THE MEANING OF HEALTH CARE SEEKING BEHAVIOR AND RESOURCE USE AMONG MALE VETERANS WHO SERVED IN THE IRAQ AND AFGHANISTAN WARS

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DEDICATION

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ABSTRACT

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THE MEANING OF HEALTH CARE SEEKING BEHAVIOR AND RESOURCE USE AMONG MALE VETERANS WHO SERVED IN THE IRAQ AND AFGHANISTAN WARS

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Iraq and Afghanistan war veterans have unique combat related medical and mental health issues including posttraumatic stress disorder (PTSD) and traumatic brain injuries (TBI). The gap between their increased need for health care and underuse of health care services indicated a need to understand the meaning of health-seeking behaviors of these veterans. The purpose of this hermeneutic phenomenological study was to better understand what seeking healthcare means to the male Iraq and Afghanistan war veterans. Purposive sampling with a snowball strategy was used to recruit twenty male veterans who had been deployed and 90% of who experienced combat. Data were collected in a onetime face-to-face interview using a semi-structured interview guide. Data were analyzed using Ricoeur's data analysis method and hermeneutic circle technique. Four themes emerged that highlighted what help-seeking meant to the veterans: "I'm never a civilian. None of us are ever civilians when we leave combat"; "I don't care so much about thinking I'm weak these days because I got help, so I have

changed my attitude on that"; "It's such a deal with the VA. It's so impersonal and it's such a huge bureaucracy"; and "Thinking about that."

The findings indicate that help seeking is a complex behavior affected by personal, structural, and socio-cultural factors that interplay in any given help-seeking context regardless of health care need. The importance of military culture values is fundamental to what seeking help means to OEF/OIF veterans. Understanding what help-seeking means to the veterans, what factors interact to impact their help-seeking behavior may facilitate formulating policies and VA initiatives that are OEF/OIF veteran-centered and further research about OEF/OIF veterans' help-seeking.

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CHAPTER I

INTRODUCTION

Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) were launched in 2001 and 2003, respectively, marking the United States invasion of Afghanistan and Iraq. Since then, more than 1.6 million US veterans have served in these two wars. Many of these veterans had multiple deployments in one or both wars. Health care issues and concerns for these veterans are numerous. Health care needs during and post deployment can include a host of psychosocial, medical, and mental health issues, physical injuries, and deaths (Reiber et al., 2010; Stecker, et al., 2010; Helmer et al. 2009; Hoge, Auchterlonie, & Milliken, 2006; Hoge et al., 2004; Hoge, et al., 2007; Seal et al., 2009; Milliken, Auchterlonie, & Hoge, 2007; Seal, Bertendthal, Miner, Sen, & Marmar, 2007; Pietrzak et al. 2009; Stecker et al., 2007; Kim, Thomas, Wilk, Castro, & Hoge, 2010; Vogt, 2011). Research indicates a particularly high prevalence of mental health problems such as post-traumatic stress disorder (PTSD), major depression, and generalized anxiety (Hoge et al., 2004; Seal, et al., 2009; Baker et al. 2009; Hoge Auchterlonie, & Milliken, 2006; Cohen et al., 2009).

A review of the treatment of these health care issues has revealed multiple disparities. Barriers contributing to health care disparities include race, lack of health insurance coverage, poverty, low social economic status, lack of health information, and physician trust (Thompson, Talley, Caito, & Kreuter, 2009; Kyung et al., 2010), patient delays

(Carroll et al., 2009), and geographic location (Wong & Regan, 2009). Somnath, Freeman, Toure, Tippens, and Weeks (2007) identified similar sources for health care disparities in the Veterans Affairs (VA) healthcare system, including veterans' medical knowledge, trust and skepticism, racial and cultural milieu, clinician judgment, patient participation, and healthcare facility characteristics.

The VA is an equal access system with initiatives to eliminate health care disparities, and improve health care outcomes for veterans. The VA has initiated programs especially for the Iraq and Afghanistan war veterans that are geared towards increasing access to mental and medical health by streamlining post-deployment screening processes and decreasing wait-time (Randall, 2012). Pre and post deployment health screenings geared towards health assessment are mandated. These include screenings for mental, psychosocial health, and deployment related issues and concerns, to generate appropriate health care referrals. While 78% of the veterans reporting their transition experience as easy, the average wait-time for OEF/OIF veterans to transition from Department of Defense (DOD) to receiving care at the VA was 3.83 months and disparities persisted (Randall, 2012). Hoge et al., (2006) did find that a positive mental screen using the Post Deployment Health Assessment (PDHA) triggered the initiation of mental health referrals, although the number of referrals were low (7.6%), calling into question the efficacy of the screening program.

Some VA studies show that the OEF/OIF veterans with medical and mental health care needs are not seeking and utilizing available health care (Seal et al., 2010; Vogt,

2011) due to concerns about stigmatization, among other barriers (Hoge et al., 2004; Kim, Thomas, Wilk, Castro, and Hoge, 2010). Public stigma and personal beliefs about mental illness contribute to the low use of mental health services (Vogt, 2011). Stecker, Fortney, Hamilton, & Ajzem (2007) found that the participants in their study did not have concerns about access to care. Despite acknowledging the advantages of care and support from others, the study participants experienced barriers such as pride, not being able to ask for help, and not being able to admit to having a problem. These findings highlight that having access to available treatments does not ensure effective health-seeking behaviors in pursuing treatment. OEF/OIF female veterans were found to heavily use outpatient services more than OEF/OIF male veterans, especially women who had medical and mental health issues (Frayne et al. 2007: Maguen et al., 2012).

Statement of Purpose

The purpose of this study is to enhance understanding of what seeking health care means to the OIF/OEF male veterans. The disconnect between veterans' increased need for health care and their relatively low use of health care services indicates a need to seek the meaning of health-seeking behaviors of male veterans of the US Iraq and Afghanistan wars. Having a better understanding of what seeking health care means to the veterans will allow health care providers to develop interventions that lead to increased health-seeking and use of health care resources among this population. The study question is: What is the meaning of seeking health care for United States male veterans who served in the Iraq and Afghanistan wars?

Rationale for the Study

This study will shed more light on what health and health care seeking mean to Iraq and Afghanistan male veterans, what informs their health behaviors, and health care decisions or choices. A better understanding of their perception of health, health belief, attitudes, values, and what prompts or influences them to seek health care or not, should help in initiating realistic interventions that not only focus on access issues but on beliefs and psychological issues. These findings should allow health care providers to develop gender appropriate interventions that may positively impact the health care outcomes of the veterans and increase OEF/OIF veterans' health seeking and resource use.

Study Assumptions

The following assumptions apply to this study

- Humans experience the world through language, are willing and have the abilities to communicate their experiences.
- Humans are intentional rational beings coexisting with the environment and constantly creating patterns of relations that reflect their personal meanings and values.
- Human beings are dynamic, freely choosing, and bear responsibility for decisions
- Participants in this study will be able to accurately and meaningfully describe their experiences.

Philosophical Underpinnings

Heidegger's interpretive phenomenology serves as the philosophical perspective for this study. Phenomenology is both a philosophy and a research method (Smith, 2009; Dowling, 2007). Phenomenology is the study of things as they appear in our experiences-the "lived experiences" ("life-world") (Dowling, 2007). It is the meanings things have in our experiences (Smith, 2009). Thus everyday human experiences are the foundational bases of knowledge and meaning.

Heidegger's Philosophy and Phenomenology (1889-1976)

The centrality of Heidegger's philosophy and phenomenology was ontology, which is the study of "Being" (Sein or presence-in-the-world) through Dasein (being-there or human existence) that endorses the situatedness of human reality in the world (Heidegger, 1962; Korab-Karpowicz, 2009; Walters, 1995). Heidegger emphasized the question of the meaning of Being: What does to exist mean? What is the meaning of Being? What does it mean to be human? The goal of knowledge is ontology through the understanding of everyday life existence and is the basis of all philosophical inquiry (Walters, 1995).

Hermeneutic phenomenology deals with existential issues of everyday life - the everyday interaction of humans with the world. Heidegger acknowledged that personal life experiences, time, and context or "historicality" (enculturation) are foundational to understanding the meaning of Being and rejected the absolute or objective truth about the nature and meaning of Being. Dasien (being-in-the-world) occurs when an individual is

thrown into a pre-existing world that is culturally defined and in which the individual functions to appropriate and project Being (Wheeler et al., 2013). Being is not separated from the world. It is the factor, or thing that makes "beings" (entities) intelligible as entities.

To Heidegger the existential characteristic of Dasein (being-there) are situated and explicated as “understanding” through engaging with the world, “discourse” through language, unlimited to factuality (present-at-hand), but a multiplicity of possibilities (Wheeler et al., 2013). Being is revealed through Dasein (being-in-the-world). Dasein belongs and engages with-the-world to reveal its Being. Heidegger called this interaction with other entities Sorge, meaning care. Therefore care is the Being of Dasein - the primary object of inquiry. Dasein is already familiar with his world and chooses the way to be in its relationships with other beings or entities lending to the multiple possibilities of Being. Humans have the freedom of choice out of many possibilities to-be-in and with-the-world but are limited by historical situations, family, education, self, and society (Wheeler et al., 2013). Hermeneutics provides explanation and understanding of human experience.

The Hermeneutic Circle

Heidegger’s hermeneutics presupposes that pre-knowledge of the world is part of the interpretive process and understanding. Humans are embodied in the world, which provides the contexts of “pre-understanding” for their actions and understanding of the world. Dasein engages with the world and reveals Being (presence-in-the-world) through

language. Interpretation is the mode of explicating and understanding the nature of a phenomenon through the application of fore-structures. Interpretation is circular, in perpetual self-discovery or re-interpretations of possibilities to reveal Dasein that is hidden and situated in the world - a hermeneutic circle.

Hermeneutics allows for multiple truths as the text presents its world differently to individual interpreters leading to multiple appropriated meanings. The hermeneutic circle allows the process of interpreting the data to move from consideration of the whole to parts and from parts to whole to foster an understanding of the data in relation to emerging interpretations and meanings of the texts (Whitehead, 2004), and as subsequent data information are collected and analyzed. The ongoing forward and backward movement, through interactions from self to event and event to self, leads to understanding that reveals the meaning of the phenomenon (Charalambous et al., 2008).

The circle holds the possibilities of knowing and understanding and must be entered in the right way through fore-structures. The task of interpretation is to work constantly with fore-conception to work out the fore-structures of the things themselves (Heidegger, 1962). To better understand Being, the researcher or interpreter brings to the inquiry presuppositions that preempt understanding, but is open to enhancement, revision, and replacement (Wheeler et al., 2013). Understanding results from a culturally defined and subjective relationship between researcher and the text to reveal the meaning of the phenomenon. Dasein's Being (existence) is constantly evolving and incomplete but ultimately ends in death, a temporal nothingness. Temporality is an internal feature of

Dasein's existence; it is a connectedness against which past, present, and future stand out as horizons while remaining interlocked (Wheeler et al., 2013). Horizons limit and in so doing disclose possibilities. The nature of Being is revealed through Dasein and language interpretation. Dasein unifies the past, the present, and the future and is the only way of achieving understanding.

The research approach for the study is dependent on the research question and the focus on understanding OEF/OIF veterans' experiences of seeking help and using health care resources. The study is not an abstraction or objectified description but a pragmatic inquiry of seeking knowledge from the veterans of their experiences of help-seeking to explicate meaning in order to understand their experiences in the context of environment and culture. Meaning is co-constituted with the environment and "lies in the individual's transaction with a situation such that the situation constitutes the individual and the individual constitutes the situation" (Annells 1996, p. 708).

The study's phenomenological approach is equally compatible with nursing as a human science dealing with individuals' lived experiences as beings-in-the-world. Heidegger's hermeneutic phenomenology will guide the method of data collection using semi-structured interviews with open-ended questions to discover the meaning of the phenomena of help-seeking and resource use by OEF/OIF male veterans. The interview narratives (as transcribed texts) are thus co-creations between the participants and the researcher. Heidegger's philosophy is centered on the meaning of Being. The subjectivity and pre-knowledge that are allowed in Heidegger's hermeneutics phenomenology support

the researcher to fully engage with the study participants during data collection and analysis through applying an understanding of the hermeneutic circle to reveal what help-seeking means to the OEF/OIF veterans.

The contextual nature (historicality) of human existence equally illuminates the assumptions of the study, as shaped by ones background (culture), past experiences, and history. This shapes the researcher's pre-understanding and is already in the world before understanding (Koch, 1995). The hermeneutic circle is the reciprocity between the researchers pre-understanding and evolving understanding. Both the participants and researcher cannot be extricated from these but are interacting and mutually creating new knowledge to better understand the OEF/OIF male veterans' help-seeking behavior. The interpreter (researcher) seeks to understand the veterans' experiences by working out her own fore-structures of the experiences under study, and then moving from the whole to parts and back in a reciprocal way (Earl, 2010). There is no absolute or objective truth but an understanding of the phenomenon made possible by engaging in the world with the veterans discussing their lived help-seeking experiences as US OEF/OIF veterans.

