and emotional breakthroughs, trying to understand themselves and the new system they are entering into. Veteran 9 supports this observation by sharing:

> My transition through the VA was slow, customer service was not helpful at all. The VA process was crazy and needs to be changed. I felt so lost… There are too many names and acronyms for the transitional program that you do not know what the difference is. They just say if you have a disability or feel you have one to attend the DTAP. Once attending, it was just the same information TAP gave me on the Vocational rehab and employment help. Seems kind of useless if you ask me. I thought I was going to get information on how to file a claim on PTSD and so forth… I wish I could change all of this but it is my new reality.

In this veteran's response, it was evident that he was going in and through the stages of the adult transition. He first felt lost and confused about the process then he came to terms with his new reality and progressed forward. To further share the effects this process had on these veterans, the researcher drew conclusions based off the personal journal and field notes. After interviewing Veteran 12, it was very eye opening, as it showed how female veterans are being treated both in active duty and transitioning out. This veteran was more concerned about the treatment of mental health veterans, and felt it was minimal to none. She expressed how the VA process was easy, but when it came to DTAP it was not helpful at all for her. Her voice in this interview was expressive and

hurt. Though it is in the past now and she has moved forward, the veteran was still confused on why war veterans are being treated as such. On top of all the female issues when on active duty, she was also faced with the same issues transitioning out.

Finding 5: Insufficient- no information provided. This question was combined with question 6, and based on professional data analyst and the researcher, the codes, responses, and themes that immerged, were the same. Question 6 asked "*How would you describe the information shared with other OEF/OIF PTSD veterans by the DTAP?"* All veteran respondents shared the same information they received all other veterans did as well; which is why this finding consist of interview question 5 and 6 combined. The overall question asked was how was description of information about DTAP provided by TAP. Eleven of 12 veteran respondents shared that it was insufficient or no information was provided to them at all. Many these veterans shared that all the information pertaining to DTAP was unclear and confusing on its sole purpose. Some even expressed that TAP gave the same information as DTAP and it needs to be changed. Veteran 7 shared: "*What is DTAP? Information concerning DTAP at the time of my departure was not shared as that- just that TAP was part of this in 2008. Everything was clumped together*."

While Veteran 8 shared "*As of right now the transition programs could be more effective. The sessions for transition are wide in scope and could be more individualized to be better suited*."

To look even further into these responses, I was able to reflect through personal journals my views on how the veteran was feeling through this stage of transition, both physically and emotionally. In fact, Veteran 2 in this interview was very surreal to the

researcher as it was someone whom she served with in Iraq. Never in a million years would I have thought he was going through such a hard time and through strong emotional events going from active duty into the civilian sector. As he shared his answers to the interview question, I instantly felt his sorrows and pain. His emptiness and feelings of not wanting to be around anymore hit strongly. Listening to this veteran it was an emotional experience for myself, as I was in such disbelieve that a veteran whom I served at war with, was being treated as if he was nothing. Towards the end of the conversation, I shared my support system with him and told him that she is always there if he needs help. I reassured him that together, we will make a change for all the other vets around the world. It was clear his experiences with his service connected disability has caused a lot of stress, depression, aggression, and false hope moving through this phase. However, this veteran learned to face these issues and move forward in his processes.

Finding 6: Obtaining proper care and mental health challenges. This interview question asked, *What types of issues have you as a OEF/OIF PTSD veteran been faced with while transitioning through this program.* This 6th finding helped express the overall experiences these veterans are going through. In fact, 11 of the 12 veteran participants revealed that obtaining proper care was one of the main issues they were faced with while transitioning through the program. While 10 of the 12 veterans shared that mental health challenges were also surfacing issues they were faced with. Veteran 5 shared:

> It did not help or support with the transition process. DTAP class was just another check in the block for me and I did not really see much value. Everything

was broad in nature and there was not really one-on-one time to individualize the process and not sure if that is even feasible. The instructors were knowledgeable however it was information overload and broad like mentioned above. Dealing with the stress of getting out without any idea of what the future holds is a very anxious situation. Add to that trying to navigate the VA medical process, claims process, and VA educational benefits process is very stressful. The BAH from the post 911 GI Bill did help the financial situation and offset not being able to work for the first few months post service.

While Veteran 7 revealed the mental health challenges by stating:

Not knowing how time has brought to surface deep underling effects the military has had on my life and family. Sleepless nights, fear of the unknown, joblessness, no security, drunkenness, anger, rage, anxiety, mental health issues, choosing clothes to wear, health issues, high blood pressure, and high cholesterol.

Sharing just these examples, it was clear that both these themes were major in these veteran responses. To look even further, the researcher revealed the emotional connection these veterans were conveying based on their responses.

While interviewing Veteran 6, it was apparent that this veteran was confused and lost about the whole transitional process through the VA. In his responses to the interview questions, it was well-defined that he was still aggravated on how the DTAP program functions. This Air Force veteran was faced with many obstacles going through the systems in place. His comments on feeling like an outcast, on edge, and mad at the world was stressed several times. It was evident that this veteran's transitional process was not something good to reflect on. Though he transitioned through the program, he is

still coping with the side effects of PTSD and other underlining combat medical related issues. This veteran shared many stories that he did not want to be disclosed in this research, but it gave the researcher a better idea of what all he has been through both while on active duty and in the civilian sector.

Though just some examples, it was clear that these veterans were moving through this transitional process based on their own time frame. Every veteran in this study was or are learning to cope with their transitional issues and how to move forward to achieve the care they need. Lopez (2011) shared that,

> [D]uring this phase, the veteran will begin to understand the new role of becoming a civilian and should be able to balance life within the new environment. VA benefits may play a critical role in these first two phases depending on what resources have been used to aid with the transition. (p. 17)

As it was discovered, many veteran respondents shared they will keep fighting until justice is serve to them and all veterans when it comes to medical and compensation. This proves that these veterans moved out of the through phase into the out phase.

Moving Out

In this final phase of the Adult Transition theory, it is well known as the end or passing of change/transition. At this stage of the transition model, the veteran should be accustomed with their new environments that they have entered. Lopez (2011) states that "during this phase, the veteran should also have a good idea of how the VA benefits used aided in the transition to civilian" (p. 17). Based off all responses and the data analysis, more than half of the veterans have either moved into this phase of transition or even out of it altogether.

Presented below are the three findings that give evidence of how these veteran participants have been able to understand the DTAP and VA process altogether. Understanding that although the system has flaws, they learned to just move on and keep pushing to fight for their benefits and compensation rights. Examples shared will help support how these veterans have come to terms with the transitional system in place, as well as where they are at now with the many dealing with mental health related issues.

Finding 7: Unhelpful- it failed. Eleven of the 12 veteran participants shared that DTAP was unhelpful or failed them during their transitional processes. This was the first sub-question of the study, asking: *How did the disabled transition program help or support Operation Enduring and Iraqi Freedom veterans with PTSD transition?* Almost all veterans shared that the system is pointless and they are still fighting for the benefits they are entitled to. While upsetting to know that these veterans must find, search, fight, and bother with getting the help they deserve, many of them shared how they are hoping their horrible experiences shared, will help other veterans. Meaning that the VA/government will listen to their complaints and ideas on making a better transitional system for all veterans. Veteran 6 shared "*I do not feel it helped support me at all. It is sad to say, but the program is worthless. It needs to be structured to help better assist those who are getting out with medical needs*."

While Veteran 8 stated:

> The most helpful during my transition were other veterans with mental health disorders not DTAP. It is pretty nice to have separated in an area that has a large population of veterans. When I started going back to school there were veterans in the class. I did not just come out and ask these veterans if they have a

disability but somehow it comes up and there is a certain trust and relationship developed.

