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VETERAN WELLNESS AND REINTEGRATION: FACTORS CONTRIBUTING TO THEIR
SUCCESS IN THE COMMUNITY

A Dissertation

by

MELISSA A ESCAMILLA

Submitted to the Graduate School of
The University of Texas Rio Grande Valley
In partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

May 2019

Major Subject: Rehabilitation Counseling

VETERAN WELLNESS AND REINTEGRATION: FACTORS CONTRIBUTING TO THEIR
SUCCESS IN THE COMMUNITY

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May 2019

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ABSTRACT

Escamilla, Melissa A., The Relational Impacts of Veteran Wellness and Community Reintegration. Doctor of Philosophy (Ph.D.), May, 2019, 98 pp., 8 tables, 10 figures, references, 162 titles.

The purpose of the following study is to determine if there is a relationship between veteran wellness based on gender, discharge status, theatre of operations, substance use disorder, veteran self-efficacy, community reintegration post discharge, stigma and veteran physical and psychosocial factors. Military veteran wellness has been the focal point of service providers for ensuring post-discharge veterans' success. During the last decade there has been an increase in military veterans reintegrating into society with chronic ailments and undiagnosed conditions. The study examined 85 Texas veterans: (a) the relationship between veterans' substance abuse and their perception of stigma, (b) the relationship between veteran self-efficacy and veteran personal wellness, (c) the impact of psychological factors of veteran wellness on veterans' reintegration into the community post discharge from the armed services, and (d) the specific demographic factors of veterans on their reintegration into the community. Results indicated veteran wellness was highly correlated with specific veteran demographic factors, and stigma. Implications of the study and recommendations for future research are included in the study to better identify factors that can improve veteran well-being.

Keywords: veteran, well-being, reintegration, stigma, self-efficacy

DEDICATION

My dissertation is dedicated to my family and all servicemen who bravely and honorably served in our nation's military defending the rights we take advantage of daily. To my son, Mateo "Matt" Solis, III, thank you for encouraging me to finish my educational journey. You were always there to cheer me on when a deadline was near and knew I could conquer anything I chose to with the extra push. You have always tested my ability to push forward and knew how to push me forward. This dissertation is not just mine but yours as well. The completion of my dissertation would not have been possible without your insightful knowledge of veterans and active duty service members. Most of all, thank you for the sacrifices you have made for our country.

The completion of my doctoral studies would not have been possible without the love and support of my family. My parents, Rolando and Marie Escamilla, thank you for understanding when I needed to complete my studies. Your understanding helped me in many ways overcome some of the challenges along my journey.

ACKNOWLEDGMENTS

First and foremost, I would like to thank God for the encouragement, protection, guidance, wisdom, strength and will throughout this journey. I will always be appreciative to Dr. Bruce Reed, chair of my dissertation committee, for all his guidance and advice. I am a better instructor, counselor, administrator and researcher because of your wisdom, guidance, and patience. Thank you for always believing I could do anything with my studies. I would like to express my heartfelt thanks to my committee members, Dr. Jerome Fischer for providing me insightful knowledge, redirection, and ideas.

I would like to express my gratitude to the University of Texas at Rio Grande Valley for supporting my research. Sincere thanks to Dr. Ralph Carlson and Dr. Paul Sale, without their assistance and insight with statistics this study would not have been analyzed appropriately. I would like to thank Dr. Noreen Graf for inspiring me to work diligently on research design and methodology. Also, a special thank you to my fellow classmates, Sergio Cuevas and Chia Vang, who made my experience at UTRGV memorable by providing undying support and encouragement when I needed it the most. You were always there to encourage me when I faced several challenges along my journey.

Lastly to my dad, “thank you daddy,” for being my silent cheerleader and messaging me when I needed encouragement to go on. You always knew when to send me a message of encouragement.

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CHAPTER I

INTRODUCTION

Military veteran wellness has been the focal point of service providers for ensuring post-discharge veterans' success. Since 2001, hundreds of thousands of military men and women have been deployed overseas to serve in Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) experiencing multiple tours of duty and significant exposure to trauma and combat (Fox, Myer, Vogt, & De Leon, 2015; Schell & Marshall, 2008). Research has demonstrated that numerous deployments can have a negative impact on how well veterans reintegrate with their families (Carrola & Corbin-Burdick, 2015). Post-deployment veterans are at greater risk of mental health problems such as post-traumatic stress disorder (PTSD), anxiety, depression, and alcohol abuse. Accordingly, combat exposure increases the risk of PTSD (Carlson, Garvert, Macia, Ruzek, & Burling, 2013) and the risk of chronic and persistent mental and physical health problems (Stebnicki, 2015).

Veterans are also at greater risk of reintegration issues due to impaired self-sufficiency, disruptions in social relationships, disabilities, a lack of social networks and various institutional and attitudinal limitations such as mental health stigma and beliefs on treatment (Lunberg, Bennett, & Smith, 2011; Sporer et. al, 2009). These problems persist despite the high availability of free or low-cost health services in both military and the U.S. Department of Veteran Affairs (VA) health care settings; however, many service members and veterans who

might benefit from treatment do not make use of available services or not have access to seek available services. As a result, the veteran is at a high risk of a variety of disabling conditions that could occur and reoccur over time.

Veterans represent a distinct sub-culture of American civilian society (Exum, Coll, & Weiss, 2011). Specific aspects of military culture can be a factor contributing to veterans not seeking treatment for chronic mental health and physical health issues. In addition, certain aspects of military culture discourage veterans from seeking mental health screening, assessment, and treatment on a regular basis. Sayer et al. (2010) noted “combat veterans had multiple challenges in multiple domains of functioning and community involvement (p.2).” Additionally, veterans may engage in healthy or unhealthy coping skills to overcome mentally and physically challenging tasks (Stebnicki, 2015).

Researchers have taken a significant interest in examining vulnerability and protective factors that are associated with mental health concerns of veterans from OIF/OEF to effectively work with future combat survivors (James, Van Kampen, Miller, & Engdahl, 2013). Previous research has suggested the exclusive focus on combat exposure has hindered understanding other important personal and environmental factors that affect mental health among veterans. Veterans are committing suicide at a higher rate than people who have not served in the military. Numerous factors contribute to the high rate of suicide. These factors include events occurring before deployment, previous exposure, financial issues, post deployment issues, and suicide associated with a veteran’s clinical diagnosis (Carrola & Corbin-Burdick, 2015). About 70% of homeless or at-risk veterans report a comorbid condition such as substance abuse or mental illness.

Wellness counseling is a new approach for a veteran which encourages positivity with preventive and developmental interventions (Carrola & Corbin-Burdick, 2015). Unlike the medical model, the veteran's wellness approach is more expansive and focuses on "a way of life oriented toward optimal health and well-being in which mind, body and spirit are integrated by the veteran" (Myers, Sweeney, & Witmer, 2000, p. 252). Although the wellness counseling model is found to promote understanding of cultural groups, military culture seems to remain a determining factor in the lack of access to social and mental health services. There are many factors that prevent the intervention of physical and mental health issues amongst veterans reintegrating post military discharge.