Heidegger's hermeneutics seeks understanding through language. Understanding is a mode of being and a characteristic of human being (Dasein). Language aids to interpret experiential events in the context in which they were encountered to reveal new knowledge on the basis that humans have prior understanding of things encounter on a daily basis, which are already meaningful to them. Therefore hermeneutics seeks to

explicate the "being-in-the-world shown by the text" (Ricoeur 1975, p. 93) and culminates in self-understanding.

Summary

The United States male veterans of the Afghanistan and Iraq wars have healthcare needs with low number of veterans seeking and using needed healthcare resources. The current study seeks to understand what healthcare-seeking means to the male veterans using a qualitative research design that is philosophically underpinned by Heideggerian hermeneutic phenomenology. Heidegger's hermeneutic circle technique will be used to explicate the phenomena of OEF/OIF male veterans' health-seeking and resources use. Phenomenological method is "an exegesis, an explication, and interpretation" (Ricoeur 1981, p. 120.) and the hermeneutical circle where the subject and object are mutually implicated by means of pre-understanding to explicate and develop understanding without transforming the phenomenon into something else but "make it become itself" (Ricoeur 1981, p. 57).

CHAPTER II

AFGHANISTAN AND IRAQ WAR VETERANS' HEALTH CARE NEEDS AND THEIR UNDER USE OF HEALTH CARE: IMPLICATIONS FOR PSYCHIATRIC-MENTAL HEALTH NURSES

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Abstract

United States Afghanistan and Iraq war veterans have combat related medical and mental health issues, notably post-traumatic stress disorder (PTSD) and traumatic brain injuries (TBI) but underuse health care resources. To better understand their health care needs, resource use, and facilitators and barriers to seeking health care, a literature review was completed. The results suggest high prevalence of mental and medical health issues, disproportionate use of quantitative research design that lacked approaches to understanding the psychosocial, cultural, and contextual factors that impact help-seeking by the veterans. Strategies to increase the likelihood that the veterans will seek needed health care, gaps in literature, and needs for further research were discussed.

Key Words: Veterans, literature review, Afghanistan and Iraq war veterans, OEF/OIF veterans, help-seeking, resource utilization, help-seeking barriers, help-seeking facilitators, masculinity, men’s health.

Background

The mental and physical sequelae of war threaten the fabric and quality of life for record numbers of veterans and their families. Since the launch of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) in 2001 and 2003, respectively, more than 1.6 million US veterans have served, with one or multiple deployments. OEF/OIF veterans have a high rate of mental health disorders (11.3% to 42.7%), notably post-traumatic stress disorder (PTSD), major depression, generalized anxiety, and substance use disorders (Hoge et al., 2004). Equally common are medical and physical health issues, including diagnosis of pain, traumatic brain injury (TBI), limb loss and amputations, head injuries, and reduced functional status (Reiber et al., 2010). Relative to their need for help, low numbers of OEF/OIF veterans are seeking and using available health care services (Seal et al., 2010; Hoge et al., 2004). Veterans reported that they are not concerned about access to care, but that their pride and inability to ask for help or admit to having a problem were barriers to seeking needed and available care (Stecker et al., 2007). Having access to available treatments is not enough to ensure that veterans will engage in health care seeking behaviors such as seeking treatment and using health care resources.

The Veterans Affairs Healthcare System (VA) is an equal access health care system with initiatives to eliminate health care disparities and improve veterans' health care outcomes. OEF/OIF veterans qualify for free healthcare for five years post deployment for service-related health issues. Findings from other studies also highlight

the discrepancy between veterans' increased health care needs and their relatively low use of health care services. Among 6201 OEF/OIF combat veterans, of those who screened positive for major depression, generalized anxiety, or PTSD, only 23-40% sought mental healthcare (Hoge et al., 2004). Unmet health care needs may have negative health consequences, including new or escalating medical and mental health disorders, alcohol and substance misuse, self-care deficits, and suboptimal psychosocial functioning. We begin with a discussion of the role of masculinity in health care seeking behaviors and then summarize current literature on OEF/OIF veterans' health care needs, including barriers and facilitators to seeking health care. The aim is to provide information to psychiatric nurses and other health care providers to support effective interventions that help veterans obtain needed care.

Method of the Literature Review

Database searches were conducted in EBSCO, PubMed, PsychINFO, and SocioIndex. Reference lists in identified articles were manually searched for additional relevant articles. Empirical studies conducted from 2001 to present, that reported on mental and medical health prevalence, health-seeking, health care resource utilization, help-seeking barriers and facilitators of OEF/OIF male veterans or active duty personnel were reviewed. The key words /phrases and mesh terms used were: OEF/OIF veterans AND help-seeking, OEF/OIF veterans AND health resource utilization, masculinity AND help-seeking, military culture AND help-seeking, help-seeking barriers OR facilitators.

Masculinity and Health Care Seeking Behavior

Compared to female veterans, male OEF/OIF veterans report fewer medical health issues, are less likely to use outpatient health care services, are less interested in receiving health care, and have longer delays in seeking mental healthcare post deployment (Maguen et al., 2012). In the US, a white male who is heterosexual, strong, stoic, and physically aggressive represents traditional masculinity. The need to conform to the characteristics of being strong and stoic reinforces health-compromising behaviors that are socio-culturally defined and accepted (Courtenay, 2000). Endorsing traditional masculinity impacts men's health attitudes, values, beliefs, help-seeking behaviors, and health. Similarly, Green et al., (2010) found that masculine values of strength, aggression, stoicism, and endurance informed the construction of soldier identity among United Kingdom ex-service men. The authors reported that emotional expression may be contrary to these values and that participants may lack the language needed to express emotional distress leading to delays in seeking care. They suggested that traditional masculinity values are part of a soldier identity, and that those who adhere to traditional masculinity values, including stoicism, consider the expression of emotional distress inappropriate. Lacking language to express distress may lead to delays in identifying mental health problems and to delays in seeking mental health care. Duck (2009) reported that Black men in the US engaged in risky health behaviors and avoided seeking health care because seeking health care was seen as weakness and unmanly.

Thus traditional ideas of masculinity may be related to men having poorer health, with higher morbidity and mortality, lower life expectancy, poorer health promotion, and greater likelihood of high-risk behaviors such as smoking and alcohol /drug use compared to women. Given this, the CDC (2011) report that life expectancy for men in the US is five years lower than for women, and men die disproportionately from coronary heart disease, stroke, and other preventable diseases, is hardly surprising. It is probable that military culture magnifies traditional ideas of masculinity and thus amplifies the risk for poorer healthcare among veterans.

Mental Health Issues

The prevalence rates for mental health disorders differ across military service branches, places of deployment, and types of disorder. Compared to OEF veterans, OIF veterans reported more mental health issues and were exposed to more combat experiences. Hoge et al., (2004) found that 71% (n=1709) of OEF soldiers and Marines reported engaging in firefight, compared to 31% (n=1962) of a similar group deployed to Afghanistan.

PTSD is the most prevalent mental health disorder reported by OIF/OEF veterans (Hoge et al., 2004). The prevalence rates of mental health disorders and PTSD among veterans have increased since the onset of the OEF /OIF wars (Seal et al., 2009). The authors reported that the percentage of veterans with a mental health disorders increased from 6.4% in 2002 to 36.9% in 2008, PTSD increased from 0.2% to 21.8%, and depression from 2.3% to17.4% during that time. Those on active duty, young age (18 to

24 years), male, of a lower rank, and serving in the Army or Marines had a higher risk for PTSD compared to those who were older (40 years and older), female, of a higher rank, and serving in other military branches. PTSD has a high co-morbidity rate with major depression, generalized anxiety, alcohol, and substance use disorders (Hoge et al., 2004). The risk for PTSD increased with longer lasting or repeated deployment and traumatic combat experiences such as handling dead bodies, witnessing landmine strikes, seeing another wounded or killed, branch of service, injury during combat, and being Marine or Army (Hoge et al., 2004). Among OEF/OIF veterans, those with higher levels of PTSD symptom severity are at greater risk for sleep and daytime dysfunction. Those with higher levels of worry and fear of loss of vigilance are more likely to experience sleep difficulties, while those with higher levels of cognitive distraction and greater military unit member support are less likely to experience sleep difficulties (Pietrzak, Morgan111, & Southwick, 2010).

High prevalence of substance abuse among OEF/OIF veterans is reported (Seal et al., 2011). Similar to PTSD, increased risks for alcohol and drug misuse disorders were related to deployment, traumatic combat experiences, branch of military service, and having a mental health disorder. Veterans who were males, ages 18-24 years, junior rank, Army or Marine combat exposure, deployed to Iraq, and had PTSD and/or depression, were more likely to report alcohol and substance misuse (Seal et al., 2011).

Suicide rates are relatively high among OEF/OIF veterans. Bagalman (2011) reported a rate of 38 per 100,000 of OEF/OIF for veterans receiving care at VA. In

comparison, in the general population, the reported suicide rates for men ages15-24 and 25-44 in 2010 were16.9 and 23.6 per 100,000, respectively (CDC 2011). PTSD, depression, and increased psychosocial difficulty increased the risk for suicide ideation, while social support and a sense of purpose lessened the risk for suicide ideation. In a sample of 272 OEF/OIF veterans, Pietrzak, Goldstein, Malley, et al., (2010) reported that those with suicide ideation were more likely to have PTSD, depression, alcohol misuse, and to score higher on measures of stigma, psychosocial difficulties, and barriers to care. They equally tended to score lower on measures of resilience and social support compared to those without suicide ideation. Having more social support, a sense of purpose, and a sense of control decreased the likelihood of having suicidal ideation. OEF/OIF veterans with a positive PTSD screen and with two or more co-morbidities, were 5.7 times as likely to experience suicidal ideation as those with PTSD, but without co-morbidities. Those with major depressive disorder, alcohol abuse, and older age were at increased risk for suicidal ideation.

OEF/OIF veterans with mental health symptoms are unlikely to obtain adequate treatment such as completing nine sessions of psychotherapy treatment within fifteen weeks. Among veterans newly diagnosed PTSD (N=49,425), only 9.5% completed an adequate treatment course of nine or more follow-ups mental health visits within fifteen weeks (Seal et al., 2010).

Medical Health Issues

It is doubly important for those working in mental health to understand the medical health issues of the OEF/OIF veterans. The first reason is because medical disorders are often associated with mental health disorders and, second, because the veterans may need mental health interventions in order to seek and receive the care they need for their medical conditions. Traumatic brain injury (TBI) is the signature injury of the Afghanistan and Iraq wars. Health outcomes of memory loss, headaches, dizziness, sleep disturbances, concussions, intracranial hemorrhage, and head injuries were reported (Morissette et al., 2011). TBI is highly associated with mental health disorders, especially PTSD and depression. Pietrzak, Johnson, Goldstein, et al., (2009) found that 18.8% (n= 277) OEF/OIF veterans screened positive for mild traumatic brain injury (mTBI) and 32% of those with PTSD reported injuries with loss of consciousness. The veterans with mTBI were younger, had unmet medical and psychological needs, high perceived barriers to mental healthcare, and work-related difficulties. Of OEF/OIF veterans who screened positive for TBI, a majority reported combat exposure, PTSD, depression, and having at least one post concussive symptom such as headache, balance problem/dizziness, or memory problem (Morissette et al., 2011), and more missed workdays.

Combat related physical injury, PTSD, and substance use are all more likely for those who experience headaches (Afari et al., 2009). Of 308 OEF/OIF veterans, 40% reported current headache, 10% reported migraines, 12% reported tension headaches (12%), and 6% reported having both migraines and tension headaches. Of those reporting

headaches, many also reported experiencing combat-related physical injury (26.2%) and depression (59.8%). The veterans with combat-related physical injuries or PTSD were more likely to have physician diagnosed migraine or tension headache or both types of headaches, or self-reported headaches, than those without combat injury or PTSD. In addition, those with substance abuse were more likely to have self-reported headaches. Compared to non-veteran peers, these veterans are more likely to have numerous medical health issues including traumatic limb loss, surgical amputations, head traumas, hearing loss, spine disorders, hypertension, asthma, and gastroesophageal reflux (Reiber et al., 2010).

Pain and pain related conditions are the medical health issues most reported by OEF/OIF veterans. In a VA study of 283 OEF/OIF veterans Reiber et al. (2010) reported that 42% experienced back pain, 76% phantom pain, and 63% residual-limb pain. Chronic pain limits physical functioning independently and is associated with PTSD, depression, and alcohol use disorders.

Male veterans aged 25-64 years were more likely to be current smokers than nonveterans. Cigarette smoking and tobacco use among OEF/OIF veterans is even higher, especially among veterans with PTSD and those of younger ages (Kirby et al., 2008). Veterans with more severe PTSD symptoms, particularly emotional numbing, are likely to be heavy smokers (twenty or more cigarettes a day). To cope with being deployed individuals in the military may begin smoking and then they may continue to use tobacco products as a coping strategy post deployment (Kirby et al., 2008). In the

study, among ninety veterans with PTSD, 59% reported a lifetime history of smoking and 50% smoked twenty or more cigarettes a day. Many reported beginning to smoke after experiencing combat-related trauma.