These responses revealed something so prevalent in this transitional system, which is that although the system seemed to fail them, they still have positive hope that the system could be restructured or changed for future veterans. Many of the veterans interviewed shared their responses and could empathize the main transitional obstacles that future veterans would be dealing with. Indicating that although it has been a long road transitioning, they have come to terms that they now understand how the system works and have moved forward. Looking even further into the physical and emotional aspects of this transitional phase, Veteran 4 reflected his hurt and anger very clearly. He expressed how he was not pleased with the entire transitional process and how he wished veterans would be treated with more respect and better service. He expressed his concerns with lack of support and help within the DTAP and TAP systems. It was clear his experiences with his service connected disability has caused a lot of stress, depression, aggression, and false hope. Though he knew he was not given the proper treatment and attention he deserved, he expressed how doing this interview for this study would be the next stepping stone needed for future veterans, fixing the issues at hand.

Finding 8: Individualized/customized supports. Through the moving out stage, it is known that the OEF/OIF PTSD veteran should be well educated of the VA system by going through TAP and DTAP. As well as having a firm understanding of the benefits they are entitled to during their transitional processes (Arman, 2016; Lopez, 2011). With this finding, it addressed the second sub-question of this study: *How could the disabled transition program be changed to better support Operation Enduring and Iraqi Freedom*

veterans with PTSD needs related to transition? Ten of the 12 veteran respondents shared that DTAP needs to be more individualized to the veterans transitioning, to give them customized support throughout their processes. Rather than giving the same information to all veterans, many of them shared that it needs to be customized based on each veteran, as it relates to their medical and transitional needs. Veteran 4 shared:

> DTAP could first be longer. They should make a program that gives extensive information on how to get started with the medical process at the VA. Maybe even help you sign up in the program to help get PTSD vets started. Maybe even have mental health counselors present to help brief vets on the transitional issues we will be facing. I think DTAP should also go over different jobs that PTSD vets can be successful in. I think maybe a week or two would be ideal for PTSD war veterans to make sure these areas are well explained and gone over.

To further illustrate the need for a more individualized and custom transition, Veteran 8 shared:

> They should establish a better process for personnel to go through to guarantee there is no traumatic brain injury or other medical conditions such as mental illness. Once they go through this process it is determined by a medical care provider that the service member is ready to separate or needs further evaluation make those steps take place first before you allow the member to go through the separation process. Once it is determined that a member has PTSD the medical process is started to make sure they are treated for their symptoms with medication and/or individual counseling.

These responses were very detailed and gave even more depth from other veteran participants, conveying that they understand what needs to happen, to make the system more progressive and successful. Based on their experiences, it makes it very clear why listening to each veteran's emotional experiences would be beneficial in ending the many horrific side effects, which often times accompany the transitioning out phase.

Finding 9: Psychological repercussions. It is no surprise that PTSD side effects include: (a) depression, (b) detachment, (c) substance abuse, (d) retention difficulties, and (e) other physical or mental issues, and are all examples of dissociative symptoms (American Psychiatric Association, 2013). In fact, this disorder has gained attention since WWI began and is still a surfacing issue today among transitioning veterans. It is also known that more than 2.6 million U.S. veterans have served in the OEF/OIF wars. After returning from these war zones veterans are faced with an enormous amount of transitional issues. Currently, one million veterans are tormented with PTSD related issues (Bateman, 2011; Chandrasekaren, 2014; Costello, 2015). Further, on average 20 OEF/OIF veterans die from suicide every day; while 11% are diagnosed with SUD (Seal, Bertenthal et al., 2007; SAMHSA, 2013). In 2010, 12,700 OEF/OIF veterans were reported as homeless and is steadily increasing daily (U.S. Department of Housing and Urban Development, 2010).

Due to this study being focused on veterans whom have been diagnosed with PTSD and have served in OEF/OIF war zones, this final sub-question of this study was so prevalent in understanding the challenges and issues these veterans face. The final sub-question asked: *What challenges and issues do Operation Enduring and Iraqi Freedom veterans with PTSD face that may interfere with their abilities to fully transition into*

civilian life? This question was critical to this study, as it unveiled how or what was affecting these veterans from fully transitioning into their new environments. Ten of the 12 veteran respondents shared that psychological repercussions were their primary reason that blocked them from fully transitioning. As illustrated by Veteran 4 who shared:

> The major issue was support. It seemed that as soon as you're injured and other injuries are identified, such as PTSD, you are looked at like the step child. My leaders broke their support and even many of my peers. Then going into a new system, the VA, you do not know anyone and feel lost. I still struggle with trust and believing medical providers because of the issues I have dealt with. I am so angry and depressed at times. It is really upsetting that as a war veteran I am treated like a dog off the street. I feel that I am still transitioning and I have been out for years.

While Veteran 7 shared:

> Physical and mental aspects. My body not being physically able to perform, back issues, sleep deprivation, tired, and unmotivated. I find myself not being able to focus for long periods of time on one thing. My job involved long hours, life and death situations every day. In the civilian community, it's hard to adjust. I find myself looking at everything still as life and death in this new environment I'm exposed to.

Looking back at all the responses, more than half of these veterans all suffered a great deal and are still trying to cope with their mental health disabilities.

It is no surprise that the outcomes of this study revealed a lot of emotional issues, distress, and hardships. Though there were many who did not want some personal stories

to be shared or recorded, the researcher was able to gather enough evidence to answer all study questions. Lopez (2011) states:

> this phase can be one of the most challenging as it signifies the ending of one chapter, which may indicate that more changes may soon be in store. This offers the potential of going back to the uncertainty of a new transition and the challenges and setbacks that accompany it as the process begins anew. (p. 17)

To further support this claim by Lopez, the journal reflection recorded by the researcher disclosed that Veteran 8 reflected anxiety, depression, and supportive peer comradery. When going over the questions it was apparent that this Navy veteran was truly invested in sharing his personal experiences. Going into details about his experiences with DTAP, his voice began to shake as if he was re-experiencing his transitional process all over again. Sharing some detailed and confidential war occurrences, this veteran showed his anxiety around this topic. His ability to relive this moment in time was truly heartfelt, as the researcher felt as though he was just looking for help and it was just simply not there. The veteran expressed that DTAP did not help support him, his fellow veterans did. This really brought this interview to reality, as it made more sense why this veteran was more expressive on his experiences with his veteran peers, than with the actual program. The peer comradery was more of a support system than his active duty leaders, VA representatives, and the transitional programs altogether.

Unexpected Findings

Much of the findings presented the researcher expected, due to her background in the field, as well being an OEF/OIF PTSD veteran herself, going through TAP/DTAP. The researchers experience with the transitional programs and her peers around her, has

been known as a problematic system. Which is why she wanted to peruse this study to understand where the issues lie. All this said, the unexpected findings were those veterans whom shared that their experiences were generally positive (4 of 12 respondents), and that their care was good or sufficient (2 of 12 respondents). Though the researcher went in with her own experiences, she also knew that it would not be the same experiences for other veterans.

Pursuing this study was ideal, as it would let the researcher know where the issues lie and how it could be improved to better assist these PTSD war veterans. When it was revealed that there were some positive experiences and care given, it let the researcher know that there can be consistency of treatment through this program. Knowing that it is just a matter of who is providing the information and who is providing the medical care needed, it gave evidence that more training, effective medical providers, mental health counselors, and DTAP trainers are needed. These unexpected findings proved that the system can work effectively, it is just a matter of successfully placing well trained and educated staff in the system. As well as creating a transitional system more individualized to those exiting out of the military.

Conclusions

Central Research Question

What are the lived experiences of Operation Enduring and Iraqi Freedom veterans with PTSD, who participate in the Disabled Transition Assistance Program? The conclusions drawn from the research question was based on all personal experiences and opinions from the PTSD OEF/OIF veteran participants. The identified experiences and issues were:

- Experiences with the transitional process through the VA: Generally negative.
- Experiences with the information and process through DTAP: Lacked information about the DTAP.
- Care provided to others through DTAP: Insufficient or lack of effective care/support.
- Shared information about DTAP provided by TAP: Insufficient or no information provided.
- Issues faced during the transition process: Obtaining proper care.