Chapter 1 begins with a background discussion on the issue of veteran wellness in community reintegration and the need to address the issue. The problem statement is expressed initially in general terms and then focuses on the impacts that may impede veteran wellness in community reintegration. A discussion of the purpose includes the research method and design and the variables of interest, population to be studied, and the geographic location where the study will be conducted. The importance of the study and significance to the field of rehabilitation is discussed.

An overall description of the research design and methods includes the sample utilized to accomplish the goals of the research. Four research questions guided the study. Definitions of terms are defined, assumptions are identified, and the scope, limitations and delimitations of the study are outlined.

Background of the Problem

After multiple lengthy deployments and frequent exposure to trauma and combat, many military veterans are returning home with several issues which go undiagnosed or untreated (Sayer, Carlson, & Frazier, 2014). Veteran wellness has been a core treatment modality for the Veteran's Administration since the return of OIF/OEF military personnel returned from active duty. Although the treatment is available, many veterans discharged from the military do not seek treatment due to stigma reinforced through military culture and civilian perspective (Weiss & Coll, 2011). Stigma, homelessness, myths about treatment, social, economic and geographic health care disparities, disruptive mental health issues, substance abuse disorders and problematic community reintegration issues are at the forefront of not seeking treatment.

Veteran populations benefit from advocacy services to connect or reconnect with their family and community members (Carrola & Corbin-Burdick, 2015). However, mental health practitioners and social work personnel who work with transitioning veterans may not be well equipped to provide culturally appropriate counseling interventions to minimize the ongoing stigma of seeking appropriate mental health services (Carrola & Corbin-Burdick, 2015). Although the Veteran's Administration provides several free and low-cost services to veterans, there are many veterans who go unserved and undiagnosed for years. Factors that impede veteran wellness may include a lack of self-efficacy of the veteran, familial and social stigmas toward mental health treatment, and access to social and mental health services. These factors

may prevent the promotion of well-being in our military veterans reintegrating into the community.

Statement of the Problem

Beliefs and perspectives of veterans can deter them from accessing social services. Many veterans go without social services to avoid the scrutiny from their workplace, loved ones and their own beliefs about accessing mental health and health services. Many veterans are not accessing free to low cost health and mental health services offered through the VA. (Vogt et al., 2014). Lang, Veazey-Morris, Berlin and Andrasik (2016) reported over half of the reported veterans in a study at Memphis Veterans Affairs Medical Center from 2009-2012 did not obtain enough mental health care. Shelton, Taylor, Bonner, and Van den Bree (2009) reported mental health status, co-occurring substance abuse issues, and chronic illness heavily contribute to veteran homelessness. Veteran's unique exposures to trauma include readjustment difficulties, combat injury, prolonged/intense combat exposure, military sexual trauma, and military service; this in turn, can lead to a physical/cognitive disability, post-traumatic stress disorder, depression, anxiety, and alcohol and/or drug abuse (Shelton et al., 2009)

Veterans also face challenges such as low social support, low/unstable income and incarceration. These challenges can lead to a veteran not wanting to access social services for fear of the social stigma (Woolsey & Nauman, 2015). Mott, Stanley, Street, Grady, and Teng (2014) reported underutilization of services may be due to a lack of awareness or understanding of treatment options, increased anxiety on expectation of treatment, and insufficient knowledge. Veterans with severe mental health symptoms are more likely to not access medical and mental health services. Blais and Renshaw (2013) noted studies indicate 56% to 87% percent of service

members experiencing psychological distress did not seek treatment. The delivery method of treatment can also be a factor in treatment outcomes for those seeking treatment for PTSD. Lang et al., (2016) noted it was important to access services in a timely manner to improve veteran's health outcomes.

Need for the Study

Vogt, Taverna, Nillni, and Tyrell (2018) stated existing measures of well-being and related constructs are limited in several ways. The researchers stated several measures focused on the health domain but, failed to address other important life domains that are relevant for defining well-being. In addition, many well-being clinical samples were intended to address the functional impact of health conditions and were not generalizable to the larger population. Vogt, Taverna and Nillni (2018) also stated very few measures allowed for separate scoring of different components of well-being which limited the areas in which individuals would benefit from support. Researchers also addressed the lack of availability and accessibility of well-being assessment tools.

U. S. Government Accountability Office (2014) has reported over 1 million active service members are expected to join the 2.3 million veterans who have been separated from military service since the September 2011 attacks. The U. S. Department of Veteran Affairs estimates there are over 40,000 organizations that provide services to promote veteran reintegration and readjustment (Berglass & Harrell, 2012; Pederson, Eberhart, Williams, Tanielian, & Scharf et al., 2015). Although research efforts have been made to address and promote veteran wellness, efforts have not appropriately addressed to meet the needs of recently separated veterans and their families (Vogt et al., 2018). In addition, some veterans may find it difficult to transition

back to civilian life independently. Veterans with complex medical and mental health issues may encounter additional burdens and barriers toward successful reintegration (Vogt et al, 2017; Sayer et al., 2010)

The Veteran Metrics Initiative Study conducted by Vogt et al. (2018) was designed to document veteran well-being, identify programs that veterans use to reintegrate into civilian life and examined the link between common program components of veteran well-being and reintegration. The initiative was the only longitudinal study conducted in partnership with public and private partnerships. However, the study was limited to veterans who were separated within the first three years from the military. Many veterans may not seek out community services or resources within the first few years of their transitional period.

Petrovich, Pollio, and North (2014) conducted a study to describe the characteristics of veterans and nonveterans to predict their use of services and compare the predictors of use of services by veterans and nonveterans. Petrovich et. al (2014) noted there are various programs available such as permanent supportive housing, transitional housing, emergency shelter, medical care, mental health and substance abuse treatment, employment training, and providers of food. The prevalence of alcoholism and substance use was also similar in both groups; this in turn, can often lead to homelessness.

Although veteran homelessness has diminished in the past few years, there continues to be a need to examine why veterans do not seek mental health and social services post discharge. Berglass and Harrell (2012) reported the most effective community-based reintegration models for delivering appropriate care and services for veterans are at the local level. In addition, those

that are the most credible are local nonprofit organizations that coordinate and deploy both public and private resources.

The Veterans Metrics Initiative study is a longitudinal study which only focuses on veterans who have been separated within the past three years (Vogt et. al, 2018). Many veterans accessing Veteran's Administration services and community resources may still have trouble transitioning after the initial three years. The veteran wellness study conducted in a community setting will address veterans who have been separated over three years and who are experiencing homelessness or at risk of homelessness. The study will inform, educate and examine the relationships of veteran wellness and other factors related to veteran community reintegration.

Purpose of the Study

The purpose of the following study is to determine if there is a relationship between veteran wellness based on gender, discharge status, theatre of operations, substance use disorder, veteran self-efficacy, community reintegration post discharge, stigma and veteran physical and psychosocial factors. To fulfill the purpose of the study, data was collected from veterans in Texas via an anonymous online survey link through Qualtrics. A descriptive survey research design was appropriate because data collected tested the hypotheses of factors relating to stigma, community reintegration and the relationship between veteran wellness, veteran self-efficacy, and substance use disorder. The research variables of interest in the study are the veteran self-efficacy and veteran personal wellness on post discharge community reintegration and to what extent does veteran wellness differ based on gender, discharge status and theatre of operations.