Help-seeking Facilitators

Seeking treatment may depend on the individual's perception, values, and beliefs about the health issues and their need for care (Table 2.1). In a VA study, OEF/OIF veterans' decisions to seek care were based on their earned benefit for military service, injuries, and need for help (Randall, 2012). Veterans who recognized that they had a health problem and were interested in receiving help were more likely to take the initiative to seek health care and to follow through with the resulting plan of care. However, an individual may perceive a need for health care without intending to receive care. Among 577 combat veterans who screened positive for PTSD, depression, or generalized anxiety disorder, more than three-quarters recognized that they currently had a metal health problem but only 40% indicated an interest in receiving help. Those who were interested in receiving help were more likely to have had previous mental healthcare. Veterans with a negative attitude towards mental health treatment or a rank of E7 and above were less interested in receiving help (Brown et al., 2011). Sayer et al., (2009) reported that veterans were more likely to receive treatment for PTSD if they recognized that they had the disorder, treatment service was available, and they held beliefs that favored receiving treatment. Health care system factors, including a web-based referral system, routine screening for symptoms, mental health referrals when

indicated, and feeling a sense of trust in the provider, increased the likelihood that an individual would seek needed help. Having a social network to provide emotional support and information about health and available resources also made it more likely that veterans would receive needed help.

Two studies, from the United Kingdom (UK) and Canada are helpful in understanding the problems that veterans may have in recognizing and seeking health care. In a UK study of Regulars and Reservists (N=821), three-quarters of those with depression, anxiety, or PTSD, recognized that they had a problem while half of those with an alcohol issue did so. The participants sought help mostly from non-professional sources. Royal Air Force veterans, female reservists, and those with a medical or mental health diagnosis were more likely to seek health care (Iversen et al., 2010). In a Canadian study of active military personnel (N=8441), Sareen et al., (2010) reported that a self-perceived need for mental health care, especially for panic disorder, was associated with female gender, marital status other than never being married, middle income, long-term restriction in activities, physical injury and disabilities, suicidal ideation, regular service status, mental disorder co-morbidity, junior rank, age 35-44 years, and the deployment related factors of deployment exposure, being in combat, or witnessing atrocities.

Those who had a positive mental health screen or were diagnosed with a mental health disorder, especially PTSD, were more likely to seek mental health treatment after their deployment (Kehle et al., 2010; Hoge et al., 2004). Kehle et al., (2010) found that of 424 National Guards soldiers who served in Iraq, 34.7% reported receiving mental health

services post deployment. Those who reported being injured in Iraq, and those who had received treatment before their deployment, had high levels of PTSD and depressive symptoms, had higher levels of post-deployment stressors, had poorer health, and had positive attitude towards mental health treatment were more likely to receive post-deployment psychotherapy or medication. Psychiatric medication use was related to interest in receiving mental healthcare, poor social support, and having a mental health problem. OEF/OIF veterans who were female, older age, active duty status, of lower rank, and had a mental health diagnosis with co-morbidities were more likely to receive mental healthcare.

Help-seeking Barriers

Multiple barriers to seeking health care have been identified in the general population. These include race, lack of health insurance coverage, poverty, low social economic status (SES) lack of health information, and lack of physician trust (Thompson, Talley, Caito, & Kreuter, 2009). Somnath et al., (2007) found similar barriers in the VA health care system: lack of knowledge regarding health care interventions, lack of trust in the provider's clinical judgment and in the usefulness of the treatment, and inadequate social support and resources. Unfortunately, a lack of trust in the providers and the quality of care is sometimes well founded. The authors reported that minority veterans, particularly African Americans, were less trusting of the benefits of medical interventions than white veterans and that clinician treatment decisions varied by veterans' race. Some VA facilities serving minority veterans had fewer available services and provided a lower

quality of care compared to those serving predominantly white veterans. OEF/OIF veterans with negative attitudes and beliefs about mental healthcare were less likely to be interested in receiving help (Brown et al., 2011; Stecker et al., 2007). Among

OEF/OIF veterans (*N*=44), half receiving treatment and half not receiving treatment, Sayer et al., (2009) identified personal, health care system, and social barriers to initiating mental health treatment. Both groups reported similar barriers to seeking care but they were more intense for those who were not receiving treatment. For those receiving treatment, although the barriers were less intense, they still resulted in delays for seeking treatment. Personal barriers were a desire to avoid discussion of traumatic experiences and holding values or having priorities that conflicted with seeking treatment. These barriers include: pride in self-reliance; treatment discouraging beliefs, such as that providers will not believe the traumatic event(s) occurred, that treatment is not effective, treatment is for the weak or the crazy, or is only needed in extreme cases; and knowledge barriers, such as lack of knowledge about PTSD and services available. The health care system barriers included difficulties accessing care, such as the time needed, treatment cost, problems with transportation and long distances to access care, and VA enrollment processes. The social barriers were negative home coming experiences, lack of social support, and society's discouragement of seeking help. Other researchers have reported similar findings (Table 1). OEF/OIF veterans reported embarrassment, pride, self-esteem, not wanting to be seen as weak or a free-loader, and shame in asking for help (Randall, 2012). Social stigmatization occurs when an

individual is excluded or labeled as “other”. The subtexts of stigma and labeling are stereotyping and discrimination. Stereotypes are socially constructed undesirable characteristics that may foster rejection and limit the stigmatized individual’s participation in the dominant group. Anticipation of experiencing stigma was a major barrier to seeking mental healthcare among OEF/OIF veterans (Hoge et al., 2004; Stecker et al., 2007). Kim et al., (2010) compared two groups with mental health problems, former active duty soldiers and former National Guard soldiers, at three and twelve months post deployment. They found that the former active duty soldiers had stronger expectations than that they would experience stigmatization for using mental health services. The health consequences of stigma for seeking mental health care included help-seeking delays or not seeking needed healthcare (Hoge, 2004), discontinuing mental health treatment (Seal et al. 2010), and low use of health care resources (Stecker et al., 2007).

Gaps

The articles reviewed provide knowledge that can be applied to practice, however many gaps remain. There is a need for further research designed to increase knowledge of the veterans’ psychosocial, cultural, and cognitive processes, including their understanding of masculinity, related to their decisions to seek-help and use health care services. Also needed are studies evaluating interventions designed to enhance access to care. Equally important, are studies focusing on military culture and its impact on veteran's help-seeking behaviors. Given the high rate of suicide among veterans the

understanding that a lack of language to express distress is related to suicide deserves further evaluation in the near future, with consideration to effective interventions to develop such language.

Implications for Practice

In summary, veterans of the OIF/OEF wars are at high risk for mental and medical illnesses and for not receiving needed care or for not completing a needed course of care. They frequently experience co-morbid illnesses. The symptoms veterans experience related to mental disorders, such as PTSD avoidance symptoms, their understanding of their symptoms and diagnoses and of the help available to them, their expectations of those who provide the help and of the likely outcomes of treatment, all affect the probability that they will seek needed help. The degree of identification with a traditional sense of masculinity, possibly reinforced by military ideals, may be a major factor in identifying a need for health care and in obtaining needed care. Other factors in seeking help, particularly related to suicidal ideation, include having the language to express distress. It is noteworthy that those of higher rank who need health care may be less likely than those of lower ranks to seek needed help. Although we did not find any literature to confirm this, we suspect that this trend is linked to a greater degree of identification with traditional masculinity/military ideals among those serving in higher ranks.

Interventions should be focused on increasing facilitators to seeking health care and decreasing barriers at community, family, and individual levels (Table 2). Psycho-

education focusing on understanding symptoms, diagnoses, and the reasons for not seeking mental or medical health care, should be provided at each level. As is common to many illnesses, and particularly to mental illnesses, there is a need to address the possible stigmatizing effect of having a diagnosis and of receiving treatment. Education that includes information about how treatment can support achieving some of the masculinity/military ideals, such as being self reliant, able to work, and provide for family, may help reduce the influence of related barriers, such as valuing stoicism, on health-care seeking. Perhaps, most importantly, all of our veterans should have access to excellent care. We have an obligation to ensure that all facilities provide such care; regardless of the predominant racial group they serve.

Key Points -Take Home Message

United States Afghanistan and Iraq war veterans have increased mental, medical, and psychosocial health care needs but the veterans delay seeking help or underuse available health care resources in response to personal and system barriers.

- Having access to care is not enough to ensure that Afghanistan and Iraq war veterans will engage in health care seeking behaviors.
- The individual veteran's perceptions, values, and beliefs about the health issues they are experiencing and their need for care influence the decision to seek care.
- Health care interventions that lead to the veteran trusting the provider, include routine screenings, provide needed referrals, and support veterans to develop a supportive personal social network promote seeking needed care

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Table 2.1

Health-seeking Facilitators and Barriers

Health-seeking facilitators	Heath-seeking barriers
Demographics: • Age >25 years • Being female • Lower rank Positive attitude to mental health and mental health treatment: • Recognizing and accepting PTSD • Receiving treatment before deployment Self-perceived need for care: • Recognizing a health problem • Interest in receiving help • Perceived threat • Poor health, Positive mental health screen or diagnosis especially PTSD: • PTSD/ with co-morbid mental health disorders	Demographics: • Younger age <25years • Being male • Rank E7 and above Negative attitude / beliefs about mental health and mental health treatment: • Treatment is ineffective • Personal beliefs and perception of mental illness and mental healthcare • Loss of control or autonomy Stigma: • Too embarrassing • Label received for being "crazy" • Being treated differently by unit leaders and members • Perceived ability to deal with the issue • Help-seeking as sign of we Continued

Continued

• Higher levels of PTSD and depressive symptoms severity System factors: • Earned benefit for military service • Access Issues (clinic location, urban living Deployment related factors: • Combat related injury • Combat and active duty status • OIF veterans (Army or Marine) • Combat experiences (witnessing atrocities, number of deployments, long-term restriction in activities, suicidal ideation in the past year)	System factors: • Perception of losing military career • Time off from work • Lack of knowledge of (PTSD care, available services, and perceive ineligibility for VA care) • PTSD diagnosed from a non-mental health clinic and outreach clinics • Access (time, cost, transportation, distance, VA enrolment processes) Masculinity norms and values: • Pride in self-reliance • Focus on job and family • Socio-cultural milieu that discourages seeking help

Continued

Table 2.2

Interventions Focused on Modifying Barriers and Facilitators to Seeking Health Care

Assessment for factors that affect the likelihood of seeking or following through with health treatment

• For demographic factors that may influence health care seeking behaviors
  • Those of younger age or of higher rank may be less likely
  • Males may be less likely than females
• For adherence to traditional ideal of masculinity
  • Those valuing strength and stoicism and devaluing emotional expression may be less likely
• For attitudes and fears about illness
  • Those with a negative attitude or beliefs about mental illness and the effectiveness of treatment are less likely
  • Fear of experiencing stigma if diagnosed and treated
  • Fear of losing military career if diagnosed and treated
  • Trust or lack of trust in health care providers
  • Past treatment experiences
• For understanding of symptoms and illness
  • Those with a positive screen or diagnosis of an illness may be more likely
  • Those who recognize that they have the illness and have an understanding of treatment may be more likely
• For knowledge about their entitlement to care and the availability of care, access to care, and the enrollment process to access care

Continued

Interventions to modify factors that affect the likelihood of seeking or following through with health treatment
• Educate military leaders, families, and communities that veterans who are younger, of higher rank, or male may need concerted support to seek health care • Educate veterans that acknowledging and seeking treatment for symptoms of mental and medical illness is a sign of strength and that such treatment will help them to establish self-control and enhance their ability to decide when to express their emotions • Educate veterans about mental illness, to provide them with a language and a foundation for expressing their experiences and understanding their symptoms and illnesses • Educate community members and leaders, including members of the military about mental illness, emphasizing the harmful effects of stigmatization and the benefits of effective treatment • Establish therapeutic relationships that provide veterans with the experience of trusting a health care provider • In general, focus on current issues, rather than on past traumatic experiences that may evoke avoidance symptoms • If the veteran chooses to talk about traumatic experiences consider how you will manage your response, both in the time with the veteran and afterward. Consider your self-care.

Table 2.3

Questions for Continuing Nursing Education (CNE) Questions Four Contact Hours

Educational Objectives and Questions:

1. Identify facilitators and barriers of health-seeking among Iraq and Afghanistan war veterans
2. Identify interventions that will enhance seeking health care and using healthcare services by OEF/OIF veterans.