These five themes were expressed by more than half of the veteran participants. Many researchers conclude that more studies like this need to take place, to better understand the value of the transitional services and the lived experiences of OEF/OIF PTSD veterans using the transition assistance programs. It was also concluded from researchers, that these types of studies would help better assist these veterans in eliminating the countless side effects of combat PTSD (Bascetta & General Accounting Office, 2002; Tanielian et al., 2008; Watkins et al., 2011). All 12 participants in this study had PTSD and all suffered with the many other mental health issues. Expressing in their responses that the transitional process was a negative activity, due to not receiving enough information from providers, the process being information overload, and the general difficulties of the adult transition and medical issues that followed. It was clear that these issues provoked their entire process and the proper care that they deserved.

Further, analyzing the data through the Adult Transition model helped explore the encounters within the veteran participant's transition and what affected these veterans while going through each stage (M. L. Anderson et al., 2012; Arman, 2016; Diamond,

2012; Schlossberg, 1981). Using this model, it was concluded by the researcher based on the data presented, that it was an appropriate selection. This transition model helped describe the OEF/OIF PTSD veteran's transition from active duty into the civilian sector. Accumulated of three phases of transition: (a) moving in, (b) moving through, and (c) moving out, each were assessed thoroughly based on the feedback from the interviews from the veterans. Revealing that all veterans have been through each phase of the Adult Transition model, progressing out at their own time and pace.

Sub-Question 1

Sub-question 1 asked: *How did the disabled transition program help or support Operation Enduring and Iraqi Freedom veterans with PTSD transition?* Moving further into the interview questions, the first sub-question helped give further depth and revealed how the veteran participants perceived how DTAP helped or supported their transitional processes. The identified experiences and issues was that it was unhelpful and or failed them altogether. Eleven of the 12 veterans concluded that today they are still fighting for the proper treatment they deserve and will not give up. It was also concluded in these findings, that the medical support is lacking severely, the medical staff are not trained enough to understand their entitlements, the system is very poor and confusing, and how the system needs to be changed to fit the needs of those with medical difficulties such as PTSD. It is evident that these veterans feel the system just needs to be revamped altogether; to better support, provide, and give veterans the help they need while transitioning.

Sub-Question 2

Sub-question 2 asked: *How could the disabled transition program be changed to better support Operation Enduring and Iraqi Freedom veterans with PTSD needs related to transition?* Based off research findings, it was concluded that countless of veterans returning from Afghanistan and Iraq war zones, feel that they are not getting the attention they have earned from the military, VA, and other institutions while transitioning out (Ahern et al., 2015; Bateman, 2011; Flournoy, 2014; Hyatt et al., 2014; Kelley, 2012). Since these veterans are not receiving the proper care, research and the data gathered from the interviews, concluded that many of these veterans are suffering with severe side effects. Depression, drug addictions, alcoholism, taking their own life, and all other mental health related issues.

Concluding further, 10 of the 12 veteran participants shared that more individualized/customized support needs to happen. Ideas that immerged were that DTAP should share more details to those suffering with service related injuries, such as making the program longer than two hours. Many suggested that a few days to a week would be more appropriate for medically injured veterans. It was concluded by the veteran respondents that one-on-one counseling would be most beneficial, rather than having the same plan for all veterans. This would allow the counselors to make more customizable transitional plans to meet the veteran's needs. Concluding the evidence of this sub-question, it was clear by the responses given, that they all supported the same ideas on DTAP becoming more structured to fit the needs of veterans with mental health injuries.

Sub-Question 3

Sub-question 3 asked: *What challenges and issues do Operation Enduring and Iraqi Freedom veterans with PTSD face that may interfere with their abilities to fully transition into civilian life?* Researchers Heinz et al. (2014) and Saxon (2011) reveals that service, care, and the transitional process in place is lacking among war veterans. While there are 2.4 million who served in the OIF/OEF war zones, these researchers disclose that only 4% of this population are seeking help or are being reported as having serious war related issues. These authors conclude that there is a major gap that needs to be filled (Heinz et al., 2014, Saxon, 2011).

Looking at the final question of this study and the data discovered, 10 of the 12 veterans conclude that the major challenges that are obstructing or have obstructed their transitional process was due to their psychological repercussions. Sharing their many challenges that all related to their PTSD injury, it was evident that their stress, insecurities, and depression all effected their process of change. This helped make the conclusion that focusing in on the mental health issues before pushing education or new careers paths, would be more efficient in these veterans' transitional processes. Medical attention needs to be the first step in these war veterans' transitional processes, to help tailor what the next step would be for them to fully transition successfully. Finally, it is further concluded that DTAP is not meeting these veterans' medical needs and are being pushed so quickly into new environments, adding more stress than needed.

Implications for Action

Based on all findings and conclusions of this study, the researcher has proposed a few implications for action. These implications are for the United States Government,

United States Armed Forces, United States Department Veterans Affairs, and all medical staff and representatives involved. The details of these implications, are all actions that need to happen to eliminate the main issues these veteran participants have discussed pertaining to DTAP, as well as what this study has unveiled pertaining to the many side effects these veterans are faced every day. The following implications for action are suggested to help progress the overall lived experiences of OEF/OIF PTSD veterans and their participation in DTAP:

- The Department of Veteran Affairs needs to develop a strategic plan for DTAP to meet the needs of mental health war veterans that focuses on their medical needs vs. education and employment. As well as extending the time of the DTAP program from two hours to five days. This will help improve the transitional system and better support injured and war vets.
- The VA should conduct quarterly surveys, interviews, and focus groups with PTSD war veterans to inquire about their needs, to achieve a more successful transition. Furthermore, the government and VA should also gather data from their representatives on what they feel should be done to improve DTAP for PTSD veterans. This will allow all parties involved to see the different variations from all sides and incorporate better improvements based on the feedback given.
- The VA should ensure every veteran understands the purpose of TAP and DTAP; by doing face-to-face close out interviews when the program is completed by the vet. This will allow for all veterans to understand the difference of the programs and how they may or may not benefit. It would

also be wise for the program representatives make it clear at the initial briefing to the veterans, on who can partake in DTAP, as well as how it can help them successfully transition.

- The VA should provide monthly tactical staff development trainings for all representatives in DTAP. This will ensure that they are well knowledgeable on the benefits and medical support available to these veterans.
- The VA should have licensed mental health counselors at all DTAP workshops to better support these veterans and questions regarding their mental health injuries. This will also ensure to eliminate the many side effects these veterans are faced with daily.
- The VA should implement a veteran peer mentoring program to help provide insights on the transitional processes, changes that will take place, what to expect from the programs, and provide moral support and camaraderie through their entire journey transitioning out. This program would consist of both active duty and transitioned veterans who can support these veterans in their transitional processes.
- The Military Branches should conduct surveys, interviews, and focus groups with active duty service members to see what they are expecting from DTAP and what they are looking for when it comes to medical support. The active duty branches should also collect data from all upper leadership staff on what they feel needs to be done. This will help reveal the variations between the active duty member's needs, what the upper active duty staff sees as relevant, and what services are needed.

- The Military Branches lead commands need to ensure that all active duty branches have VA and mental health staff available for all veterans exiting out of the military. This will allow for these veterans to ask questions before entering in the transitional programs that are more pinpointed to their out-processing concerns, medical needs, and overall thoughts on transitioning out. This could help identify serious medical injuries that need attention, as well as relieve some tension off the veterans before going through the transitional processes. Essentially, providing support before the transitional change.

Recommendations for Further Research

The following are recommendations for future research on OEF/OIF PTSD veterans who are transitioning out of the military through DTAP:

Recommendation 1

Researchers should replicate this phenomenological study using current 2018 OEF/OIF veterans transitioning out with PTSD around the United States or even world-wide. This would broaden the research study and expand upon the issues at hand within DTAP, rather than staying focused on a specific organization or location.