Research Questions

The following research questions were used to guide the researcher in the proposed study are as follows:

1. Is there a relationship between treatment seeking and specific veteran demographic factors (gender, theatre of operations, substance abuse, discharge status) and stigma beliefs?

H Φ I: There is no relationship between treatment seeking and specific veteran demographic factors (gender, theatre of operations, substance abuse, discharge status, substance abuse) and stigma beliefs.

2. Is there a relationship between self-efficacy and specific veteran demographic factors (gender, theatre of operations, substance abuse, discharge status, substance abuse) and stigma beliefs?

H Φ II: There is no relationship between self-efficacy and specific veteran demographic factors (gender, theatre of operations, substance abuse, discharge status, substance abuse) and stigma beliefs.

3. Is there a relationship between well-being and specific veteran demographic factors (gender, theatre of operations, substance abuse, discharge status, substance abuse), and stigma beliefs?

HΦIII: There is no relationship between well-being and specific veteran demographic factors and stigma beliefs.

4. What is the relationship between self-efficacy and vocational, financial, health and social well-being?

HΦIV: Self efficacy is not a function of vocational, financial, health and social well-being.

Significance of the Study

Most studies on veteran reintegration are conducted in Veteran's Administration programs in other parts of the United States not including Texas. Texas is the second largest state in the nation and second ranked state in the nation where veterans call home. According to the National Center for Veterans Analysis and Statistics (2016), 48% of 20.4 million veterans in the United States utilized a Veteran's Administration in fiscal year 2016. Therefore, 52% of veterans are not receiving any type of service from the VA. Although the veteran population is predicted to decrease, it is also predicted that Texas will be the top ranked state where veterans call home by 2027. Veterans returning home from recent conflicts in Iraq, Afghanistan and Syria are coming home to more complicated healthcare needs than can affect the overall wellness of a veteran. Families and communities may not be prepared or equipped to handle the complex

needs of the veteran. Appropriate healthcare and access to veteran services also may not be readily available based on geographic location of a veteran in Texas.

The intent of the study was not only to identify and examine the relationships of veteran wellness on several factors but to gain a perspective on the attitudes of veterans accessing social service resources outside the Veteran's Administration and to examine the quality of life among veterans who utilize community services. This study examined the relational impacts that aid veterans throughout their post discharge community reintegration period. It also examined the connection of veterans receiving community services between veteran wellness, veteran self-efficacy, substance use disorders and community reintegration.

Significance to the Field of Rehabilitation

There has been a significant increase in ill or injured veterans returning from combat since OIF and OEF deployments (Lang, Veazey-Morris, Berlin, & Andrasik, 2016). The length of deployments, number of deployments, and injuries incurred while in service have impacted the reintegration process for promoting veteran wellness. This study intends to: (a) identify the relational factors that promote veteran wellness post military discharge, (b) to examine the relational link between veteran wellness and community reintegration programs and resources, and (c) educate rehabilitation professionals on the barriers and/or limitations veterans face when reintegrating into society. In addition, results of this study would provide rehabilitation counselors insight between relational factors relating to self-efficacy, veteran wellness, and differences (if any) among veteran's community reintegration concerning gender, discharge status, and theatre of operations.

Definition of Terms

The following terms are defined operationally as they are used throughout the study:

Community Reintegration: Veterans who discharge from the military and return to participation in life roles in the community and/or at home (Resnik et al., 2012).

Post Discharge Status: When a member of the armed forces is released from his or her obligation to serve (gpo.gov)

Post-Traumatic Stress Disorder: A mental disorder, known as battle fatigue, occurring after a traumatic event outside the range of usual human experience, and characterized by symptoms such as reliving the event, reduced involvement with others, negative thoughts or feelings that worsen after a traumatic event, manifestations of autonomic arousal such as hyper alertness and exaggerated startle response, symptoms that last for more than one month, symptoms create distress and functional impairment, and symptoms are not due to medication, substance use or other disorder (American Psychological Association, 2013).

Stigma: According to Link (2001), elements of labeling, stereotyping, separation, status loss and discrimination co-occur in a power situation that allows them to unfold

Substance Use Disorder: According to the Diagnostic and Statistical Manual of Mental Disorders (5th edition; American Psychiatric Association, 2013), a diagnosis is based on evidence of impaired control, social impairment, risky use and pharmacological criteria which

may be mild, moderate, or severe to indicate the level of severity, which is determined by the number of diagnostic criteria met by an individual. Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.

Veteran: A person who served in the active military, naval, or air service, regardless of length of service, and who was discharged or released there from, excluding any one who received a dishonorable discharge or was discharged or dismissed by reason of a General court-martial (PL 114-315; 38 USC § 2002(b)). The period of active service must include service in active duty for purposes other than training (U.S. Department of Veteran Affairs [VA], 2017).

Veteran's Administration: The federal agency charged with administering benefits provided by law for veterans of the armed forces.

Well-Being: consists of status, functioning, and satisfaction within the key life domains of vocation, finances, health and social relationships (Vogt, Taverna, Nillni, & Tyrell 2018).

Assumptions

The following assumptions were made for this research study:

1. Veterans who participated in this study were aware of the vocabulary used throughout the questionnaire.
2. Veterans who participated responded honestly and to the best of their ability.

3. The researcher was non-biased, and the interpretation is a true testament of the veteran's response to stigma, wellness and reintegration.

Limitations and Delimitations

There were several limitations found in this study. The distribution of the survey was limited to veterans who resided in the state of Texas. The responses of these veterans may not reflect the responses of all veterans in community reintegration settings. Results were limited to assessing the answers to the research questions. In addition, a non-probability (convenience) sampling method was utilized to ensure a significant number of participants take part in the study. Another limitation is the possibility of participants responding in a socially desirable fashion.

The research study had the following delimitations:

1. The sample of the study will be limited to veterans located in the state of Texas.
2. The study will be delimited to the use of an online survey instrument for data collection.
3. The study will be delimited to veteran's voluntary participation.

Summary

Veteran wellness has become of significant importance since the return of veterans serving in OIF/OEF tours of duty. Most notably, veterans returning home have experienced longer deployments and exposure to significant combat experiences and prolonged trauma. The returning veteran may encounter issues in reintegrating back into the community due to a lack of adequate mental and physical health care services. Stigma related to military culture can play an

important role in the veteran's life. In addition, the lack of adequate care has led to experiences in homelessness, suicidal ideation, health care disparities and reintegration issues within the community and family. Veteran wellness programs are encouraged as an alternative to treatment; however, many veterans are not accessing the services provided in their own communities. Although there has been a concentrated effort to offer mental health services and treatment in the Veteran's Administration Medical Centers, there has not been enough evidence outlining the relational factors which prevent reintegrating veterans from accessing community services for personal wellness. A review of the relational factors and analysis of veteran's responses to stigma, self-efficacy, substance use disorder and mental wellness would be beneficial to community settings who serve the discharged veteran.

CHAPTER II

REVIEW OF LITERATURE

The following chapter is a review of literature on the framework of veteran wellness, mental health, stigma, and factors impacting a successful community reintegration post discharge for veterans. This chapter lays the groundwork for the study with a thorough review of published literature related to the study by focusing on: (a) military culture, (b) veteran wellness, (c) stigma, (d) community reintegration post discharge, (e) self-efficacy, and (g) effective mental health and substance abuse treatment.