1. In the study reported by Pietrzak, Goldstein, Malley, et al. (2010), which statement is true?

    1. Veterans who reported suicide ideation were more likely to have depression, alcohol misuse, and scored higher on measures of stigma, psychosocial difficulties, and barriers to care.
    2. Having more social support, a sense of purpose, and a sense of control decreased the likelihood of having suicidal ideation.
    3. Veterans with major depressive disorder, alcohol abuse, and older age were at increased risk for suicidal ideation.
    4. All of the above

2. From the table (1) provided by the authors, help-seeking facilitators do *NOT* include the following:

    1. Having a positive attitude to mental health and mental health treatment.
    2. Self-perceived need for care.

Continued

3. Stigma
4. Positive attitude to mental health and mental health treatment.

3. What deployment related factors facilitate help-seeking among OEF/OIF veterans?

1. OIF veterans, Army or Marine only.
2. Non-deployment or reservist status only.
3. Answers 1 & 4 only.
4. Traumatic combat experiences such as witnessing atrocities only.

4. The risk of reporting PTSD and substance use by OEF/OIF veterans is higher in:

1. Veterans aged 40 years and older, and in females.
2. Veterans aged 18 to 24 years, who were in the Army or Marines.
3. Veterans who did not have traumatic combat experiences.
4. Veterans with a rank of E7 and above.

5. Which statement about PTSD is correct?

1. PTSD is the most prevalent mental health disorder reported by OIF/OEF veterans.
2. PTSD has a high co-morbidity rate with major depression, generalized anxiety, alcohol, and substance use disorders.
3. The risk for PTSD increased with longer lasting or repeated deployment and traumatic combat experiences.
4. All of the above

6. In the study reported by Pietrzak, Goldstein, Malley, et al. (2010) OEF/OIF veterans with a positive PTSD screen and with two or more co-morbidities, were ---------- as

Continued

likely to experience suicidal ideation as those with PTSD, but without co-morbidities.

1. 6.7 times
2. 3.7 times
3. 5.7 times
4. 4.7 times

7. The medical health issue most often reported by the OEF/OIF veterans was:

1. Traumatic brain injury (TBI)
2. Headaches
3. Pain and pain related conditions
4. Cigarette smoking and tobacco use

8. Stigma impacts veterans' seeking mental health care. The health consequences of stigma includes all *EXCEPT:*

1. Delays or not seeking needed health care
2. Discontinuing mental health treatment
3. Low use of health care resources
4. None of the above

9**.** Interventions to modify factors that affect the likelihood of seeking or following through with health treatment suggested by the authors are:

1. Educate veterans that acknowledging and seeking treatment is a sign of strength.
2. Educate veterans about mental illness to provide them with a language for expressing their experiences and to increase their understanding their symptoms

Continued

and illnesses.

3. Educate community members and the military about mental illness, emphasizing the harmful effects of stigmatization and the benefits of effective treatment.
4. All of the above

10. True or False: Alcohol and drug use disorders were related to deployment, traumatic combat experience, and having a mental health disorder.

CHAPTER III

METHODS

Procedure for the Collection and Treatment of Data

The purpose of this hermeneutic phenomenological study was to examine the experiences of health care seeking and health care resource utilization by male United States veterans who served in the Afghanistan and Iraq wars. This study was guided by the precepts of Heidegger's hermeneutic (interpretive) phenomenology and Lindseth and Norberg's (2004) method for the data analysis. The study focused on understanding the meaning of health seeking to the veterans. The study design was guided by Heidegger's ontological phenomenology, focusing on the possibilities of Dasein (being-in-the-world) to understand the meaning of Being (existence) or the phenomenon being researched. Humans exist in and interact with the world or environment. Therefore to understand human existence, a hermeneutic approach is appropriate. This chapter presents information on the study setting, participants, protection of human subjects, data collection and analysis, and qualitative rigor.

Setting

The setting for the research was a large metropolitan city in the Southwest. The Lone Star Veterans Association (LSVA) agreed to disseminate the recruitment flyer to potential participants (Appendix A). The association is an online and physical network of veterans of Operations Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and

Operation New Dawn (OND) (Appendix B). It is a non-for-profit organization that was started in 2009. It has over 1500 members who are Iraq and Afghanistan war veterans. Membership includes United States military veterans and active military personnel. The association is the largest Iraq and Afghanistan veteran organization in the state of Texas. LSVA assists the veterans and their families in making the transition from military to civilian life by providing social programs, peer mentoring, PTSD support, family events, and community service projects. It also provides advocacy to prevent veteran unemployment, substance abuse, family challenges, homelessness, crime, and suicide by coordinating direct and innovative programs.

Participants

Purposive sampling was used to select participants. The inclusion criteria were that participants be United States male veterans, who served in either, or both, the Afghanistan and Iraq wars and who are community dwelling veterans wars. The following characteristics were considered: race, ethnicity, rank, education, areas of military service, and relationship status. A snowball strategy was employed to enhance recruitment. The final sample size was determined by saturation of analytic data. Achieving data saturation is influenced by the scope of the research question and the ongoing quality of data collected. A sample size is estimated to reach up to thirty participants.

Protection of Human Subjects

Prior to the collection of research data, the researcher obtained approval from the Institutional Review Board at Texas Woman's University (Appendix C). Informed

consent was obtained before data collection began and participants also consented to voice recordings (Appendix D). Each participant was provided with an overview of the study's purpose. Participants were asked to spend a maximum of one hour talking to the researcher. Interviews were held at a location that provided auditory privacy and that the participants and the researcher agreed upon. A professional transcriptionist transcribed all participant interviews verbatim for analysis.

Data Collection

A semi-structured interview (Appendix: E) was designed and used to generate a discussion with participants about their lived experiences of seeking and using health care. The interview process began by collecting demographic data information (Appendix F) and then proceeding to the interview guide. Answers from the participants drove the use of probing questions. During the interview the researcher took notes, documented nonverbal cues to support the recorded data, and made field notes after the interviews.

Data Analysis

Heidegger did not describe a method for analyzing data. Therefore a modification of Ricoeur's method for textual analysis was applied in this study (Lindseth & Norberg, 2004). Congruent with Heidegger's focus on meaning, Ricoeur postulated that an understanding of the intentions of the participants is not the aim of text interpretation; rather the aim is to understand the meaning of the text itself. The world of the text is "the ensemble of references opened up by every kind of text, descriptive or poetic (Ricoeur, 1976, p. 37). Distanciation objectifies the text by giving it a life of its own, making it

autonomous from authorial intentions, context, initial audience, and can be read and appropriated by anybody that can read (Allen & Jensen 1990; Geanellos, 2000). The world of text is an empirical one that is decontextualized from the authors intent, historical factors, and the listener's interactions, allowing the text to disclose multiple possibilities and modes of being-in-the-world, which the reader appropriates or makes his own (Wiklund et al., 2002; Ricouer, 1975).

In the tradition of Heidegger's phenomenology, and particularly the hermeneutic circle, in order to understand the text, one moves from what the text says to what it talks about (Ricoeur, 1981). The researcher goes beyond the initial context, the intentions of the participants, and the researcher's situation, allowing the text to disclose multiple possibilities of being-in-the world, which can then be appropriated or made ones' own (Ricoeur, 1981; Wiklund et al., 2002). The researcher is thus oriented in multiple ways or possibilities to understand the phenomenon, enriching understanding or uncovering new possibilities.

Divergent views and themes will be identified for balance and credibility as well as to provide rich contextual texts for the report that support the themes or conclusions researched (Whitehead, 2004). Analysis of the transcripts will be stepwise, with the initial reading and analysis of transcript being completed and the results compared to findings from previous transcripts, before the next interview is undertaken. This constant comparison allows for modification of subsequent interviews if indicated, and will continue until saturation is reached (Polit & Beck, 2008).

In keeping with Heidegger's hermeneutic phenomenology, the researcher did not bracket her own pre-knowledge, as this knowledge is valuable in understanding the OEF/OIF male veterans' help-seeking experiences. According to Heidegger (1962), things are encountered in the world and understood within the individual's background (culture) or history. The researcher's pre-understanding is enlightened through the interactions with the participants' world and the interpretation of the textual world created from the interviews (Koch, 1996).

Text Interpretation (Lindseth & Norberg, 2004)

The relationship between explanation and understanding underscores the hermeneutic circle, which involves moving forth and back between naïve and in-depth interpretation (Tan et al., 2009), a movement between the researchers' pre-knowledge, the textual world, and the emerging understanding. The steps of text interpretation to reveal the meaning of a text moves from explanation (what the text says), understanding the world of the text (what the text talks about) includes:

1) Naïve understanding is the initial readings of the text to grasp the meaning of the text as a whole (Lindseth & Norberg, 2004; Wiklund et al., 2002).

2) Thematic structural analysis is the search for narratives and deep structures to identify and formulate themes that disclose deeper understanding of the meaning of the text. The text is re-read as a whole and divided into "meaning units" (Lindseth & Norberg, 2004, p. 149), which are read and reflected on for similarities and dissimilarities based on the researchers' naïve understanding. These are further condensed into main themes and sub-

themes that are expressed in everyday language, not abstractions. Thus, what is transferred from the narrative is not the experience as lived but its meaning which for the current study, is the meaning of the lived experiences of the United States OEF/OIF male veterans' health-seeking and health care resources used.

3) Comprehensive understanding is interpreting the text as a whole. The researcher reflects on the emerging themes and sub-themes and validates these in relation to the research question and context of the study, and current literature evidence. The whole text is reread, having in mind the formulated main themes, sub-themes, and naïve understanding, and keeping an open mind towards discovering new meanings. Throughout the process the researcher will maintain an attitude of critical reflection about the emerging findings (Lindseth & Norberg, 2004). This aids in the revision, broadening, and deepening of the researcher's pre-understanding, enhanced by discussions with others and by relevant literature evidence in the subject area, to "expand our possibilities" (Lindseth & Norberg, 2004, p. 150) or widen the researcher's horizon. The literature evidence illuminates the interview text (parts or whole) and vice versa. The analysis focuses on the possible meanings of the lived experience in the world opened by the text.

Qualitative Rigor

Phenomenology is not a scientific inquiry and should not be viewed through the lens of quantitative methods of establishing reliability and validity (Pratt, 2012). The purpose of qualitative inquiry is creating or transforming understanding of knowledge, not solving the research question or theory development that may warrant generalization.

For the current study, participant validation and team analysis (Walters, 1995) were not indicated due to the philosophical underpinning and analytical method using Heidegger's hermeneutics principles. The intention of the study was not arriving at an objective truth or essential structures of the human experience. Heideggerian hermeneutics considers the interpretative process as ever incomplete, ever discovering new knowledge to better understand human experience. There is no absolute truth.

Qualitative rigor or trustworthiness (credibility, transferability, confirmability, and dependability) is established by methodic consistency, resulting in the potential for replication and for establishing the readers' trust in the research findings (Thomas and Magilvy, 2011). Rigor was maintained through congruency between the study design, research question, the philosophical underpinning, and methodology, such as the interview technique for data collection and analysis through textual interpretation (Polit & Beck, 2008; Whitehead, 2004). Credibility is the confidence in the truth of the data and the interpretation of participant experiences and was established through prolonged engagement with the topic through literature review and with participants over the period of data collection. One aspect of credibility is establishing that data collection continue until data saturation. To ensure representativeness of the data, transcripts were reviewed for the similarities and dissimilarities of experiences across participants. A reflexive journal and a field journal were maintained for self-awareness of critical decisions made during data collection and analysis, such as choice of participants to interview or not, and reflections on emerging themes examined with pre-understanding. While member

checking was not warranted, there was extensive consultation and debriefing with the dissertation committee throughout the data collection and analysis. According to Koch (1996), maintaining a reflexive journal ensues a proper way of getting into the hermeneutic circle. The journal was used to record, describe, and interpret the researcher's experiences. The field journal is a rich description of the researcher's conduct; interaction processes, participant behaviors, reactions, interview contexts, and these were considered during analysis.

Dependability is established through an audit trail, which shows decisions made during analysis. The audit trail describes the purpose of the study, how and why the participants were selected for the study, data collection method, how long the data collection lasted, how the data were reduced for analysis, interpretation, and presentation of the research findings, and the techniques that were used to determine the credibility of the data (Thomas & Magilvy, 2011). The final report has a detailed description of the research methods. Confirmability is the faithful depiction of lived experience that is achieved when credibility, transferability, and dependability are established (Thomas & Magilvy, 2011). Through the interview and analysis process, the researcher made an effort to have open mind and did not allow preconceptions to drive the interviews and analysis. During the interview probing questions and clarifying of statements, words, or slangs helped ensure an accurate understanding of the participants' meanings, separate from the researcher's preconceptions. Transferability is the ability to transfer study findings or methods to other settings or groups. Readers will determine if this was

achieved by considering the thick description of the participants, including inclusion and exclusion criteria, and the demographic data of the participants. The study report, a description of reaching data saturation, and de-identified data is available to interested readers.