Recommendation 2

Researchers should explore focusing in on OEF/OIF female veterans transitioning with PTSD and the quality of care they receive. This type of study, either mixed method or phenomenological, would consist of comparing and contrasting the lived experiences/perceptions of the metal health care among female OEF/OIF PTSD veterans, throughout the military branches. This type of study would help reveal the differences of

treatment among men and women veterans, as well how many female veterans report their PTSD disabilities.

Recommendation 3

Researchers should further replicate this phenomenological study by using a descriptive mixed-methods research design. Mixing methods as such, would help give more stabilization with the data collection and analysis; by obtaining and providing greater quantities of information, more pinpointed data, and more in depth analysis of the data. This would help provide more extensive data and give the researchers information that would be overlooked using just one methodology.

Recommendation 4

Researchers should explore the quality of transitional care provided to PTSD war veterans, perceived by the medical health providers. Rather than focusing in on the views of veterans, this type of study would take the view of the transitional medical providers and how they see these veterans are being treated. Researchers could measure the quality of transitional care provided in the VA system, focusing in on the effectiveness of the care from the provider's viewpoint.

Recommendation 5

A study examining OEF/OIF veterans who transitioned out of the military without disabilities should be assessed. Examining these individuals, would allow for an even more diverse study providing data on the effectiveness of the transitional system overall. This would help the researcher reveal the underlining issues among all separating war veterans and the many issues they are faced with without known disabilities.

Recommendation 6

An additional recommendation for future research would be to study the treatments PTSD war veterans receive while on active duty. Rather than looking at the effects of the VA systems, this study would focus in on the active duty medical systems in place for PTSD veterans who return from war. This study will help compare and contrast systematic issues these veterans face at the active duty medical facilities around the United States. Looking particularly at those whom return within the first 90 days of deployment and have recognize PTSD symptoms. This could help better understand the effects that war has on these veterans and the beginning stages of transitional issues they face.

Concluding Remarks and Reflections

"It's about how we treat our veterans every single day of the year. It's about making sure they have the care they need and the benefits that they've earned when they come home. It's about serving all of you as well as you've served the United States of America."

- Barack Obama

Suffering with PTSD issues obtained from an OIF war zone and transitioning through DTAP I was encouraged to conduct this study predominantly to expand understanding and awareness on the significance of having an effective transitional assistance program to better support our war veterans. As an OIF PTSD war veteran, I reflected on my experiences being at war, coming home with anxiety, insomnia, night sweats, transitional issues with family, friends, and society. Remembering that it was not easy when the United States Army said I was no longer fit for duty and had to be processed out due to my mental and medical inquiry issues. Being a veteran transitioning

through DTAP, I remember the process as being disappointing, untrustworthy, and not helpful in my transitions. Once transitioned, I saw the many flaws and opportunities for improvement from both a veterans and educational researcher perspective. The DTAP is a service that requires steady and persistent attention, commitment, structure, desire, and unswerving innovation from the U.S. Government, U.S. Armed Forces, and VA system.

What is it that OEF/OIF PTSD veterans need while transitioning to help eliminate these horrible side effects? This was a revolving question I had during a meeting with the VFW leadership team. It was expressed that they need support, the ability to find normalcy in the civilian world, the ability to express their mental health issues without being judged, and medical attention that suits their needs. Speaking with these VFW members, it was expressed that the VA does not help much and that is why the VFW was initially created to help war veterans with their transitional needs. In fact, one war veteran shared that if it was not for the VFW helping him with his VA claim and being a representative for him, he would have never been compensated or seen for his war injuries. This resonated with me and I was prompted to seek more answers on the many issues that OEF/OIF PTSD veterans are faced with transitioning and possible answers to fix the many challenges that arise.

Throughout my Army career, I have witnessed many veterans exit out of the military- not receiving the proper care they needed. Moving into the civilian sector and understanding the surfacing issues my counterparts received, it was clear that there was an issue that needed to be addressed. Although this study may not fix everything that the veteran participants addressed in this study, I am is hopeful that it can be used as a stepping stone in finding better ways to improve the transitional system; which can also

help eliminate the many issues war veterans are faced with daily outside of the military. It is our duty to help pay it forward to those who protect us, risk their own lives, and commit to making sure there is freedom for all. Understanding and listening to the veterans that participated in this study was so rewarding. I was able to learn from the experiences of veterans from all backgrounds and understand that they can be the voices of change for future transitioning veterans. It is my hope that the findings from this study will be eye opening to the world around us and greater action begins to unveil.

I am so grateful to say to all my veteran participants, thank you for the time and commitment in sharing your stories and experiences. Without you this study would not have been possible. Your commitment, dedication, and sacrifice to this country is appreciated on so many levels and will be forever praised. Here is to future changes in the transitional system and I thank you from the bottom of my heart for your generosity and trust.

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APPENDICES

APPENDIX A

Synthesis Matrix

Synthesis Matrix	THEMES	Methodology/Theory	Transitioning	Mental Health	PTSD	Veterans & Symptoms	OEF/OIF	DoD/VA Medical System	TAPS/DTAP
REFERENCES									
Adams, C. (2016, July 28). 2.5 Million went to war in Iraq and Afghanistan: Many returned with lifelong scars.			x	x	x	x	x		
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American Psychiatric Association. (2004). Practice guidelines for the treatment of patients with acute stress disorder and posttraumatic stress disorder.			x	x	x				
American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders.			x			x	x	x	
AMITA Health (2015). Virtual Reality Offers Hope for Veterans.		x							
Amstadter, A. B., McCart, M. R., & Ruggiero, K. J. (2007). Psychosocial interventions for adults with crime-related PTSD.			x	x	x	x	x		

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Anderson, M. L., Goodman, J., & Schlossberg, N. K. (2012). Counseling adult's in transition: Linking Schlossberg's theory with practice in a diverse world.		x	x	x					
Angermeyer, M.C., Matschinger, H., & Riedel-Heller, S.G. (1999). Whom to ask for help in case of a mental disorder?			x	x	x	x	x		
Arman, N. N. (2016). Tales from the Field- A Phenomenological Study on the Unique Challenges Iraq: Afghanistan PTSD Veterans Experience While Attending a Community College in Southern California. (Doctoral Dissertation).		x	x	x	x	x	x	x	
Asnaani, A., Reddy, M.K., & Shea, M.T. (2014). The impact of PTSD symptoms on physical and mental health functioning in returning Veterans.			x	x	x	x	x	x	x
Avery, M., & McDevitt-Murphy, M. (2014). Impact of Combat and Social Support on PTSD and Alcohol Consumption in OEF/OIF Veterans.						x	x		
Baker, K. A. (2011). The Effect of Post Traumatic Stress Disorder on Military Leadership- An Historical Perspective.			x	x	x	x	x	x	

Bartone, P. T. (2006). Resilience under military operational stress: Can leaders influence hardiness?			x	x		x	x		
Bascetta, C. A., & General Accounting Office, W. D. C. (2002). Military and Veterans' Benefits: Observations on the Transition Assistance Program. Testimony before the Subcommittee on Benefits, Committee on Veterans' Affairs, House of Representatives.			x	x	x		x	x	
Bass, E., & Golding, H. (2012). The Veterans Health Administration's treatment of PTSD and traumatic brain injury among recent combat veterans.				x	x	x	x		
Bateman, D. J. (2011). PTSD symptoms and occupational termination in the U.S. Army. (Doctoral Dissertation).		x		x					
Berger, J. L. (2015). Factors affecting post deployments social support and help seeking during OEF/OIF veterans readjustment to civilian life. (Doctoral Dissertation).			x	x	x	x	x		
Berglass, N. (2010). America's duty: The imperative of a new approach to warrior and veteran care.			x	x	x	x		x	
Betthauser, L. M. (2016). PTSD, play, and relationship satisfaction in OEF/OIF veterans. (Doctoral Dissertation).		x		x	x	x			