The literature review focuses on factors that may impact veteran wellness. The studies included in the literature review are related to veteran wellness, community reintegration including impact on physical and mental health, suicide, substance use and comorbid disorders, veteran employment, veteran homelessness, stigma, and effective mental health and substance abuse treatment.

Introduction

During the last decade there has been an increase in military veterans reintegrating into society with chronic ailments and undiagnosed conditions. U.S. Census Bureau (2012) and Ysasi, Silva, and Becton (2016) reported more than 16.1 million veterans have served in the U.S. Armed Forces. Of those 16.1 million, 2.5 million veterans were directly involved with Operation

Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). The U. S. Government Accountability Office (2014) has reported over 1 million active service members are expected to join the 2.3 million veterans who have been separated from military service since the September 2011 attacks. There is concern over the many mental health and physical disabilities incurred from combat operations. Zeber, Noel, Pugh, Copeland, and Parchman (2010) reported over 40,000 active duty veterans had traumatic injuries. Schell and Marshall (2008) reported over half of the veterans who screened positively for probable post-traumatic stress disorder or major depression had not received any mental health care. Although many veterans report a successful transition back to their communities, Sheng et al, (2016) reported a significant number of veterans are having trouble with community reintegration post discharge. Lack of mental health care can lead to a multitude of issues for veterans reintegrating into society post discharge. Although the literature cites treatment of PTSD, traumatic injuries and effective treatment interventions in Veteran's Administration Medical Centers, literature does not address the challenges faced by the military veteran accessing community resources including personal wellness and mental health treatment outside the Veteran's Administration (Finley et al., 2010).

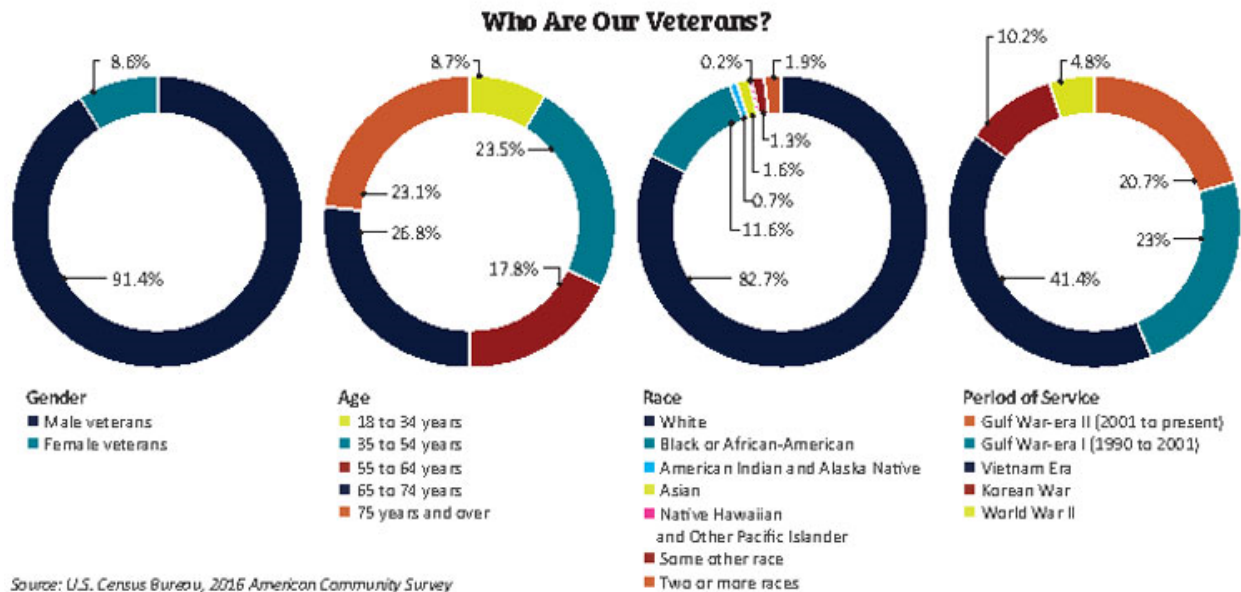


Figure 1: Who are Our Veterans? (U.S. Census Bureau, 2016)

Military Culture

Military culture plays a significant role in the lives of veterans. Coll, Weiss, and Yarvis (2011) identified military culture as a distinct sub-culture of American civilian society. Coll et al. (2011) identified five military value characteristics which included honor, courage, loyalty, integrity and commitment. In addition, Coll et al. (2011) also reported military veterans are often conflicted in emotions as they work towards peace while simultaneously protecting a country that may be perceived as a threat. Therefore, veterans may see themselves as secluded from civilian society. Military veterans can also have difficulties with simple tasks such as shopping because autonomy and individualism is not encouraged in the military. According to Coll et al. (2011), three virtues that shape military personnel include peacefulness, restraint, and obedience.

Military culture does not encourage a life of seeking mental health screening, assessment, and treatment on a regular basis. Sayer et al. (2010) noted, “combat veterans had multiple challenges in multiple domains of functioning and community involvement (p. 2)” Carrola and Corbin-Burdick (2015) discussed the view of veteran identity will have implications not only for client functioning but how treatment is received. Taylor and Baker (2007) expressed the importance of cultural and social development in promoting veteran wellness. Overall, wellness for military and non-military persons can have an impact on the ability to function in a culturally diverse environment.

Veteran Wellness

In the past two decades, wellness has been identified as an ideal approach in healthcare for counseling and development. Wellness is a strengths-based approach to mental health (Smith, 2001) that includes diversity and self-direction. There have been a variety of wellness models since its inclusion in the health care industry; however, the Wheel of Wellness model is currently the only counseling based theory (Myers & Sweeny, 2004). Alfred Adler, founder of individual psychology, proposed three major life tasks of work, friendship, and love. The Wheel of Wellness model incorporated Adler’s three major tasks and the two additional tasks of self and spirit (Myers & Sweeny, 2004). Myers, Sweeny, and Witmer (2000) modified the Wheel of Wellness model bringing the total of subtasks to 12.

The Wheel of Wellness encompasses spirituality as a core component in relation to other life tasks that affect personal wellness. Life forces include family, religion, education, business/industry, media, government, and community. After years of validating the psychometric properties of the Wellness Evaluation of Lifestyle, Hattie, Myers, and Sweeny

(2004) concluded the data did not support the hypothesized circumplex model and created the new Indivisible Self model of wellness.