CHAPTER IV

THE MEANING OF SEEKING HELP TO UNITED STATES MALE VETERANS OF IRAQ (OIF) AND AFGHANISTAN (OEF) WARS: AN INTERPRETIVE PHENOMENOLOGICAL STUDY

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Abstract

The Afghanistan and Iraq war veterans (Operations Enduring Freedom and Operation Iraqi Freedom, OEF/OIF) have medical and mental health issues related to deployment and combat experiences but underuse health care resources. To understand what help-seeking means to the veterans interpretive phenomenological methods were followed. Twenty (*N*=20) male OEF/OIF veterans were interviewed in a face-to-face, semi-structured interview. Participants were deployed and most were combat veterans. Findings indicate that help-seeking is a complex and dynamic behavior impacted by personal, structural, and socio-cultural factors that interplay in any given help-seeking context regardless of the health care need. For veterans, help-seeking was constructed and performed within the context of military culture values. Four themes emerged from analysis that highlighted what help-seeking means to the veterans: “I’m never a civilian. None of us are ever civilians when we leave combat”; “I don’t care so much about thinking I’m weak these days because I got help, so I’ve changed my attitude on that”;

"It's such a deal with the VA. It's so impersonal and it's such a huge bureaucracy"; and "Thinking about that." Strategies and interventions that may improve OEF/OIF veterans' health care experiences to enhance help-seeking are discussed.

Key Words:

Veterans; Afghanistan and Iraq war (OEF/OIF) veterans; help-seeking; help-seeking barriers and facilitators; resource utilization; military culture; interpretive phenomenological; qualitative research.

Introduction

More than 2.3 million United Sates service men and women have served in the Afghanistan-Operation Enduring Freedom (OEF) and Iraq-Operation Iraqi Freedom (OIF) wars (1), with many veterans having served multiple deployments. The OEF/OIF veterans sustained physical and psychological war injuries with lasting health and psychosocial implications. The result is a high prevalence of mental health disorders, notably posttraumatic stress disorder (PTSD), generalized anxiety disorders, substance use disorders, suicidal behaviors, and deaths (2;3;4). PTSD has reported rates of 13%-37.3% (5;6;7), increasing with multiple deployments and combat exposure. PTSD has a high co-occurrence with other mental health disorders (8;9). Equally, veterans have medical health issues related to physical injuries that include traumatic brain injury (TBI), burn injuries, limb injuries, limb loss, and concussions, that may result in chronic pain, memory loss, headaches, sleep dysfunctions, hearing loss, and death (8;10).

The Department of Defense (DOD) and the Veterans Affairs Health Care System (VA) have initiatives aimed at enhancing the transition from DOD to the VA and access to care. OEF/OIF veterans qualify for free healthcare services for five years post deployment for service-related health needs. Despite efforts to improve veterans' healthcare access and improve health services use, current evidence suggests that many OEF/OIF veterans with heightened medical and psychological healthcare needs are not seeking or utilizing available healthcare services (2;11;12;13).

Understanding the meaning healthcare seeking has for OEF/OIF male veterans will help formulate policies and programs supporting veterans' access to and use of needed healthcare. The reasons why OEF/OIF veterans do or do not seek and use available healthcare resources are not fully understood (14). To gain further understanding, the current study explored the research question: What is the meaning of seeking healthcare for the United States male veterans who served in the Iraq and Afghanistan wars?

METHODS

Setting and Participants

For this interpretive phenomenological study, the first participants were recruited from a veterans' organization in a large metropolis in the South West United States. Using snowball sampling, participants were asked to refer other OEF/OIF veterans. Flyers were posted on the organization's website and Facebook. Inclusion criteria were United States male veterans, who served in either, or both, the Afghanistan and Iraq wars,

and were community dwelling. A purposive sampling technique was used to ensure that various demographic groups were represented. Potential participants contacted the researcher via telephone or e-mail. Interview venues were mutually agreed to. Human subject approval was received from the Institutional Review Board. The final sample size (N=20) was determined after saturation was reached, that is no new information was elicited in the final few interviews.

Data Collection

A researcher developed semi-structured interview guide was used to elicit responses about the meaning health and healthcare seeking had for participants. Face-to-face interviews lasted about thirty minutes. Before beginning the interview, informed consent and demographic information was obtained. All interviews were audio-recorded and transcribed. All participants received a $25 gift card.

Data Analysis

Ricoeur's theory of interpretation (15), as adapted by Lindseth and Norberg (16), guided data analysis. Each transcript was read several times to identify salient words, phrases, and longer quotes. These were categorized and further merged in a coding process based on the hermeneutic circle. This involved moving back and forth from specific data to the whole to achieve an understanding of the meaning implicit in the individual and aggregate data.

Qualitative rigor was maintained through congruency of study design, research question, data collection method, and analysis (17). The primary investigator consistently

met with experts in phenomenology to review data collection, analysis, emerging concepts, and themes. Divergent views and themes were identified and are reported for balance and credibility. Descriptive data and rich texts are provided to support themes and conclusions that depict the veterans' demographics and experiences. Using this information, readers will determine if the results are transferable to others.

RESULTS

The majority of the informants were single white males between 25-40 years of age. All were deployed veterans and 90% had experienced combat. Most served in the Army and were deployed more than once (Table 4.1). Four main themes representing the meaning seeking health-care had for the veteran-participants emerged (Table 4.2a; Table 4.2b): "I'm never a civilian. None of us are ever civilians when we leave combat"; "I don't care so much about thinking I'm weak these days because I got help, so I've changed my attitude on that"; "It's such a deal with the VA. It's so impersonal and it's such a huge bureaucracy"; and "Thinking about that." Help-seeking is a dynamic and complex behavior that is impacted by interrelated personal, structural, and cultural factors in the context of healthcare needs.

"I'm never a civilian. None of us are ever civilians when we leave combat"

Military culture provides the context for Veterans' help seeking behavior. Most informants continued to have the mindset of being in the military and being warriors. The job of accomplishing the military mission comes first and rises above individual needs including seeking healthcare. Most informants said the military had a negative view of

seeking healthcare. As one said: “only seek it when absolutely needed.” They feared seeking care would negatively impact their military career or make them “non-deployable.” So going to Sick-in-Quarters (SIQ) Call was a choice most informants did not make while in active duty because those that did were made fun of, were considered not tough enough, and as wasting time. As active military members they had to conform to the military culture of self-reliance, resilience, and strength. They described military culture as “hardcore,” “a mindset,” “a thought process,” that demanded a “suck it up, drive on; I’m a hard-ass” mentality. Military values were:

> Ingrained in your soul. It’s not just something you’re taught; it’s a way of life. I mean it’s not something you just do. It’s a culture…combat veterans have our own culture.

All informants endorsed self-reliance manifested in self-care, a can-do-attitude to seeking help, a “tough guy mentality,” or “I can deal with it on my own” attitude. As veterans they continued to live up to these values and self-treated, self-monitored, “tough-out” illnesses, and engaged in watchful-waiting before deciding to seek help.

One informant said: “if I’m feeling sick I’ll put it off for a couple of days and wait and see how it goes. Ninety-nine percent of the time it’ll go away.” They described self-reliance, self-pride, and resilience in solving their problems. They self-diagnosed and self-treated, seeking professional help only as “a necessity,” a last resort, and when they were without a choice:

> Seeking help - I'm more of those kind of guys that likes to help themselves…for me to go and seek help it's got to be pretty bad. It's got to be real bad. It's got to be to the point where I pretty much have no solutions whatsoever. I can't - I've tried everything and I can't do it; so I've got to get somebody else to help me.

Some participants described being stigmatized for seeking help and others feared that seeking help would lead to being stigmatized. They did not want to show vulnerabilities and described help-seeking as a "sign of weakness," "malingering," "fake," "fraud," being "lazy," "working the system," "a wuss," and "a pansy."

Informants were concerned with stigma if they sought mental healthcare. They described the fear of losing their freedom and the right to own and carry guns; being perceived as broken, "can't do his job"; and of "being committed" or institutionalized. One informant described his reaction to the media reports that an army personnel who perpetrated a mass shooting had PTSD:

> We're in denial. We don't want help. We think we can do it on our own…there's nothing wrong with me; everybody else is crazy…getting a diagnosis of PTSD when everybody just ranting and raving about: Did the shooter from Fort Hood have PTSD? …The media's initial attack was he is diagnosed with PTSD…did they want to make PTSD public enemy number one?

Despite the stigma and fears, some informants did seek healthcare. This required acknowledging their inability to always be self-reliant, to "fix," and getting over their own self-stigma toward seeking help, to feeling it was okay to seek help if the health

need was beyond what they could take care of. One informant noted: “I’ve done everything beyond my means to fix myself and I just need them to do it and they’re the people that can fix me.”

Another said:

> It kind of brings your spirit down a little bit because it’s something you can’t do yourself. I mean Marine Corps taught us to improvise and to do stuff our way…But then you realize you can’t do that and it makes you feel down on yourself because that was one task you couldn’t do yourself. But then like now I realize that it had to be done, that I wouldn’t have been able to do it by myself.

There were exceptions; veterans who grew up in families where obtaining healthcare was part of the routine of self-care were less likely to experience help-seeking as problematic. For most, help-seeking provoked mixed emotions of anxiety, frustration, self-doubt, fear, powerlessness, and eventually the satisfaction of having tried, leading to changing attitudes.

“I don’t care so much about thinking I’m weak these days because I got help, so I’ve changed my attitude on that”

The informants described individual and system barriers and facilitators that transcended simply making a decision to seek help or not (Table 4.2a; Table 4.2b). They came to terms with personal values attitudes and beliefs, and psychosocial factors that impacted seeking care. Some delayed seeking care several years post discharge because

they did not experience a self-perceived need for help and placed low priorities on healthcare compared to careers and other life obligations.

> In my mind I didn't think there was anything wrong. I thought it was just everything else- everybody else was crazy; it wasn't me…my family had said I had changed and I didn't see what they were talking about.

Others minimized their healthcare needs and only sought care for trauma, serious medical issues, and emergencies. Worsening symptoms led some to seek care, while some who experienced severe symptoms ignored them and did not seek care because they felt a sense of shame, embarrassment, and guilt because they were not deserving of services when other veterans died

or were permanently physically maimed. They said resources should be saved for those with physical injuries, not those with mental health needs:

> I feel weak when I ask for help…there are guys here who've been burnt up and got their leg torn off or died even and there's nothing physically wrong with me but my mind is just not right. It's not that it's completely messed up; it's just got a few lose wires.

Personal factors, notably advancing age, time from discharge, life events, recognizing a healthcare need, the healthcare experiences and outcomes of others, especially military buddies, and family health history tended to promote a willingness to seek healthcare. An informant shared the death of his father to illustrate his reason for seeking help:

> I was nineteen years old at the time and he would never go to the doctor and he was a chain smoker…when he finally started feeling really bad…he reluctantly went to the doctor and at that point they had told him lung cancer had developed and he passed away just a couple of months after that.

Some informants discussed how support from family members, friends, and military buddies, whom they trusted helped them to seek care:

> And then things just progressively got worse and finally my wife says, "You've got to go to the doctor." And I went and then I've just been educated on [PTSD] ever since.

However, lack of family support, poor coping and communication skills, and inability to "open up" deterred seeking help:

> I used to get drunk and then want to kill myself. I used to call…my brother and just want to talk to him but it didn't seem he wanted to talk about it I guess he was tired of it and I never went and got help for it.

Beyond their personal responses and experiences, the difficulty of dealing with the healthcare system played a role in help-seeking.

"It's such a deal with the VA. It's so impersonal and it's such a huge bureaucracy"

There are system factors that affected informants' healthcare experiences at the VA. They described the VA as an "impersonal" bureaucracy for older veterans and for retirees:

> It's the bureaucracy at VA that makes it really troublesome to go down there. It seems like everybody has different paper works but nobody knows what's really going on.

And not meeting their healthcare needs:

> Working with the VA I've never got anything resolved. I ended up going and seeking a private care provider even though…I got five years of total healthcare. But I also have the right to use the VA for care.

Some were disappointed because the treatment they received did not provide relief from symptoms and was ineffective in meeting their health needs. Those with a negative perception of the care they received, including impersonal treatment and the use of medications with undesirable side effects instead of interpersonal interventions, were less likely to seek care. An informant who preferred face-to-face counseling instead of videoconferencing for PTSD treatment said:

> Every time I went, I had a different psychiatrist. I never got the same psychiatrist twice. And that aggravated me and then when I went to set up an interview…it was a videoconference…I like the face-to-face. And they gave me all the information saying: 'alright you need to call these numbers' and I just never called.

Most informants longed for the structure in the military healthcare system and expressed frustration with the less structured VA system and not knowing "how the VA system worked." They described the VA as slow and inefficient. In the military it was

"usually one talk, one-stop-shopping and you got it done and you moved on." Some felt that insufficient staffing and unprofessional attitudes of VA health workers accounted for poor customer service, dissatisfaction with care experiences, feeling unwelcomed, and a lack of empathy from the staff. One informant likened the VA to "a healthcare farm or a healthcare mill; people-in, people-out," that made veterans not want to come to the VA, because "I feel like I'm inconveniencing them."