Bloomberg, L., & Volpe, M. (2008). Completing your qualitative dissertation: A roadmap from beginning to end		x							
Binneveld, J. M. W. (1997). From shell shock to combat stress: A comparative history of military psychiatry.				x	x	x	x		
Bliese, P.D., Wright, K.M., Adler, A.B., Thomas, J.L., & Hoge, C.W. (2007). Timing of Post combat mental health assessments.			x	x	x	x		x	
Bogacz, T. (n.d). War Neurosis and Cultural-Change in England, 1914-22: The Work of The War-Office Committee-of-Enquiry into Shell-Shock.			x	x	x	x			
Bolton, E. E., Lambert, J. F., Wolf, E. J., Raja, S., Varra, A. A., & Fisher, L. M. (2004). Evaluating a Cognitive-Behavioral Group Treatment Program for Veterans With Posttraumatic Stress Disorder.				x	x	x	x	x	
Brancu, M., Straits-Tröster, K., & Kudler, H. (2011). Behavioral health conditions among military personnel and Veterans: Prevalence and best practices for treatment.		x	x			x			
Brown, N. D. (2008). Transition from the Afghanistan and Iraqi Battlefields to Home.			x	x	x	x	x	x	x
Brunger, H., Serrato, J., & Ogden, J. (2013). 'No man's land': The transition to civilian life.			x			x			

Buckley, K. (2013). Report: Veterans Affairs Fails to Curb Suicide Epidemic, Report.			x	x		x	x	x	
Burnett, S. E., & Segoria, J. (2009). Collaboration for Military Transition Students from Combat to College: It Takes a Community.			x			x	x		
Card-Mina, M. L. (2011). Leadership and post-traumatic stress symptoms.			x	x		x		x	x
Chandrasekaren, R. (2014). A Legacy of Pain and Pride.		x	x	x	x	x			
Chase, S. (2014). Assessing the mental health needs of returning deployed: An action research study.			x	x	x	x	x	x	x
Church, T. E. (2009). Returning Veterans on Campus with War Related Injuries and the Long Road Back Home.			x	x	x	x			
Cifu, D. X., MD & Blake, C. (2011). Post-Deployment Syndrome: The Illness of War.			x	x	x	x			
Cohen, B. E., Gima, K., Bertenthal, D., Kim, S., Marmar, C. R., & Seal, K. H. (2010). Mental Health Diagnoses and Utilization of VA Non-Mental Health Medical Services Among Returning Iraq and Afghanistan Veterans.			x	x		x	x		x
Cohen, E., Zerach, G., & Solomon, Z. (2011). The implication of combat-induced stress reaction, PTSD, and attachment in parenting among war veterans.			x	x	x	x	x	x	x

Costello, C. (2015). PTSD veteran: I'm not crazy.			x	x	x	x	x		
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Creswell, J. W. (2013). Research design: Qualitative, quantitative, and mixed methods approaches (4th ed.).		x							
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Department of Defense (DoD) (1999). Combat Stress Control (CSC) Programs; DOD Directives 6490.5.			x	x	x	x	x		
Department of Defense (DoD) (2013). Defense Casualty Analysis System.			x	x		x		x	
Department of Defense (DoD) (2014). Transition Assistance Program (TAP), TAP101/ Overview Info Sheet.			x	x				x	x
Department of Defense (2017). About.			x					x	x
Diamond, A. M. (2012). The adaptive military transition theory: Supporting military students in academic environments (Doctoral Dissertation).		x	x	x	x	x		x	x

Draper, D. A. (2014). Ongoing and Past Work Identified Access Problems That May Delay Needed Medical Care for Veterans.			x			x		x	x
Eaton, J. (2013). From Warrior to Civilian: An Exploratory Look at the Warrior Archetype in Military Veterans and the Effects of Transitioning Back to Civilian Life. (Doctoral Dissertation).			x	x	x	x	x	x	
Eber, S., Barth, S., Kang, H., Mahan, C., Dursa, E., & Schneiderman, A. (2013). The national health study for a new generation of United States veterans: Methods for a large-scale study on the health of recent veterans.			x	x	x	x	x		
Erbes, C., Curry, K., & Leskela, J. (2010). Treatment presentation and adherence of Iraq/Afghanistan Era veterans in outpatient care for posttraumatic stress disorder'.			x	x	x	x	x	x	x
Flipp, C. (2014, January 15). Qualitative vs. Quantitative. [Video File].		x							
Flournoy, M. A. (2014). We aren't doing enough to help veterans transition to civilian life.				x	x				
Fontana, A., & Rosenheck, R. (2008). Treatment seeking veterans of Iraq and Afghanistan: Comparison with veterans of previous wars.			x	x	x	x	x	x	
Forkin, K. A. (2015). Transition Assistance. Marine Corps Gazette.			x					x	x

Gaudet, T. (2014). Transforming the Veterans Health Administration System: Personalized, Proactive, and Patient-Centered Care.			x	x		x		x	x
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Goldsmith, J. M. (2015). Combat Stress Reaction (CSR).				x	x	x			
Haecker, F. R. (2014). Female student veterans postsecondary education experience (Doctoral dissertation).		x	x			x			
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Heflin, C. M., Hodges, L. B., & London, A. S. (2016). TAPped Out: A Study of the Department of Defense's Transition Assistance Program.			x					x	x

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Hicks, L., Weiss, E. L., Coll, J. E. (2017). The Civilian Lives of U.S. Veterans: Issues and Identities [2 volumes].			x			x		x	x
Hoge, C. W., Auchterlonie, J. L., & Milliken, C. S. (2006). Mental health problems, use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan.			x	x	x	x	x	x	x
Hoge, C.W., Castro, C.A., Messer, S.C., McGurk, D., Cotting, D.I., & Koffman, R.L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care.			x	x	x	x	x	x	x
Hoge, C.W., Terhakopian, A., Castro, C.A., Messer, S.C., & Engel, C.C. (2007). Association of posttraumatic stress disorder with somatic symptoms, health care visits, and absenteeism among Iraq War Veterans.		x	x					x	
Hyatt, K., Davis, L. L., & Barroso, J. (2014). Chasing the care: soldiers experience following combat-related mild traumatic brain injury.		x	x			x		x	

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James, D. A. (2002). A transitional day treatment program for soldiers with severe post-traumatic stress disorder. (Doctoral Dissertation).		x	x			x		x	x
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Joint Chiefs of Staff. (2007). Deployment and redeployment operations.			x					x	x
Jones, E., Fear, N. T., & Wessely, S. (2007). Shell shock and mild traumatic brain injury: a historical review.				x	x	x	x		
Jones, J. A. (2013). From Nostalgia to Post-Traumatic Stress Disorder: A Mass Society Theory of Psychological Reactions to Combat5.		x	x	x	x	x			
Karairmak, O., & Guloglu, B. (2014). Forgiveness and PTSD among veterans: the mediating role of anger and negative affect.				x	x	x	x		
Kelley, M. B. (2012). The US Government Is Failing Miserably at Helping Veterans.				x	x	x	x	x	

Kim, P. (2010). Stigma, Barriers to Care, and Use of Mental Health Services Among Active Duty and National Guard Soldiers After Combat.			x			x		x	
Knetig, J. A. (2012). Mentalization, social competence and the use of social support in a military population: The impact on post-traumatic stress (Doctoral Dissertation).		x	x	x		x		x	
Lazaro-Munoz, G., & Juengst, E. T. (2015). Challenges for Implementing a Ptsd Preventive Genomic Sequencing Program in the U.S. Military.			x	x	x	x	x	x	
Lewis, J., Wassermann, E., Chao, W., Ramage, A., Robin, D., & Clauw, D. (2012). Central sensitization as a component of post-deployment syndrome.			x			x	x		
Lopez, L. M. (2011). The veteran perception: Exploring the role of veterans benefits on the transition from service member to civilian. (10128475 Ph.D.).		x	x	x				x	x
Loughran, D. S. & Klerman, J. A. (2008). Explaining the Increase in Unemployment Compensation for ex-Service Members During the Global War on Terror.			x			x	x		
MacGregor, A. J., Shaffer, R. A., Dougherty, A. L., Galarneau, M. R., Raman, R., Baker, D. G., Corson, K. S. (2009). Psychological correlates of battle and nonbattle injury among Operation Iraqi Freedom veterans.			x	x	x	x	x	x	