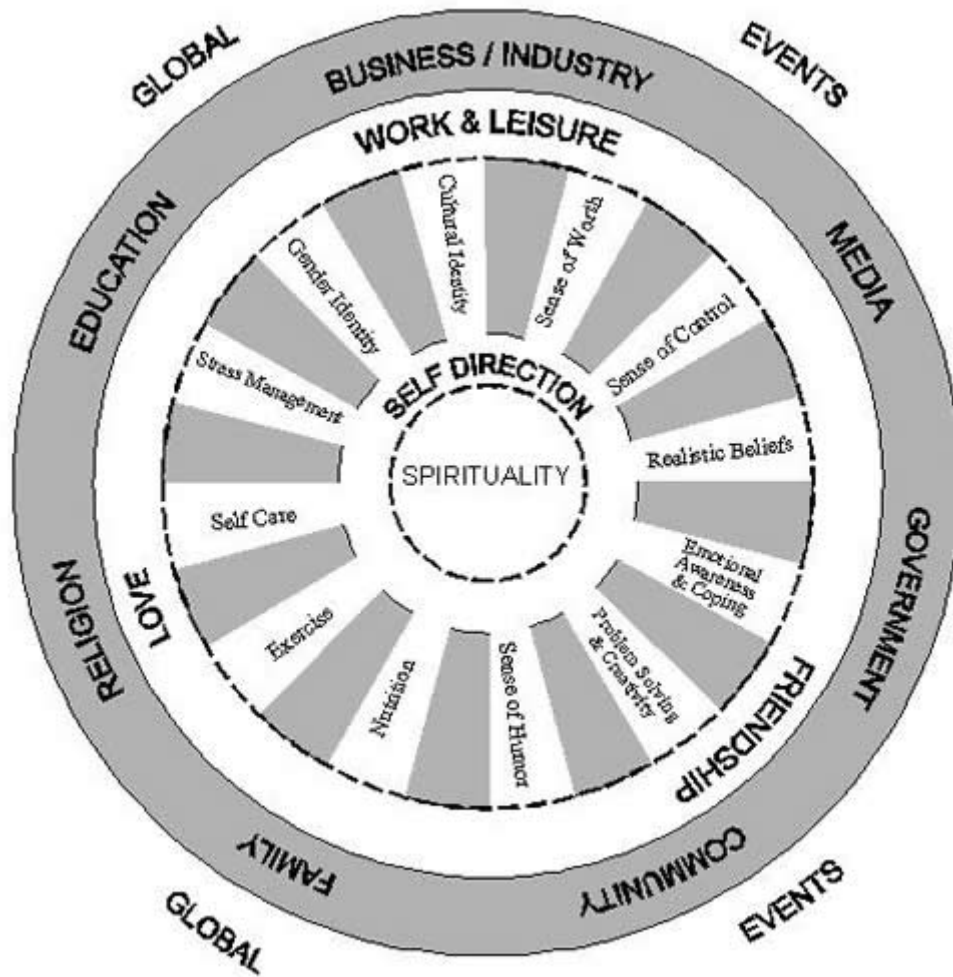


Figure 2: The Wheel of Wellness (Witmer, Sweeney, & Myers, 1988)

The Indivisible Self model is fundamental to evidence-based practice for mental health and counseling practitioners (Myers & Sweeney, 2004). The model is based on wellness behaviors that reflect intentionally in lifestyle decisions. Researchers note the model is also a

way of including Adlerian theory and methods into the mainstream of research and clinical practice. The Indivisible Self model includes 17 discrete components of the Wheel, 5 life tasks and 12 subtasks of self-direction. Researchers noted the philosophy of Adler's proposed holism or the indivisibility of self and purposiveness was essential to understanding human behavior. This understanding allowed researchers to better understand the structure of other wellness studies where relationships were at a higher order and seemingly indivisible factor

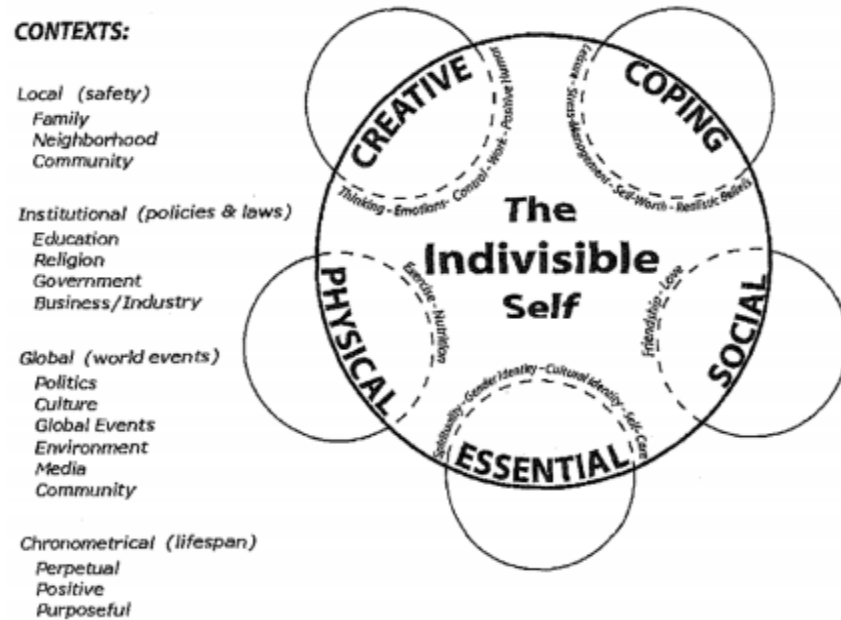


Figure 2. The Indivisible Self: An Evidence-Based Model of Wellness.

Figure 3: The Indivisible Self: An Evidence-Based Model on Wellness (Myers and Sweeney, 2004)

The Institute of Medicine (2013) reported not all community programs available for veterans are well equipped to handle the needs many of our veterans. Many veterans experiencing community reintegration are encountering problems with a variety of chronic stressors including but not limited to vocational attainment, legal, financial, housing challenges,

mental health conditions, and social and/or interpersonal issues (Perkins et al., 2019). Carter (2013) noted in response to veteran's needs there are a significant number of programs and services specifically for veterans. However, little knowledge is available on the programs veterans utilize. Perkins et al. (2019) noted social service providers can be more effective and helpful through increased awareness and understanding of the most common needs of a veteran. In addition, the researchers also noted social service providers should be aware of the resources veterans are utilizing for transition services. Research findings on veteran's well-being is not always shared with other organizations or funding sources. Many research studies that were conducted on veteran well-being focused on one organization, the Veteran's Administration. In turn, this lack of shared knowledge can reduce the relevance of the research for other partners or organizations (Vogt et al., 2018).

Impact of post-deployment on physical and mental health.

Veterans with chronic and disabling injuries face difficulty in achieving successful community reintegration (Belmont, Schoenfeld, & Goodman, 2010; Spelman, Hunt, Seal, & Burgo-Black, 2012;). Perkins et al., (2019) recently conducted a baseline assessment on The Veterans Metric Initiative (TVMI). The researchers reported 34% of transitioning veterans have an ongoing mental/emotional health condition, illness or disability. The most common reported injuries to returning wounded service members include vision and hearing loss, burns and mobility impairment, and mental health disabilities (Church, 2009).

About 22% of the wounded service members from Iraq and Afghanistan have experienced a traumatic brain injury (TBI) (Bowling & Sherman, 2008; Okie, 2005). TBI may pose a challenge for family reintegration as TBI often involves changes in mood and behavior,

including impulsiveness, and difficulty with concentration and memory (Bowling & Sherman, 2008). While research targeting family caregivers of people including veterans with TBI is sparse (Daggett, Bakas, & Habermann, 2009; Saban, Mathews, Bryant, O'Brien, & Janusek, 2012), studies consistently demonstrate that informal caregivers are at risk for developing depression, anxiety, alterations in immune response, poor quality of life, and health problems (Saban, Hogan, Hogan, & Pape, 2015).