However, some felt the VA "nurses and doctors do care" but have an increased number of veterans in the Health Care System to care for. In contrast to the participant who did not make appointment for telehealth care, some who sought mental healthcare reported positive, effective treatment experiences:

> "Overall it's been a good experience. A lot of people there care…I feel like people are concerned with my concerns and that sort of validation makes me feel good knowing that there is help."

Their distrust of the VA and VA providers was greater when they did not know what services the VA offered, and did not understand their eligibility for VA benefits and the processes for accessing VA resources or obtaining health insurance coverage. Some were concerned for their privacy and the confidentiality of their health information at the VA. They feared their medical records would be released to the military or their employers. Some did not trust physicians, as one said: "doctors like lawyers cut corners…I don't trust them." Others had concerns about health professionals'

competence and skill levels in caring for veterans and expected VA providers to be more tolerant of veterans' "aggressive tendencies" compared to civilian physicians.

Informants reported long wait-times to schedule appointments and receive care. They described VA benefit claim processes as complicated and slow leading to long waits to process their service-connected disabilities. One informant said: "It's been over a year and I'm still waiting on even getting a doctor appointment with the VA." A homeless informant shared why he did not seek help from VA:

> For the last two years I've been jerking around with living in my car…living behind a dumpster and I know I could get help but I wouldn't go. I just didn't want to deal with the VA process because it just takes forever…It's too slow.

Participants described getting referrals as a long and frustrating process, including waiting for appointments to see primary care practitioners and then waiting for months for appointments for specialty care. Most informants recounted long wait-times to be seen in emergency rooms and triage centers. An informant said:

> "If it's at the VA…I won't go because I don't want to wait that long…I'll suck it up and hope for the best. It's just that wait at the VA is just horribly long.

Informants reported having to deal with the financial burden of seeking healthcare, including co-pays, medications, hospital bills, inability to take paid time off from work, and a lack of or limited healthcare coverage for non-service connected health needs. One informant said: "I don't think I'm eligible like I have limited eligibility not full VA eligibility." Some are "in insurance limbo" with limited VA benefits for non-

service connected injuries or “in a donut hole” if retired but still in the reserve, without having either military or VA coverage.

Having private health insurance provided the choice to seek care at the VA or elsewhere. Informants considered private health insurance more streamlined, efficient, and time-friendly than the VA. An informant described seeking urgently needed healthcare elsewhere due to the long wait-time for care at the VA:

> I had gallstones…I went to VA they said that would be an elective surgery…they scheduled it for two months later…I had so much pain that rather than going back to VA and dealing with their bureaucracy I went to a private hospital and I had emergency surgery that next morning.

“Thinking about that”

Informants were self-aware and knowledgeable of their healthcare needs and made healthcare decisions after deliberating and accepted the consequences of their decisions. They described the decisions, choices, consequences, and regrets for their health behaviors. One informant said:

> It took a few days before I decided to go. It was constantly just sitting there thinking about that. It was weighing the pros and cons to it. If I do this okay then- You’ve got one side you weigh the other side. So okay what will happen later on down the road if it gets worse? And then you start going off into the what-ifs. Okay if I don’t go where will I be in another couple of years?

Informants considered the seriousness and severity of the symptoms of health needs and effects on daily functioning and living. It was about making personal choices and taking responsibility for the resulting health consequences. They questioned themselves in many ways: “Do I really need help or am I just being a big baby about it?”; “Is my life going to get better?”; and “Is it going to make anything better?” Some were more pragmatic in making their decision to seek help: “How much time it’s going to take until the appointment”; “Do I have the time to go do it?”; “Can I take two weeks off from work or not, only be paid for one of those weeks or two days”; and “Do I have co-pay? If I’m going to get a prescription; how much is it going to cost me?” Some felt not seeking help saved time, money, and resources for others who needed them. They acknowledged making personal choices and being accountable for their health decisions by “doing the adult thing...recognize there’s a problem and doing something about it.” One informant noted:

> To not just sit there and wait and let it get worse…it’s better to go off and get [help] now when that happens than wait. That was the biggest thing I had to learn.

DISCUSSION

For OEF/OIF male veterans help-seeking was unraveling and dealing with personal, cultural, and structural barriers that determined whether they sought help. The study results highlight the complex and dynamic psychosocial basis of OEF/OIF veterans help-seeking behaviors. Participants were mostly combat veterans. Combat experience is shown to increase medical, mental, and psychosocial healthcare needs (2;18;10;19).

The study supports and adds to earlier findings from OEF/OIF veteran studies of personal and structural barriers and facilitators including access issues, stigma, attitudes and beliefs that impact OEF/OIF veterans' help-seeking and resources use (20;12;2;21;22;23). Participants' lack of self-perceived need for help is manifested in delays in engaging in healthcare; noncompliance with initiating and sustaining treatment; and setting other priorities than healthcare. Findings from the current study highlight that the interaction of military culture, and the related stigma of help-seeking, with veterans' personal values and beliefs, the influence of social and personal factors and VA policies and procedures, and the engagement in deliberative decision-making, all contribute to veterans' help-seeking decisions.

Policy, Practice Implications, and Future Studies

To improve OEF/OIF veteran's access to care there is a need to decrease wait-times for care and benefit-claims and to make healthcare experiences more veteran focused. These measures and more are addressed in the new Veterans' Access to Care through Choice, Accountability and Transparency Act of 2014 (VACAA) (24). Increasing accountability of employees to reflect the VA mission and values of Integrity, Commitment, Advocacy, Respect and Excellence (I-CARE) will make OEF/OIF veterans care experiences more in line with Patient-Centered Care Model. Findings from this study include specific recommendations to improve OEF/OIF Veterans' healthcare experiences at the VA (Table 4.3).

More studies are needed to explore socio-cultural norms that foster the avoidance of seeking care by male OEF/OIF veterans including the interaction of personal values of masculinity with military culture values. Qualitative and quantitative studies that explore OEF/OIF veterans' perceptions of the "fit" in the VA with their personal needs and the health outcomes of veterans who are cared for in the VA, and to ascertain the efficacy and acceptability of existing access initiatives and programs by veterans are needed.

Strengths and Limitations

Findings from this study are limited to community dwelling male veterans of the OEF/OIF wars. The participants were recruited from one large metropolitan area in the Southwest United States therefore findings may not be transferable to others. A strength of this study is that most previous studies on OEF/OIF veterans help-seeking use VA data from surveys of veterans who seek VA care, while the data for this study was collected in interviews that supported veterans to provide rich descriptions of their experiences. The exclusion of female OEF/OIF veterans from the study was not considered a limitation as female OEF/OIF veterans have been shown to seek and utilize health services more readily than male OEF/OIF veterans (25;26). The small representation of officer ranks may be a limitation however the data did not indicate significant differences in healthcare seeking by the veterans who had been officers compared to those who had not been officers. The findings may not be applicable to non-deployed OEF/OIF veterans. A major strength of this study is the rich descriptions the participants provided, both of the

meaning help-seeking had for them and of how their beliefs and values interacted with their VA experiences leading to recommendations for interventions (Table 4.3).

CONCLUSION

The informants were interested in healthcare and they engaged in self-surveillance or self-monitoring, to "wait it out"; self-treatment to "fix"; and if these failed they made rational decisions on when and how to seek healthcare or not. The meaning help-seeking had for veterans resulted from the interaction of personal expectations and values with military culture and then with VA experiences. Many participants expressed their desire for a care environment that promotes patient-focused care:

> The primary for me is that when I go to a doctor; I want them to first listen. This is my body; I probably know it a hell lot better than any doctor does. And to not just sit there and write on a tablet, walk out, come back in and have a prescription in your hand. That's unacceptable in my opinion.

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Table 4.1

Participant Demographics (N=20)

Characteristics	Values (%)
Age Range:	
• 25-40yrs	16 (80%)
• >40yrs	4 (20%)
Race:	
• Black	7 (35%)
• White	11 (55%)
• Other (Asian)	2 (10%)
Relationship Status:	
• Married	6 (30%)
• Single/Divorced/Separated	14 (70%)
Living Situation:	
• Lives alone	8 (40%)
• Lives with family	9 (45%)
• Homeless	3 (15%)
Highest Education completed:	
• High School / Some College	13 (65%)
• College Degree	7 (35%)

Continued

Characteristics	Values (%)
Employment Status: • Employed • Unemployed / Retiree / disability	 12 (60%) 8 (40%)
Military Rank: • E1-E4 • E5-E9/warrant officer • Officer	 10 (50%) 8 (40%) 2 (10%)
*Service Branch: • Army • Marine • Navy	 15(75%) 4 (20%) 2 (10%)
Deployment: • Iraq • Afghanistan • Both	 9 (45%) 4 (20%) 7 (35%)
Tour of Duty: • 1 or 2 times • 3-5 times	 14 (70%) 6 (30%)
*Combat Status: • *Combat • Noncombat	 18 (90%) 2 (10%)

*Two veterans served in dual military service Branches, 3 maintain reservist status, and 3 veterans served in combatant and non-combat missions.

Table 4.2a.

Themes with Supporting Categories

I'm never a civilian. None of us are ever civilians when we leave combat"

- Military culture values of resilience and self-reliance
- Conforming to military
- Help-seeking stigma
- Mental health stigma
- Help-seeking façade and military leadership
- Impact on military career

"I don't care so much about thinking I'm weak these days because I got help, so I've changed my attitude on that"

Barriers

- Lack of self-perceived need for help
- Prioritizing healthcare secondary to seeking career, living, and other life obligations
- Procrastination and "making the time"
- Symptoms severity may or may not necessitated seeking help or compliance to treatment
- Treatment ineffectiveness and unmet health care needs
- Negative perception of quality of care, treatment modality, and concern for medication side effects

Continued

- VA care expectations: VA care is less efficient compared to active duty and private healthcare

Facilitators:

- Advancing age, time from discharge, life events and needs moderate attitude to seeking help
- Recognizing a healthcare need and willingness to seek help
- Others health care experiences and outcomes especially military buddies
- Family health history
- Positive Perception of the VA, quality of care, and treatment modalities
- Positive perception of mental health treatment as effective

  Positive family and social support such as trusted friends and military buddies

Table 4.2b.

Themes with Supporting Categories

"It's such a deal with the VA. It's so impersonal and it's such a huge bureaucracy"

Access

- Negative perception of the VA as impersonal, a bureaucracy, and for older veterans and retirees
- Lack of or limited healthcare coverage for non-service connected health issues
- VA benefit claim processes, delays for service connected disability and backlog
- Lack of knowledge of VA benefits and benefit claim processes

Logistics and Health Facility Factors

- Transportation and distance to nearest VA
- Geographical variations in VA care and veterans care experiences
- Lack of physician trust
- Concern for health professional competence and skills
- Not validating combat experience by healthcare providers

VA care experience and wait–time for care

- Long wait-time for scheduling appointments and specialty care
- Unmet healthcare needs at VA
- VA care processes and referral practices
- Personnel Issues: poor staffing
- Poor customer service

Continued

Facilitators

- Having private health insurance other than the VA

"Thinking about that"

- Weighing options to seek help and making personal choices
- Being deliberative
- Being Pragmatic
- Being responsible for healthcare decision and consequences

Table 4.3.

Strategies and Interventions: " the more that you all understand our point of view and the way we see it the better we're going to be able to work together."

Self-directed care:

- Modify personal and structural barriers by developing policies and interventions to enhance veterans help-seeking
- Implement interventions that incorporate self-management approaches into help-seeking

Education …we have a tough guy mentality it's just a matter of convincing us that the doctor is not a bad place...

- Education to:
  - "…Encourage people and applaud them when they do seek those services…as a

Continued

sign of courage; as a sign of responsibility…I think that starts with the military leadership"

- Clarify health professional's competence and skill levels
- Clarify the services the VA offers
- Clarify eligibility for VA benefits and for accessing VA resources
- Ensure understanding of privacy and confidentiality policies and procedures

- Encourage military leadership and a culture of seeking help to curb stigma related to help-seeking
- **Make VA care experiences more timely and efficient**
- Develop policies and procedures to:
  - Decrease wait-time for appointments and care including wait time for emergency, triage, and specialty care and consult tim**e**
  - Provide primary care clinics for episodic or non-emergent care, to decrease burden on emergency rooms
  - Speed benefit claim processes
  - Provide services on weekends and evenings

Quality and the experience of care: "Pay attention to the staff… how they treat us."

- Improve quality of care
  - Through shared decision making
  - Through patient-centered care that includes good customer service at all levels, providing treatment that is personalized and includes a relationship with a primary

Continued

healthcare provider

- Measure quality of VA care and satisfaction from veterans perspective

Revise policies to prevent insurance limbo and reconsider the policy that limits healthcare coverage to service connected health needs to provide veterans with one place to meet their healthcare needs.