Mazzucchi, J. F. (1997). Joint Preventive Medicine Policy Group Charter.			x	x		x	x		
McMillan, J. H., & Schumacher, S. (2010). Research in education evidence-based inquiry (7th ed.).		x							
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Myers, M. D. (2009). Qualitative research in business and management.		x							
National Defense Authorization Act for Fiscal Year 1991, P.L. 101-510 .			x				x	x	
Navy Live (2015). Transition Assistance- Resources that Unlock the Future.			x					x	x
Navy Personnel Command (2017). Transition GPS.			x					x	x
Nicholson, W. F. (2015). Qualitative Study of the United States Marine Corps Wounded Warrior Regiment. (Doctoral Dissertation).		x	x	x	x	x	x	x	

Ostovary, F., & Dapprich, J. (2011). Challenges and Opportunities of Operation Enduring Freedom/Operation Iraqi Freedom Veterans with Disabilities Transitioning into Learning and Workplace Environments.			x	x	x	x	x	x	x
Panangala, S. V. (2016). Health Care for Veterans: Answers to Frequently Asked Questions.				x		x		x	x
Patton, M. (2015). Qualitative research and evaluation methods (4th Edition).		x							
Patten, M. L. (2009). Understanding research methods: An overview of the essentials (7th ed.).		x							
Pezalla, A. E. Pettigrew, J., & Miller-Day, M. (2012). Researching the researcher-as-instrument: An exercise in interviewer self-reflexivity.		x							
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Ramchand, R., Karney, B. R., Osilla, K. C., Burns, R. M., & Caldarone, L. B. (2008). Prevalence of PTSD, depression, and TBI among returning service members.			x	x	x	x	x		

Roberts, C. M. (2010). The dissertation journey: A practical and comprehensive guide to planning, writing, and defending your dissertation (2nd ed.)		x						
Ruscio, A. M., Weathers, F. W., King, L. A., & King, D. W (2002). Male war-zone veterans' perceived relationships with their children: The importance of emotional numbing.				x	x	x	x		
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Saxon, A.J. (2011). Returning Veterans with Additions.			x			x		x	
Schlossberg, N. K. (1981). A model for analyzing human adaptation to transition.		x	x						
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Sherman, S. S. (2016). Military Preventive Medicine: Mobilization and Deployment.		x	x	x		x	x	x	
Solomon, Z. (1993). Combat stress reaction: The enduring toll of war.				x	x	x			
Spelman, J. F., Hunt, S. C., Seal, K. H., & Burgo-Black, A. L. (2012). Post deployment care for returning combat veterans.			x	x	x	x	x		
Stagner, A. C. (2014). Defining the Soldier's Wounds- U.S. Shell Shock in International Perspective (Doctoral Dissertation).			x	x	x	x	x	x	
Stecker, T., Fortney, J. C., Hamilton, F., & Ajzen, I. (2007). An assessment of beliefs about mental health care among Veterans who served in Iraq.			x	x	x	x	x	x	
Stecker, T., Fortney, J., Hamilton, F., Sherbourne, C.D., & Ajzen, I. (2010). Engagement in mental health treatment among Veterans returning from Iraq.			x	x	x	x	x	x	
Stecker, T., Shiner, B., Watts, B.V., Jones, M., & Conner, K.R. (2013). Treatment seeking barriers for Veterans of the Iraq and Afghanistan conflicts who screen positive for PTSD.			x	x	x	x	x	x	
Substance Abuse and Mental Health Services Administration (SAMHSA) (2013)Behavioral Health Issues Among Afghanistan and Iraq U.S. War Veterans.				x	x	x	x	x	

Sundin, J., Fear, N., Iversen, A., Rona, R., & Wessely, S. (n.d). PTSD after deployment to Iraq: conflicting rates, conflicting claims.			x	x	x	x	x	x	
Tanielian, T. L., Rand, C., California Community, F., Jaycox, L., & Health, R. (2008). Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery.			x	x	x	x	x		
Transition Assistance Program (TAP) (2016). Careers for Transitioning Military: TAOnline.			x					x	x
United States Army (2016, July 12). Soldier for Life: Transition Assistance Program.			x					x	x
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United States Government Accountability Office. (2011, October). Number of veterans receiving care, barriers faced, and efforts to increase access.			x		x	x	x	x	x
United States Marine Corps (2017). Transition Readiness.			x					x	x

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U.S. Department of Labor (1995). Veterans Employment and Training. Transition Assistance Program: Phase III Impact Analysis.			x					x	x
U.S. Department of Veteran Affairs (2012). Summary of Benefits: FY2000 to 2012.			x	x	x	x	x	x	x
U.S. Department of Veterans Affairs. (2014). VA core values and characteristics.								x	x
U.S. Department of Veterans Affairs (2015a). Date and names of conflicts.							x	x	
U.S Department of Veteran Affairs (2015b). Mental Health Effects of Serving in Afghanistan and Iraq.			x	x	x	x	x	x	
U.S. Department of Veteran Affairs (2016a). Transition Assistance Program.			x	x				x	x
U.S. Department of Veteran Affairs (2016b). VA Suicide Prevention Program: Facts about Veteran Suicide.			x	x	x	x	x		
U.S. Department of Veteran Affairs. (19 January 2017). I Care core values.								x	x

U.S. Department of Veteran Affairs. (2017a). PTSD: National center for PTSD.					x		x	
U.S. Department of Veteran Affairs (2017b). VA History in Brief.			x	x	x	x	x	x	
U.S. Department of Veteran Affairs Health Administration (2015). VA Marks 81 Years of Service to America's Veterans.			x				x	x
U.S. Department of Veteran Affairs Office Inspector General (2007). Audit of Vocational Rehabilitation and Employment Program Operations.							x	x
U.S. Department of Veterans Affairs, Vocational Rehabilitation and Employment (2016). Eligibility and Entitlement.			x	x			x	x	x
U.S. General Accounting Office, Military and Veterans' Benefits: Observations on the Transition Assistance Program.			x				x	x
Vasterling, J. (2006). Neuropsychological Outcomes of Army Personnel Following Deployment to the Iraq War.			x	x	x	x		
Veterans Authority (2016). The Disabled Transition Assistance Program.			x	x	x	x	x	x	x
Veterans Health Administration (2008, August). Analysis of VA health care utilization among US Southwest Asian war veterans, Operation Iraqi Freedom, Operation Enduring Freedom.			x	x	x	x	x	x

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Walker, R., Clark, M., & Sanders, S. (n.d). The "Postdeployment Multi-Symptom Disorder": An Emerging Syndrome in Need of a New Treatment Paradigm.			x	x	x	x			
War Related Illness & Injury Study Center (WRIISC) (2014). Operation Ensuring Freedom, Operation Iraqi Freedom, and Operation New Dawn.			x	x	x	x	x	x	
Waters, E., Corcoran, D., & Anafarta, M. (2005). Attachment, other relationships, and the theory that all good things go together.		x	x						
Watkins, K. E., Pincus, H. A., Smith, B., Paddock, S. M., Mannle Jr, T. E., Woodroffe, A., & Call, C. (2011). Veterans Health Administration mental health program evaluation.			x			x		x	x
Westwood, M., McLean, H., Cave, D., Borgen, W., & Slakov, P. (2010). Coming home: a group-based approach for assisting military verterans in transition.			x	x	x	x	x	x	
Wheeler, D. P., & Bragin, M. (2007). Bringing it all back home: social work and the challenge of returning veterans.			x	x	x	x	x	x	
Winter, J. (2000). Shell-Shock and the Cultural History of the Great War.			x	x	x	x			
Yates, J., & Leggett, T. (2016). Qualitative Research: An Introduction.		x							

APPENDIX B

Interview Script

Date/Time:

Veteran #:

Interviewer: Tiffany D. Ware

Interview time: Approximately 30 to 60 minutes

Interview location: San Diego VFW 3788

Recording devices: Digital recorder, video recorder, journal

Introduction: Thank you for agreeing to participate in this interview. As a member of VFW 3788 and US Army veteran, I understand the many issues we all face. Your participation in this study can help future veterans and assist in bettering the transitional system in place. Your help is very much appreciated and know that it is all confidential and between me and you only. The purpose of this dissertation study was to describe the perceptions of Operation Enduring and Iraqi Freedom veterans with PTSD, who are transitioning from active duty to civilian life, regarding their participation in the Disabled Transition Assistance Program.