Post-traumatic stress syndrome (PTSD) is often persistent and debilitating which sometimes leads to family dysfunction (Marek & D'Aniello, 2014; Riggs & Riggs, 2011). Between 12% and 30% of combat veterans who served in Vietnam and the more recent conflicts in Afghanistan (OEF) and Iraq (OIF) experience high irritability in the context of PTSD (Hoge et al., 2004; Renshaw, 2011; Schlenger et al., 1992). Taft, Schumm, Panuzio, and Proctor (2008) found that Operation Desert Storm combat exposure was linked to more severe PTSD symptoms and poorer adjustment during reintegration (Marek & D'Aniello, 2014).

Upon returning from deployment, service members often report they feel anxious, have difficulty connecting to others, experience sleep problems, and miss the structure and camaraderie of military service (Bowling & Sherman, 2008). According to several estimates, approximately 15-20% of combat troops have symptoms of anxiety disorders or depression (Blevins, Roca, & Spencer, 2011; Mental Health Advisory Team, 2008; Milliken, Auchterlonie & Hoge, 2007; Taniellian & Jaycox, 2008). They may face difficulties with depression, substance abuse, and intimate relationships over time. Due to the limitation of VA health benefits being restricted to only 60 months after discharge (Hinojosa, Hinojosa, Nelson, & Nelson, 2010), some veterans are more than likely to use non-VA primary care clinics which

have limited knowledge of veteran issues (Hinojosa et al., 2010; Gross et al, 2004). Veterans may also use non-VA primary care clinics due to the stigma associated with mental health service among military service members (Hinojosa et al., 2010; Mental Health Advisory Team, 2009).

Veteran suicide

Veterans pose the highest risk of suicide compared to the general U.S. population (Kang, et al., 2015). It is 22 times more likely that a veteran will commit suicide than their non-veterans (VA, 2017). The most recent data for veteran suicides shows 22 veterans a day commit suicide. Although overall rate of suicide has decreased, an alarming increase in the suicide rate amongst older and younger veterans has increased. In 2017, the VA Office of Public and Intergovernmental Affairs reported 65% of all veterans over 50 and older committed suicide. Data shows the suicide rate amongst younger veterans was 1.5 times greater than a person who has never served in the military. The *Military Times* (Shane, 2018), reported the suicide rate amongst younger veterans age 18-34 rose by 10 percent.

In 2016, Texas suicide rate among veterans was an estimated 33%. Ninety-five percent of the total Texas veteran suicides were male (VA, 2016). According to the U.S. Department of Veteran Affairs (VA, 2016), 70% of all veteran suicide deaths are a result of firearms. Rural veterans are at a higher risk of suicide due to geographic and social isolation and access to lethal means (Cantrell, Valley-Gray, & Cash, 2012; Hirsch & Cukrowicz, 2014). Bossarte (2018) noted suicidal ideation and interpersonal violence does not constitute violence involving a firearm.

McCarten, Hoffmire, and Bossarte (2015) reported data on veteran suicide was based on the veterans who utilized Veterans Health Administration (VHA) services. Veterans who received services from VHA were less likely to commit suicide than a veteran who did not receive VHA services. Maguen, Skopp, Zhang, and Smolenski (2015) and the VA (2016) report veterans with severe depression and major psychiatric diagnoses have the highest rate of suicide attempters. Veteran suicide rates may be higher since not all veterans access VHA services. Additionally, not all veterans have access to VHA services; a veteran's discharge status may limit the services available to them.

More than half of the service members who served in OIF/OEF know a 9/11 member who committed suicide. Barnes et al. (2017) emphasized strategies to encourage healthy decision making for suicide prevention. Although not all veterans pose a risk, it is important to identify and intervene when all possible. The VA (2017) implemented Reach Vet to help reduce the risk of veteran suicide amongst veterans receiving VHA services. In addition to Reach Vet the VA also implemented the Coaching into Care Program for families who are experiencing difficulties with their service member transitioning to the community. The Coaching into Care Program provides the veteran with a counselor who can provide information and referral based on the needs and barriers the veteran is encountering with transition (VA, 2017).

Substance use and comorbid conditions

Kahn et al., (2016) cited 81.5% of Global War on Terror veterans have acute or chronic pain. Although limited research is available on substance abuse issues and public stigma, it remains of importance when working with veterans with comorbidities. Individuals with mental health disorder and substance use disorder may experience additional social disapproval

compared to other stigmatized groups such as people who are obese or people experiencing homelessness (Kahn, et al. 2016; Room, 2005). Addiction may be perceived by the public as a character flaw for substance abuse users. Additionally, people may view people with substance use disorder as more dangerous than people with mental illness (Corrigan, Kuwabara, & O'Shaughnessy, 2009).

In a study conducted with veterans admitted in a Substance Abuse and Mental Health Services Administration (SAMHSA) funded jail, Harnish et al. (2016) found substance abuse was more stigmatizing than mental illness. Additionally, their findings aligned with previous literature by Corrigan, Schomerus, and Smelson, (2016) on addiction discrimination. These researchers reported addiction discrimination is legally sanctioned and culturally supported. Public service announcements meant to deter substance use and misuse more likely may increase public stigma. Additionally, Harnish et al. (2016) noted the opioid epidemic and legislation through the Affordable Care Act has increase public awareness of substance use disorders however, the impact or effects of diminishing public stigma are unknown.

Opioid abuse. The opioid crisis has become a top priority as it has reached epidemic proportions (Daum, Berkowitz, & Benner, 2015). The crisis is in part due to prescribed medications in the U.S. The Centers for Disease Control and Prevention (CDC, 2015) has noted the crisis has a devastating impact on public health and safety. In 2010, opioids constituted 75% of all prescription drug poisoning deaths (CDC, 2011). The Centers of Disease Control (2014) reported in 2012, the number of written prescriptions for analgesics (259 million) was enough to supply every U.S. household a bottle of pills. Zedler et al. (2014) reported 60% of overdoses are medical users of maximum prescribed daily morphine equivalent doses of 100 mg or more.

There are many factors that contribute to opioid overdose such as demographic characteristics and comorbidities. Zedler et al (2014) stated men have a higher rate of opioid related overdose; however, female deaths are on the rise. In addition, researchers have examined cases where opioid related deaths occurred. Researchers found individuals aged 45-64 had the highest death rates, non-Hispanic whites, American Indians, and Alaskan natives and rural and impoverished areas. Additionally, individuals with comorbid conditions such as liver disease, skin ulcers, pancreatitis, substance abuse or severe mental illness had a higher incidence to die from an opioid overdose (Zedler, et al., 2014).

The crisis is not foreign to the veteran population. An increased number of veterans are returning home from lengthy wars and deployments with not only chronic pain but other comorbid conditions such as substance abuse or mental illness. PTSD amongst veterans has increased the risk of opioid use and detrimental clinical outcomes. Jones, Mogali, and Comer (2012) noted patients who utilized illicit drugs with opioid prescriptions were at risk of overdose.