CHAPTER V

SUMMARY OF THE STUDY

US OEF/OIF veterans have increased health care needs including mental and medical health issues (Hoge, et al., 2004; Seal, et al., 2007; Stecker, et al., 2010; Morissette, et al., 2011; Nworah, et al. 2014) but they underuse health care resources (Hoge et al., 2004; Seal, et al., 2010; Stecker, et al., 2007). Many studies have identified possible barriers and facilitators at individual and structural levels (Pietrzak, et al., 2009; Stecker, et al., 2007; Kehle, et al. 2010; Vogt, 2011; Nworah, et al. 2014). However, veterans' underuse of health care resources is still not fully understood (Nworah, et al 2014). To increase understanding the current study addressed the research question: "What is the meaning of seeking health care for United States male veterans who served in the Iraq and Afghanistan wars?"

Heidegger's phenomenological philosophy underpinned the study. Ricoeur's (1975) interpretative approach, as adapted by Lindseth and Norberg (2004), guided the data analysis. Using hermeneutic methods and the hermeneutic circle approach a deeper understanding of what seeking help meant for the veterans emerged. True to Heidegger's "Dasein" (Being-in-the-world) the situatedness or context of the phenomena of help-seeking provided the foundational basis of the participants' help-seeking behaviors and resources use. The context was the veterans' military culture values, which continued to

shape and influence their seeking care. Below the findings are summarized and discussed in relation to extant literature on OEF/OIF veterans' help-seeking and resources use. Conclusions, implications to practice and policy, and recommendations for further studies are provided.

Summary of Findings

Twenty deployed, mainly combat, male veterans described their help-seeking experiences. The four themes that emerged were: "I'm never a civilian. None of us are ever civilians when we leave combat"; "I don't care so much about thinking I'm weak these days because I got help, so I've changed my attitude on that"; "It's such a deal with the VA. It's so impersonal and it's such a huge bureaucracy"; and "Thinking about that".

The theme "I don't care so much about thinking I'm weak these days because I got help, so I've changed my attitude on that" highlighted the impact and importance of the military culture of self-reliance and resilience in shaping the help-seeking behaviors of the veterans as civilians. The military personnel continuously strive to conform to these even beyond active military duty service. Not conforming to these military culture norms carry the consequence of stigmatization and possible discrimination. There is a stigma associated with seeking help as well as the stigma of a mental health diagnoses including PTSD. Seeking help was "a sign of weakness", "malingering," being "fake," "fraud," "freak," "lazy," "working the system," "a wuss," and "a pansy."

The theme "I don't care so much about thinking I'm weak these days because I got help, so I've changed my attitude on that" highlights the importance of personal

beliefs, attitudes of individual veterans, and the socio-cultural contexts of their healthcare decisions. Some factors that facilitated seeking help were advancing age, time from discharge, life events, recognizing a health need, a willingness to seek help, and having private health care coverage. Having family and social support enabled seeking care. Some informants only sought help at the request of family members and after talking with military buddies who have sought care.

The theme "It's such a deal with the VA. It's so impersonal and it's such a huge bureaucracy" highlighted the influence of their VA experiences. The VA was described an "impersonal" bureaucracy for older veterans and for retirees which was reason for some participants preferring the Vet Centers compared to the VA. Most informants described their VA care experiences as not veteran friendly, lacked professionalism, and customer service. They described distrust of health care providers, disappointment with treatments, over reliance on pharmacotherapy and its side effects, negative perception of quality of care and treatment modalities, very long wait-times to make appointments for primary care and specialty care due to an inefficient VA referral system, emergency room, and triage center care. Participants also described long wait-times for benefit claims due to backlog in processing the claims to determine service-connected disabilities as they qualify for five years of health-care for service connected health care from the date of discharge from the military.

The theme "Thinking about that" highlights the deliberative process the veterans engaged in. The veterans had to process and unravel the barriers and facilitators in help-

seeking situations to either seek care or not. They deliberated their actions or inactions based on their individual realities and accepted responsibilities for the consequences of their health care decisions. The informants were not uninterested in health care but they engaged in self-surveillance or self-monitoring to "wait it out"; self-treatment to "fix"; and if these failed, made rational decisions on when and how to seek health care or not.

Discussion of the Findings

The findings show that seeking help is a complex behavior that is impacted by multifaceted personal, structural, and cultural factors that are interrelated within the contexts of participants' health care needs. For the participants, the meaning of seeking help is the unraveling and dealing with personal, system, and cultural barriers and facilitators.

The findings underscore the delay and underuse of health care resources by Iraq and Afghanistan war male (OEF/OIF) veterans reported in earlier studies (Hoge, et al., 2004; Stecker, et al., 2007; Kehle, et al., 2010; Pietrzak, et al., 2009) by providing an understanding of what seeking help means to the study participants. Stigma as a factor in seeking mental healthcare among OEF/OIF veterans is widely cited in extant literature (Hoge, et al., 2004; Kehle, et al., 2010; Pietrzak, et al., 2009) as well as veterans' attitudes and belief (Stecker, et al., 2007) were supported from study results. The importance of Veterans' perception of help seeking as an indication of psychological weakness and their fear that help seeking may have a negative impact on their military career are evident in current study and earlier studies (Pietrzak, et al., 2009; Randall,

2012; Stecker, et al., 2007). However, findings from this study indicate that the expectation of experiencing stigma is not limited to seeking mental health treatment. The stigma of "help-seeking" transcended any one health care need. Help-seeking had negative connotations for a majority of the participants and who considered it a "weakness", "malingering", being a "fraud", and "gaming the system" and these connotations evoked anxiety for the veterans in making the decisions to seek care or not.

Seeking help was constructed through the lens of traditional masculinity, multiple masculinities, and military culture values. The military has its own culture and sub-cultures with its norms, values, and traditions that endure long after active military duty ends. The military culture values of self-reliance, strength, resilience, and self-discipline, provided the context of OEF/OIF veterans' help-seeking behaviors that interplay with similar traditional masculinity values (Courtenay, 2000; Courtenay, 2003). Most informants endorsed some form of traditional masculine values as they described self-reliance, self-pride, and resilience in solving their problems. The veterans reported striving to conform to these military culture norms beyond active military duty. Masculinity and military culture values promoted self-care, self-monitoring, a "tough guy mentality," and "I can deal with it on my own" attitude. The collaborative culture in the military that encourages group affiliation or the "we-mentality", selflessness, and responsibility to others, may conflict with civilian culture of "I-mentality" and individuality in seeking personal health care and using health care resources by the veterans.

Help-seeking triggered mixed emotions of anxiety, frustration, self-doubt, fear, powerlessness, and a sense of satisfaction for having tried. Informants recognized their health care needs and sought help in various need situations suggestive of multiple masculinities rather than traditional masculinity values (Addis & Mahalik, 2003), which may be paradoxical to the military culture of self-reliance. The informants acknowledged their inabilities to always be self-reliant, "fix" or self-treat in some health care situations, and sought care despite endorsing traditional masculinity values of self-reliance, strength, and resilience. They felt it was tolerable to seek help if: "it's beyond my knowledge;" "something that I can't take care of by myself;" "the situation has gone beyond my means and I need somebody that is a lot more advanced to fix this body I have;" or "I've done everything beyond my means to fix myself and I just need them to do it and they're the people that can fix me." These realities support that the performance of masculinity in help-seeking is not fixed but changes within and between individuals (Addis & Mahalik, 2003).

Structural or system barriers impact seeking care among the participants including access issues: lack of health care coverage, distance from nearest VA facility, lack of knowledge about VA benefits, care delivery modality, wait-time to schedule an appointment, not having consistent primary care provider, and lack of physician trust. Similar findings were reported in OEF/OIF veteran studies (Pietrzak, et al., 2009; Randall, 2012; Sayer, et al., 2009; Stecker, et al., 2007). In the study, perception of treatment as ineffective and lack of self-perceived need for help by veterans was shown

in not recognizing health care needs and manifested in procrastinating to engage in health care, not being compliant with treatment, and setting other priorities than healthcare.

Family and social support positively impacted help-seeking in OEF/OIF veteran studies (Pietrzak, et al., 2010). This finding is supported by the response of family members, friends, and military buddies who the participants trusted. While the findings of this study are consistent with findings from earlier studies, this study makes clear that veterans are deliberative in making decisions to seek health care and that others can take actions that will support them to seek needed care.

Conclusions

OEF/OIF veterans' help-seeking must be considered in the broader context of veterans' health care needs, decision making, and socio-cultural values that inform the decision to seek help or not. The health care challenges of the OEF/OIF veterans call for continued efforts to provide health care services in ways that minimize the disparities in seeking and using health care resources. Understanding what help-seeking means to the veterans and what factors interact to impact their help-seeking behaviors enables providers to formulate policies and programs that are OEF/OIF veteran-centered. As one informant said: "the more that you all understand our point of view and the way we see it the better we're going to be able to work together."

1. Help-seeking is a complex and dynamic behavior impacted by interrelated factors at personal, system, and cultural levels.
2. Help-seeking behaviors are situated in contexts.

3. Help-seeking is constructed through the lens of military culture values that interplay with traditional masculinity values of self-reliance, strength, toughness, stoicism, and aggression.
4. Military culture values of toughness, self-reliance, aggression, and resilience impacted seeking help.
5. Help-seeking is considered a stigma and a sign of weakness and evoked a sense of powerlessness regardless of health care need.
6. Seeking help was a "necessity," a last resort, and done when in "dire straights."
7. For many veterans the meaning of help seeking changed over time.
8. Veterans followed a deliberative path in making health care decisions and were personally accountable for their decisions.

Implications for Practice and Policy

The following recommendations are included based on the result findings:

1. Initiate programs to reduce the stigma of seeking help and mental health stigma in the military.
2. Revaluate military culture values and operations from enlisting to incorporate help seeking as an acceptable norm during active military duty to ameliorate the sense of stigma about help-seeking and positively influence veterans help-seeking behaviors post deployment.

3. Anti-stigma programs and campaigns which take account of military culture needs to address how to reduce help seeking barriers and support help-seeking facilitators.
4. Initiate strategies and policies to improve VA health care experiences including access, veteran satisfaction, and decrease wait-time to schedule appointment and specialty care.
5. Initiate programs and education to increase veterans' knowledge of VA care processes and available benefits and resources at individual and community levels.
6. Identify modifiable personal and structural barriers and tailor policies and interventions to bring change through veterans and public education and advertising.
7. Make VA more visible to the veterans through focused advertising and marketing to be aware of new care initiatives that emphasize customer service, veterans' satisfaction, and creating environments that meet their care expectations.
8. Expand VA peer facilitation program to all VA facilities for veterans to speak to other veterans from personal experiences that reinforces military camaraderie.
9. Increase the work force at the VA to handle the increased demand in number of veterans and the skills of health care providers.

Implications for Further Research

From the result findings, the following recommendations for further studies are:

1. More studies to explore socio-cultural norms that facilitate the avoidance of seeking care by male veterans.
2. Qualitative studies that explore facility mediated barriers and of OEF/OIF veterans' "fit" in the VA.
3. Studies that evaluate existing access initiatives and interventions to ascertain their efficacy and veterans acceptability and satisfaction of them.
4. More qualitative research studies are needed to shed more light on what informs OEF/OIF veterans help-seeking behaviors and resource utilization.
5. Studies are needed on the pact of military culture and masculinity values on OEF/OIF male veterans help seeking and resources utilization.
6. Studies on age and number of years since discharge from military service and how these impact veterans' beliefs that are mediated by masculinity and military culture values on help-seeking.
7. Qualitative studies on OEF/OIF veterans VA care experiences and customer satisfaction from their perspectives to continue to expand our understudying of their help-seeking behaviors.

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APPENDIX A

Recruitment Flyer

Recruitment Flyer

Dear Veteran,

My name is Uchenna Nworah. I am a student at Texas Woman's University, Houston campus and a Nurse Practitioner at the Veterans Affairs hospital system. I am conducting a research study for my doctoral degree. I am interested in learning more about how male US veterans of the Iraq or Afghanistan wars make and carry out decisions about seeking and using the health care resources that are available to them. The title of the study is: *The Meaning of Health Care Seeking Behavior and Resource Use among United States Male Veterans Who Served in Iraq and Afghanistan Wars.*

If you are a male US veteran of the Iraq or Afghanistan wars you are eligible to participate in the study. I am reaching out to members of the Lone Star Veteran's Association who have served in the Iraq or Afghanistan wars. If you participate you will be asked to meet with me for an in-person interview about your experiences seeking and using health care. The maximum time for commitment is 60 minutes. Participants will receive a $25 gift certificate.

If you are interested in learning more and participating in the study, please contact me at 713-906-0081, or email me at unworah@twu.edu. If you know other male US veterans of the Iraq or Afghanistan wars who might be interested in participating in the study, please share this invitation with them.

Thank you.

Uchenna Nworah, MSN, RN, FNP-BC

Texas Woman's University

APPENDIX B

Letter of Support from Lone Star Veterans Association

Letter of Support from Lone Star Veterans Association

John W. Boerstler o Executive Director o 832-408-0270 o
John@LoneStarVeterans.org

July 11, 2012

Dear Texas Woman's Institutional Review Board,

The Lone Star Veterans Association would like to give Ms. Uchenna Nworah support and permission to reach out to our members and families by sending informational fliers about her study through our subsriber lists.