This study will fill in the gap in the research regarding your perceptions as an Operation Enduring and Iraqi Freedom veteran with PTSD, transitioning from active duty to civilian life, regarding your participation in the Disabled Transition Assistance Program. Results from this study will help reveal what you as a veteran go through while transitioning out of the military using the Veteran Affairs (VA) DTAP, identifying the following: areas that lack in the program, further programs that maybe needed and systems these veterans feel would be most beneficial. The results of this study may assist the VA and Armed Forces in the tools needed to help these veterans overcome possible barriers that restricts their use of the VA mental health services and transition programs. In addition, it can help the VA find a better medical system, program, or early intervention that assists the transition of these veterans more efficiently, understanding the changes that will occur overtime. Leading to the elimination of the common side effects that yourself and other veterans alike deal with.

As you know, information from this interview will be incorporated in my dissertation findings. To ensure that your identity is not revealed, you will be recognized as veteran 1,2,3 etc. Only you and I will know your veteran number and this is my promise. While you have signed the consent form to participate in this dissertation study, you have the right to choose to withdraw from this study at any time. Are there any further questions or concerns before we begin this interview process?

Interview Questions:

1. What events led to your medical separation or transition out of active duty into the civilian sector?
2. How would you define the transitional process through the VA?
3. How would you explain the information and process established through the DTAP?
4. How would you describe the care provided to other veterans by the DTAP at the VA?
5. How would you describe the information shared with you by the transitional assistance program (TAP) on DTAP?
6. How would you describe the information shared with other OEF/OIF PTSD veterans by the DTAP?
7. How did the DTAP help or support with your transition process?
8. How could the DTAP be changed to better support OEF/OIF veterans with PTSD needs related to transition?
9. What challenges can you describe as a OEF/OIF PTSD veteran, that may have obstructed your ability to fully transition into the civilian life?
10. What types of issues have you as a OEF/OIF PTSD veteran been faced with while transitioning through this program?

Closing Script

This concludes the interview questions that I have for you at this time. Thank you for taking your time out to sit down with me for my study. All information shared will not be displayed with your direct information and will only be identified in my study as your assignment veteran number. Confidentiality will be followed and it is my promise to keep it that way. If you have any further questions please let me know, or if you think about them later please feel free to reach out. Your help can possibly make history, thanks so much!

APPENDIX C

Interview Observer Feedback Reflection Questions

Conducting interviews is a learned skill set/experience. Gaining valuable insight about your interview skills and affect with the interview will support your data gathering when interviewing the actual participants. As the researcher, you should reflect on the questions below after completing the interview. You should also discuss the following reflection questions with your 'observer' after completing the interview field test. The questions are written from your perspective as the interviewer. However, you can verbalize your thoughts with the observer and they can add valuable insight from their observation.

1. How long did the interview take? _____ Did the time seem to be appropriate?
2. How did you feel during the interview? Comfortable? Nervous?
3. Going into it, did you feel prepared to conduct the interview? Is there something you could have done to be better prepared?
4. What parts of the interview went the most smoothly and why do you think that was the case?
5. Were there parts of the interview that seemed to be awkward and why do you think that was the case?
6. If you were to change any part of the interview, what would it be and how would you change it?
7. Were the interview questions appropriate or should there be adjustments?
8. What suggestions do you have for improving the overall process?

Additional Comments:

_____

_____

_____

_____

APPENDIX D

Interview Critique by Participants

As a doctoral student and researcher at Brandman University your assistance is so appreciated in designing this interview instrument. Your participation is crucial to the development of a valid and reliable instrument.

Below are some questions that I appreciate your answering after completing the interview. Your answers will assist me in refining both the directions and the interview items.
You have been provided with a paper copy of the interview, to remind you of the questions asked in case it is needed.

1. How many minutes did it take you to complete the interview, from the moment the interviewee spoke until closing? _____

2. Did the questions ask upfront for you to read the consent information and sign the agreement before the interview began concern you at all? _____
   If so, would you briefly state your concern _____
   _____
   _____

3. Was the Introduction sufficiently clear (and not too long) to inform you what the research was about? _____ If not, what would you recommend that would make it better?
   _____
   _____
   _____

4. Were the directions clear, and you understood what to do? _____
   If not, would you briefly state the problem _____
   _____
   _____

5. Were the interview questions clear, appropriate, and easy to understand? _____ If not, briefly describe the problem _____
   _____
   _____

6. As you progressed through the interview, were their questions that arose as to why the question asked was necessary or further explanation was needed regarding the question? _____ If so, would you briefly state so and the interview questions of concern (*please highlight the questions on the interview paper given or state the # here)*
   _____
   _____
   _____

Additional Comments:

_____
_____

Thanks so much for your help!

APPENDIX E

Confirmation Request

September 1, 2017

Dear Commander of VFW 3788

I am a VFW member and current doctoral candidate at Brandman University. I am conducting a study on *the experiences and perceptions of Operation Enduring and Iraqi Freedom veterans with PTSD, who are transitioning from active duty to civilian life, regarding their participation in the Disabled Transition Assistance Program.*

I am asking you for your assistance by granting me the permission to recruit veterans within your organization to participate in this study. An email has been drafted for the purpose of recruiting veterans with PTSD who served in the OEF/OIF war zones transitioning out through DTAP. My recruiting method consist of sending the drafted email through your organization as a correspondence with your approval.

If you agree to afford me this opportunity, then please email me at tware@mail.brandman.edu. A formal consent to conduct the research in the VFW on the organizations letterhead or through email that includes the VFW information would be greatly appreciated.

Please note that all data collected will be completely confidential. No names will be attached to any notes or records from the interview. All information will remain in the locked files accessible only to the researcher. No one will have access to the interview information other than the participants.

I am available at xxx-xxx-xxxx or by email, to answer any questions you may have. Your contribution to this study would be greatly valued.

Sincerely,

Tiffany Ware

APPENDIX F

Social Media Participation Recruitment Flyer

APPENDIX G

Participant Email Communication

Requestor: Tiffany D. Ware, doctoral candidate (Brandman University)

Population: OEF/OIF PTSD veterans who went through the Disabled Transition Assistance Program (DTAP) and is part of the San Diego, CA Veteran of Foreign Wars (VFW) 3788.

Purpose: To identify research participants for the study

Sender: tware@mail.brandman.edu

Message: Greetings Fellow VFW members, I am Tiffany Ware, VFW post 3788's current webmaster and VOD chair. I am currently a doctoral candidate in the Organizational Leadership program at Brandman University. As a OIF PTSD Army veteran and Human Resources expert, I am seeking to better understand the experiences and perceptions of Operation Enduring and Iraqi Freedom veterans with PTSD, who are transitioning from active duty to civilian life, regarding their participation in the Disabled Transition Assistance Program. Due to the large amount of this population, I decided to funnel in on the San Diego, CA VFW 3788 veterans, as it would be most appropriate. In additional to this study, it is my hopes that the results from this study will help reveal what these veterans go through while transitioning out of the military using the VA's DTAP, identifying the following: areas that lack in the program, further programs that maybe needed and systems these veterans feel would be most beneficial. The results of this study may assist the VA and Armed Forces in the tools needed to help these veterans overcome possible barriers that restricts their use of the VA mental health services and transition programs.