Many veterans post 9/11 rely on the VA for their care of chronic pain associated with combat and noncombat injuries. Although the VA (2017) has placed safeguards and protections for veterans to reduce the risks of opioid overdose the VA continues to see veterans at high risk of using and abusing opioids with other substances.

Alcohol abuse. Alcohol use disorder encompasses a range of health and socioeconomic problems including psychiatric comorbidities, motor vehicle accidents, domestic violence, fetal alcohol syndrome, cognitive impairment, poor medication adherence, and high economic cost and lost productivity (Fuehrlein et al, 2016). The American Public Health Association (APHA, 2014) estimated that 40% of combat veterans reported problem alcohol abuse. Military veterans

are at a high risk for psychiatric morbidities that are associated with alcohol substance disorder. There are various studies where factors such as age, trauma history, combat exposure, and unpartnered marital status have been explored with alcohol use disorder (Fuehrlein et al., 2016).

The normalization of heavy drinking in military culture can be a detrimental dynamic in alcoholism in veterans. Few studies on the prevalence of alcohol use disorder amongst military veterans have been conducted outside the VA (Fuehrlein et al., 2016). Wisco et al. (2014) reported less than 20% of military veterans utilize VA healthcare services as their primary source of health-care. Fuehrlein et al. (2016) conducted a national study on U.S. veterans aged 21 years and older; results revealed 40% of U.S. military veterans reported alcohol use disorder compared to 30% of the general U.S. population. Additionally, researchers reported veterans with life-time alcohol use disorder also had increased rates of mood and anxiety disorder comorbidities. Researchers have examined alcohol use disorder in military veterans and concluded alcohol may be used as a coping mechanism to palliate stress and negative adverse effects of psychological comorbidities (Dixon et al. 2009; Kehle et al. 2011; Ullman, Townsend, Starzynski and Long, 2007).

Rittmueller et al. (2015) noted hypertension can co-occur with alcohol misuse amongst military veterans. As a result of misuse, hypertension can worsen and lessen the effects of anti-hypertensive medication and promote poor self-care behaviors.

Veteran employment

Along with the prevalence of substance abuse and chronic pain, veterans who experience anxiety and depression are less likely to be employed (Zivin et al., 2015). Working aged veterans

who utilize VA services unemployment rates are low in comparison to other veterans who do not utilize the VA for services (Zivin et al., 2015). Diagnosable anxiety and depression among veterans can also impact work functioning and access to work. The RAND Center for Military Health Policy and Health Policy Research reported veterans' barriers to seeking help include concerns about negative career repercussions (Kahn, et al. 2016). Abraham et al. (2014) reported less than 6% of veterans who were diagnosed with anxiety or depression accessed VA employment services within a year.

Many veterans with mental health conditions must work to have sustainable finances for the continuum of care they need to improve their quality of life. Factors influencing the lack of employment may be barriers to employment, employment search, self-efficacy, and work performance. The Department of Veteran Affairs does provide employment services to veterans with severe mental illness or mental health conditions such as schizophrenia or bipolar disorder; however, Zivin et al. (2015) suggested veterans who are in need are those who receive primary care from the VA clinic. It was more likely veterans with physical health impediments need job seeking services than a veteran with mental health conditions. Additionally, Zivin et al. (2015) suggested health care and employment need to interface to have optimal uptake, acceptance and impact. Employment services offered by the VA should also be relevant and helpful to veterans who experience depression or anxiety.

Veteran Homelessness

Efforts to end homelessness among veterans has increased since 2010. Veterans experiencing homelessness in the United States has declined by forty-six percent (VA, 2018). Veterans of military service continue to represent a sizable subpopulation of the people who are

homeless in the United States. Veterans are twice as likely as other Americans to become homeless (APHA, 2014). The National Coalition on Homeless Veterans (NCHV, 2018) reported 11% of the homeless population are veterans. On any given night there are 40,056 veterans who are homeless (U.S. Department of Housing and Urban Development (HUD, 2018); it is estimated that over 130,000 veterans will experience homelessness over the course of a year (Mittal et al., 2013). One-third of the veteran homeless population served in a war zone while two-thirds of the homeless population served for three or more years (NCHV, 2018).

African Americans and Hispanics make up 45% of the homeless veteran population in the U.S. despite only accounting for 10.4% and 3.4% of the overall U.S. veteran population (NCHV, 2018). Although the number of homeless has been reduced in recent year, the number of women veterans tripled. According to the VA (2011) women veterans are the fastest growing homeless population. The National Coalition for Homeless Veterans (NCHV, 2018), reported 70% of homeless veterans have substance abuse problems, 51% have disabilities, and 50% have serious mental illness.

The lack of affordable housing, livable income and access to healthcare can be contributing factors to homelessness. Additionally, unemployment can be a factor in homelessness. Many military occupations and training are not transferable to the civilian workforce (NCHV, 2018). There are an estimated 1.4 million veterans at risk of homelessness due to poverty, substandard housing, and limited access to support services or resources.

Additionally, time served in a state or federal prison can lead to homelessness. There are an estimated 140,000 veterans held in correctional facilities in the U.S. About 57% of veterans incarcerated were serving for violent crimes (NCHV, 2018). Many veterans upon release may

not have the support services needed to reintegrate into society. Factors contributing to homelessness include substance abuse, military sexual trauma, post-traumatic stress, low levels of social support and challenges associated with family life. About 70% of homeless veterans report a comorbid condition such as substance abuse or mental illness (NCHV, 2018)

Researchers have taken a significant interest in examining vulnerability and protective factors that are associated with whole health initiatives and mental health concerns (James et al., 2013). Homeless veterans reported high rates of exposure to high magnitude stressors (HMS) than a community sample of adults. Homeless veterans need safe, affordable housing, access to supportive services, mental health counseling, basic physical health care, substance abuse care and aftercare, and personal development and empowerment (NCHV, 2018).

Stigma

The symptoms, distress, and disability that come with mental illness can create barriers for individuals pursuing personal goals. In addition to barriers, many individuals with mental illness endure social injustice due to a lack of understanding of mental illness (Corrigan & Watson, 2002). Impressions regarding mental illness can stem from internalizing ideas, self-esteem, and anger over prejudice.

Stigma can affect everyone from the mental health professionals to individuals in an uninformed community. Corrigan and Watson (2002) noted attitudes about persons with mental illness have become more stigmatizing in terms of dangerousness over the past 30 years. Researchers reported media, film, and print have characterized individuals with mental illness as homicidal maniacs, have childlike perceptions of the world, and/or are rebellious free spirits. In addition, Corrigan et al. (2000) stated the general public disapproved of people with psychiatric

disabilities significantly more than persons with physical illnesses. Public stigma can prevent an individual with mental illness acquire a job, apartment, or be falsely accused of a crime.

Coorigan (2000) described a socio-cognitive model of public stigma and self-stigma. Stereotypes, prejudice, and discrimination make up this model. Stereotypes are social because they represent what is accepted in groups. Prejudice is a general attitude toward a group which may consist of anger and hostility. These behaviors can lead to discrimination and impact the quality of help a person with mental illness receives. Corrigan and Watson (2002) also noted many individuals are aware of the stereotypes and can either internalize it or not.