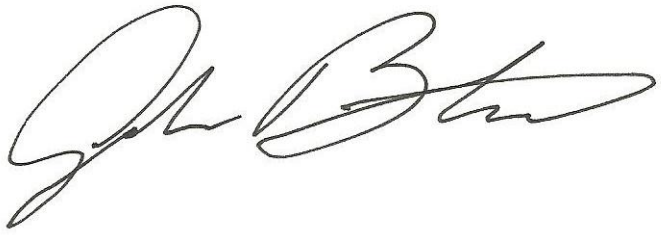
Our staff firmly believes that the research Ms. Nworah is conducting will be critical in better understanding the issues our returning veterans face upon transition particularly as it relates to enrollment in the Veterans Health Administration.

Thank you in advance for your consideration of this letter and please call or email me if I can provide any additional information.

Very Respectfully,

John W. Boerstler Executive Director, Lon

We've Been There.



The Lone Star Veterans Association is a non-profit 501(c)(3)* organization that envisions a Houston community where Post 9/11 veterans and their families are supported by direct communications, advocacy, employment assistance, mentoring, services and social programming.

THANK YOU FOR BEING A PART OF LONE STAR VETERANS ASSOCIATION

*Federal Tax ID#:27-1427288

APPENDIX C

Institutional Review Board Approval Letters

TWU
TEXAS WOMAN'S UNIVERSITY
DENTON DALLAS HOUSTON

Office of Research
6700 Fannin Street
Houston, TX 77030-2343
713-794-2480 Fax 713-794-2488

August 29, 2012

Ms. Uchenna Nworah
College of Nursing
6700 Fannin Street
Houston, TX 77030

Dear Ms. Nworah:

Re: The Meaning of Health Care Seeking Behavior and Resource Use among United States Male Veterans Who Served in the Iraq and Afghanistan Wars (Protocol #: 17103)

Your application to the IRB has been reviewed and approved.

This approval lasts for one (1) year. The study may not continue after the approval period without additional IRB review and approval for continuation. It is your responsibility to assure that this study is not conducted beyond the expiration date.

Any modifications to this study must be submitted for review to the IRB using the Modification Request Form. Additionally, the IRB must be notified immediately of any unanticipated incidents. If you have any questions, please contact the TWU IRB.

The signed consent forms, as applicable, and final report must be filed with the Institutional Review Board in the Office of Research, IHS 10110, at the completion of the study.

Sincerely,

Carolyn Kelley, PT

Carolyn Kelley, PT, DSc, NCS
Institutional Review Board - Houston

TWU
TEXAS WOMAN'S UNIVERSITY
DENTON DALLAS HOUSTON

Office of Research
6700 Fannin Street
Houston, TX 77030-2343
713-794-2480 Fax 713-794-2488

August 26, 2013

Ms. Uchenna Nworah
College of Nursing
6700 Fannin Street
Houston, TX 77030

Dear Ms. Nworah:

Re: The Meaning of Health Care Seeking Behavior and Resource Use among United States Male Veterans Who Served in the Iraq and Afghanistan Wars (Protocol #: 17103)

The request for an extension of your IRB approval for the above referenced study has been reviewed by the TWU Institutional Review Board (IRB) and appears to meet our requirements for the protection of individuals' rights.

If applicable, agency approval letters must be submitted to the IRB upon receipt PRIOR to any data collection at that agency. A copy of the approved consent form with the IRB approval stamp is enclosed. Please use the consent form with the most recent approval date stamp when obtaining consent from your participants. A copy of the signed consent forms must be submitted with the request to close the study file at the completion of the study.

This extension is valid one year from August 26, 2013. Any modifications to this study must be submitted for review to the IRB using the Modification Request Form. Additionally, the IRB must be notified immediately of any unanticipated incidents. If you have any questions, please contact the TWU IRB.

Sincerely,

Jan Foster

Jan Foster, PhD, APRN, CNS
Institutional Review Board - Houston

cc. Dr. Karen Lyon, College of Nursing - Houston
Lene Symes, PhD, College of Nursing - Houston
Graduate School

APPENDIX D

Informed Consent

TEXAS WOMAN'S UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

Title: The Meaning of Health Care Seeking Behavior and Resource Use among Male Veterans Who Served in the Iraq and Afghanistan Wars

Investigator: Uchenna Nworah unworah@twu.edu 281-485-8804
Advisor: Lene Symes, PhD LSymes@twu.edu 713-794-3151

Explanation and Purpose of the Research
You are being asked to participate in a research study for Uchenna Nworah's dissertation at Texas Woman's University. The purpose of the research is to provide an understanding of the meaning of health care seeking behaviors of the Iraq and Afghanistan male veterans, and their use of health care services. This will allow health care providers to develop interventions that will lead to increased health care seeking and health resource use among these veterans. You are asked to participate in this study because you served in the Iraq or Afghanistan wars

Description of Procedures
As a participant in the study you will be asked to spend a maximum of one hour and 30 minutes of your time in a face-to-face interview with the researcher. You will be asked questions about the healthcare decisions you have made and how you reached those decisions. Time and location for the interview will be determined by you and agreed to by the researcher. The interview will be audio recorded to enable the researcher to accurately study and write what you have said. To participate in the study, you must be an adult who had served in either the Iraq or Afghanistan wars or both.

Potential Risks
The researcher will ask you questions about your health care decisions and what seeking health care means to you. There are no physical risks to you associated with this study. A possible risk in this study is stress. You may choose not to answer a question or stop answering questions at any time and end the interview. The researcher will provide you with information for obtaining supportive resources from the VA, if you become obviously stressed. You may also become tired. You are free to take breaks or stop the interview at any time.

A potential risk in this study is loss of confidentiality. Confidentiality will be protected to the extent that is allowed by law. The interview will be held at a location that you and the researcher have agreed to, where the conversation is unlikely to be overheard. You will not be asked to state your full name or any other identifying information during the interview to minimize the loss of confidentiality. A code will be used to label the recording, instead of your name. The researcher is the only person on the research team who will know your name. The recording and the consent form will be stored in a locked cabinet in the researcher's home. Only the transcriptionist, the researcher, and the study committee will hear the recording. The recordings will be destroyed on or before

_____
Initials

5/1/215. No information identifying you will be included in the study reports that will be presented at research conferences and published in research journals.

You should let the researchers know of any problem that arises during the interview at once for help. But TWU does not provide medical services or financial assistance for injuries that might happen because you are taking part in this research.

Participation and Benefits

Your participation in this study is completely voluntary and you may withdraw from the study at any time. Your benefits and care at the VA hospital and clinics will not be affected if you do not participate in the study. You will receive a gift certificate of $25 for participation in the study. The researcher will notify you of the result of the study when it is completed by mail or e-mail.

Questions Regarding the Study

You will be given a copy of this signed and dated consent form to keep for your record. For questions regarding the study, you can call the researcher at the number provided at the top. If you have questions about your rights as a participant in this research or the way this study has been conducted, you may contact the Texas Woman's University Office of Research at 713-794-2480 or via e-mail at IRB@twu.edu.

_____ _____

Signature of Participant Date

If you would like to know the results of this study tell us where you want them to be sent:

Email: _____
Or
Address:

_____

_____

_____

APPENDIX E

Semi-structured Interview Guide

Semi-Structured Interview Guide

Concepts	Questions	Probes
Health Maintenance and Healthcare-seeking behavior Wellness	1) Tell me about a time you decided to see a healthcare provider when you were feeling well.	What was the situation before you decided? How did you feel about your decision later? Tell me more – Give me examples How has getting help affected that?
Sickness	2) Tell me about a time when you decided to see a health care provider when you were *NOT* feeling well.	What were your thoughts before you decided? Later? Who did you talk to about going to see a healthcare provider? If so, did that influence your decision? How did you feel about your decision to get help---or not? What were your feelings before you decided? And later? Tell me more about that OR Give me an example.
	3) Tell me about a time when you needed to see a healthcare provider and you *decided not to go?*	What was the situation before you decided? And Later? Did you eventually go? What were your feelings before you decided? How did you feel about your decision to seek help?

Continued

Reflective about healthcare decisions		How does not getting help affect that?
	4) Tell me about a time that was different than what you have told me about?	Same probes as above
	5) What do you consider when making the decision to seek help or not?	Tell me more --- Give me an example---
	6) How does being in the military affect your decision to seek help?	Tell me more --- Give me an example--
	7) As you think about the health care decisions you have made, what is important to you in deciding about seeking health care?	Tell me more --- Give me an example---
Closing	8) What does it mean to seek health care? 9) Is there anything else that you would like to add to help healthcare workers understand how you and other male military veterans make health care decisions?	Tell me more --- Give me an example---

APPENDIX F

Demographic Data Form

Demographic Data Form

Age: How old are you?
Race:
- Black
- White
- Hispanic
- Other

Relationship Status:
- Single / Never married
- Married
- Divorced / Separated/Widowed

Living Situation:
- Lives alone
- Lives with family
- Homeless

Education: Highest level of Education Completed:
- High school
- Some college /Associate Degree
- College degree

Employment Status
- Employed
- Unemployed /Retired
- Disability

Military Rank:
- E1-E4
- E5-E9
- Officer

Branch of Military service:
- Air force / Marine /Army / Navy

National Guard / Reserve

Deployment:
- Iraq
- Afghanistan
- Iraq and Afghanistan

Number of Tour of Duty:
- One time
- 2 -3times
- >3 times

Combat Service Status

Combat

Non-combat

APPENDIX G

Acceptance E-mail Manuscript JPN-2013-059 Version 1

Acceptance E-mail Manuscript JPN-2013-059 Version 1

I am pleased to inform you that your manuscript entitled "Afghanistan and Iraq War Veterans' Health Care Needs and Their Under Use of Health Care: Implications for Mental Health Nurses," manuscript #JPN-2013-059 Version 1, has been accepted for publication in the Journal of Psychosocial Nursing and Mental Health Services, pending minor revisions. Please address the following in your revised manuscript:

1.Please put the focus of the manuscript in the first paragraph. It's on page 2, at the end of the top paragraph.

2. Page 4-- 5 lines down--surely you mean "soldier"?

3. Throughout the manuscript, be selective in the references you use to make your point. Two of the most relevant would be enough. Reduce the total number of references (guidelines for authors states a maximum of 15). For a 15 page manuscript, 10 pages of references are far too many.

4. Review the manuscript to reduce redundancy--- e.g.- page 5--"repeated deployment" on adjacent lines.

5. Bottom of page 6-- What is meant by "excessive social integration"?

Please submit your revised manuscript online at www.RapidReview.com. Scroll down to SLACK Incorporated and click the Author button. Enter your user name and password in lower case using your first initial and your last name for both fields, unless you have assigned your own user name and password previously. You will now see your Inbox. Locate the title of the manuscript. Click on Resubmit, follow the prompts, then

upload your files.

IMPORTANT: All elements of the paper (e.g., abstract, text, references, tables, figures) must be resubmitted, even if no changes were made, to ensure the manuscript is complete in the system. The system does not retain your original files, only the PDF created.

When you submit the revised manuscript online, please outline the changes you made to the manuscript in the cover letter. If you have any questions about the revision, please contact the Executive Editor, Aileen Wiegand, by telephone at 856-848-1000, ext. 447, or by e-mail at awiegand@slackinc.com.

In accordance with the International Committee of Medical Journal Editors' (ICMJE) guidelines, all authors are required to complete and submit the ICMJE Form for Disclosure of Potential Conflicts of Interest (http://www.healio.com/ICMJEform). This form must be uploaded for each author at the time of version 2-manuscript submission (please upload using the category "Form File" when resubmitting). Completion of this form for each author is required prior to acceptance of any manuscript.

Thank you again for your contribution and welcome to JPN.

Sincerely,

Shirley A. Smoyak, RN, PhD, FAAN

Editor

APPENDIX H

Manuscript submission: MS# MILMED-D-14-0060

Manuscript submission: MS# MILMED-D-14-0060

Dear Mrs. Nworah,

Your submission entitled "The meaning of seeking help to United States male veterans of Iraq (OIF) and Afghanistan (OEF) wars: An interpretive phenomenological study." has been assigned the following manuscript number: MILMED-D-14-00605.

You will be able to check on the progress of your paper by logging on to Editorial Manager as an author. The URL is http://milmed.edmgr.com/.

Thank you for submitting your work to this journal.

Kind regards,

Joanne L. Manelli, M.A.

Journal Staff

Military Medicine

APPENDIX I

Journal of Psychosocial Nursing Authorization

Journal of Psychosocial Nursing Authorization

Dear Ms. Nworah,

You may include the article in your dissertation, as per our guidelines:

Author Rights Related to Published Journal Articles

Scholarly Uses of Content:

> Dissertations or Theses: Authors may reuse all or part of the submitted, accepted, or final version of their article in a thesis or dissertation that the author writes and is required to submit to satisfy the criteria of degree-granting institutions, provided that it is not published commercially and copies are not offered for sale or distributed in any systematic way.

Regards,

Aileen