I would like to invite you to contribute to this study by participating in an individual interview that will last between 30-60 minutes. If you agree to participate in an interview, you may be assured that it will be completely confidential. No names will be attached to any notes or records from the interview. All information will remain in locked files accessible only to the researchers. All information will remain in locked files accessible only to the researchers. No VFW leaders or members will have access to the interview information. You will be free to stop the interview and withdraw from the study at any time. You are encouraged to ask any questions, at any time, that will help you better understand the study.

To participate in this study, you must meet all the following conditions:

1. OEF/OIF veteran.
2. Diagnosed with PTSD.
3. Discharged from the U.S. Armed Forces (separation, retirement, or medical).
4. Went through the DTAP while transitioning out of the Military service.

5. Receiving mental health care through VA system and associated transitional programs at the time of the study.

For further questions concerning participation in this study please do not hesitate to contact me by email at tware@mail.brandman.edu or by phone at (808) 225-1999. You may also You may also contact or write the Office of the Executive Vice Chancellor of Academic Affairs, Brandman University, 16355 Laguna Canyon Road, Irvine, CA 92618 (949) 341-7641.

Thank you so much for your time and your consideration.

Respectfully,

Tiffany Ware

APPENDIX H

National Institute of Health (NIH) Clearance

Certificate of Completion

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

Date of completion: 05/01/2016.

Certification Number: 2067054.

APPENDIX I

BUIRB Approval Form

Dear Tiffany D. Ware,

Congratulations, your IRB application to conduct research has been approved by the Brandman University Institutional Review Board. This approval grants permission for you to proceed with data collection for your research. Please keep this email for your records, as it will need to be included in your research appendix.

If any issues should arise that are pertinent to your IRB approval, please contact the IRB immediately at BUIRB@brandman.edu. If you need to modify your BUIRB application for any reason, please fill out the "Application Modification Form" before proceeding with your research. The Modification form can be found at the following link: https://irb.brandman.edu/Applications/Modification.pdf.

Best wishes for a successful completion of your study.

Thank you,
Doug DeVore, Ed.D.
Professor
Organizational Leadership
BUIRB Chair
ddevore@brandman.edu
www.brandman.edu

APPENDIX J

Informed Consent Form

DATE:

INFORMATION ABOUT: From War to Home: The Systematic Issues Operation Enduring and Iraqi Freedom Veterans Face Transitioning with PTSD

RESPONSIBLE INVESTIGATOR: Tiffany D. Ware, MAOL.

PURPOSE OF STUDY: The purpose of this phenomenological study was to describe the perceptions of Operation Enduring and Iraqi Freedom veterans with PTSD, who are transitioning from active duty to civilian life, regarding their participation in the Disabled Transition Assistance Program.

This study will fill in the gap in the research regarding the perceptions of Operation Enduring and Iraqi Freedom veterans with PTSD, who are transitioning from active duty to civilian life, regarding their participation in the Disabled Transition Assistance Program. Results from this study will help reveal what these veterans go through while transitioning out of the military using the Veteran Affairs (VA) DTAP, identifying the following: areas that lack in the program, further programs that maybe needed and systems these veterans feel would be most beneficial. The results of this study may assist the VA and Armed Forces in the tools needed to help these veterans overcome possible barriers that restricts their use of the VA mental health services and transition programs. In addition, it can help the VA find a better medical system, program, or early intervention that assists the transition of these veterans more efficiently, understanding the changes that will occur overtime. Leading to the elimination of the common side effects with these veterans today.

By participating in this study, I agree to participate in a one-on-one, face-to-face interview. The interview will last between 30-60 minutes and not exceed 2 hours, involving just the veteran. Completion of the interview will take place **(place date here).**

I understand that:

a) There are minimal risks associated with participating in this research. I understand that the Investigator will protect my confidentiality by storing any research materials collected during the interview process in a locked file drawer in which only the researcher has access to.

b) The possible benefit of this study to me is that my input may help add to the research regarding OEF/OIF PTSD veterans transitioning through DTAP and the impacts it has on them. The findings will be available to me after the study and will provide new insights about the VA transitional systems in place for these veterans and future solutions.

c) I understand that I will not be compensated for my participation in this study. My participation in this research study is voluntary. I may decide to not participate in the study and I can withdraw at any time. I can also decide not to answer particular questions during the interview if I so choose. I understand that I may refuse to participate or may withdraw from this study at any time without any negative consequences. Also, the Investigator may stop the study at any time.

d) Any questions I have concerning my participation in this study will be answered by Tiffany Ware. She can be reached by email at tware@mail.brandman.edu or by phone at xxx-xxx-xxxx or Dr. Jalin Johnson (Advisor) at jbrooks@brandman.edu or xxx-xxx-xxxx.

e) I understand that the interview will be audio taped. The recordings will be available only to the researcher, and will be used to capture the interview dialogue to ensure the accuracy of the information collected during the interview. Upon completion of the study, all transcripts and notes taken by the researcher during the interview will be shredded.

My participation in this research study is voluntary. I understand that I may refuse to participate in or I may withdraw from this study at any time without negative consequences. Also, the investigator may stop the interview at any time. I also understand that no information that identifies me will be released without my separate consent and that all identifiable information be protected to the limits allowed by law. If the study design or the use of data is to be changed I will be so informed and my consent obtained. I understand that if I have any questions, comments, or concerns about the study or the informed consent process, I may write or call the Office of the Executive Vice Chancellor of Academic Affairs, Brandman University, at 16355 Laguna Canyon Road, Irvine, CA 92618 Telephone (949) 341-7641.

I acknowledge that I have received a copy of this form and the Research participant's Bill of Rights. I have read the above and understand it and hereby consent to the procedure(s) set forth.

_____ _____

Signature of Participant of Responsible Party Date

_____ _____

Signature of Principle Investigator Date

APPENDIX K

Demographic Data Sheet

San Diego, CA VFW Research Study

Title: *From War to Home: The Systematic Issues Operation Enduring and Iraqi Freedom Veterans Face Transitioning with PTSD*

Date of Interview: _____

Time Started: _____

Time Finished: _____

Participant Number (Veteran One, Two, etc.): _____

Age: _____

Gender: _____

Ethnicity

American Indian or Alaska Native _____

Asian _____

Black/African American _____

Native Hawaiian or other Pacific Islander _____

Hispanic or Latino _____

White _____

Date of PTSD diagnoses? _____

Military discharge date? _____

Reason for separation (retirement, medical, expiration term of service/ETS)? _____

Currently Employed (if yes please state position and if not please state why)? _____

_____

APPENDIX L

Participant Bill of Rights

BRANDMAN University Chapman University System

BRANDMAN UNIVERSITY INSTITUTIONAL REVIEW BOARD

Research Participant's Bill of Rights

Any person who is requested to consent to participate as a subject in an experiment, or who is requested to consent on behalf of another, has the following rights:

1. To be told what the study is attempting to discover.
2. To be told what will happen in the study and whether any of the procedures, drugs or devices are different from what would be used in standard practice.
3. To be told about the risks, side effects or discomforts of the things that may happen to him/her.
4. To be told if he/she can expect any benefit from participating and, if so, what the benefits might be.
5. To be told what other choices he/she has and how they may be better or worse than being in the study.
6. To be allowed to ask any questions concerning the study both before agreeing to be involved and during the course of the study.
7. To be told what sort of medical treatment is available if any complications arise.
8. To refuse to participate at all before or after the study is started without any adverse effects.
9. To receive a copy of the signed and dated consent form.
10. To be free of pressures when considering whether he/she wishes to agree to be in the study.

If at any time you have questions regarding a research study, you should ask the researchers to answer them. You also may contact the Brandman University Institutional Review Board, which is concerned with the protection of volunteers in research projects. The Brandman University Institutional Review Board may be contacted either by telephoning the Office of Academic Affairs at (949) 341-9937 or by writing to the Vice Chancellor of Academic Affairs, Brandman University, 16355 Laguna Canyon Road, Irvine, CA, 92618.

Brandman University IRB Adopted November 2013