Self-stigma includes prejudice and whether the person agrees with prejudice or disagrees. Low self-esteem and low self-efficacy are prevalent in self-prejudice. Bandura (1989) defined self-efficacy as the expectation that one can successfully perform a behavior. Self-prejudice may include behavioral responses from the individual such as demoralization or low self-efficacy. Coorigan and Watson (2002) stated in some situations persons with mental health issues may report loss of self-esteem due to stigma. Individuals of stigmatized groups may believe the negative stereotypes as fair. It was noted people who perceive their disease or disorder as negative are likely to have low self-esteem. In addition, collective representations can also affect self-esteem and self-efficacy. Information that develops from an individual situation can impact cultural stereotypes by perceived legitimacy (Coorigan and Watson, 2002).

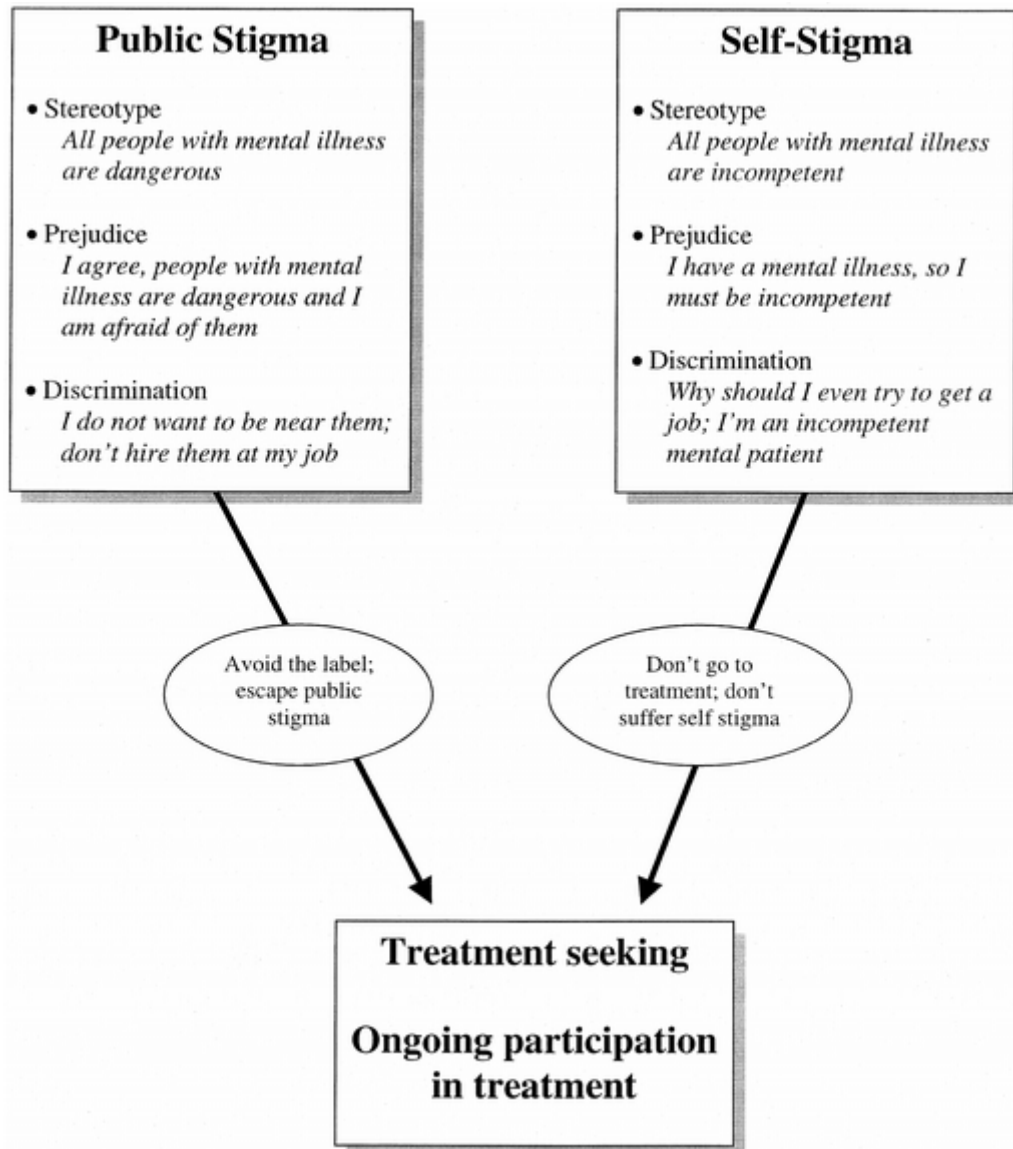


Figure 4: Public vs Self-Stigma (Coorigan, 2002)

Veteran Stigma

Public and self-stigma may impact a veteran's perception and limit access to community and mental health services. Stigma is a powerful deterrent for service members accessing medical, mental, and social services. Stigma, including self-stigma, public stigma, and stigma

within a service member's unit, is a major factor in low treatment utilization (Stecker, Shiner, Watts, Jones, & Conner, 2013). OIF/OEF veterans are at high risk of physical and mental health problems. A substantially high proportion of military service members deployed in support of recent wars have some form of post-traumatic stress disorder (PTSD), depression, or substance use disorder (James, Van Kampen, Miller, & Engdahl, 2013).

PTSD is one of the most common mental health concerns (Spoont et al., 2014). Over 58% percent of veterans suffer from PTSD (Lang et al., 2016). Although the access to low cost or free health care is widely available to service members, many choose to not access treatment. Lang et al. (2016) stated half of the reported veterans access services through the VA do not obtain enough mental health care. Spoont et al. (2014) reported a growing number of military service members do not receive treatment from the VA for mental health services. Factors include age, treatment initiation, illness severity, travel distance, and whether diagnosis was made by a mental health specialist can be associated to accessing treatment.

Beliefs on Treatment

Previous research has shown negative beliefs about treatment are prevalent among individuals with mental illness who do not seek treatment (Spoont et al., 2014). Perceptions of service availability and personal beliefs about treatment have been known barriers to treatment. In addition, Vogt et al. (2014) noted personal beliefs and the extent to which one will be stigmatized by others for experiencing a mental health problem can be fundamental barriers to care for veterans. Stecker et al. (2013) conducted a study on a sample of OIF/OEF veterans who screened positive for PTSD. Forty percent of the participants reported anticipated treatment experience as the most prevalent cause for not seeking treatment.

Vogt et al. (2014) suggested the high value placed on competence, confidence, and emotional toughness in the military can contribute to increased stigma. Jones (2014) reported studies that have shown psychological strength can be built through training, emotional well-being as well as physical well-being. Environmental factors can play a role in accessing medical, mental health and social services in the military. Hoge et al. (2014) reported that active duty soldiers were most concerned about being perceived as weak, their leaders regarding them less positively, and undermining peer confidence if they seek help. Hoge et al. (2014) added this may be in relation to military culture, which promotes invincibility among soldiers, and acknowledging mental illness is likely to be viewed as a sign of weakness and a potential threat to their careers. The basis for underutilization of treatment interventions may include a lack of awareness or understanding treatment options, increased anxiety on expectation of treatment, and insufficient knowledge for psychotherapy (Mott et al., 2014). Hoge et al., (2014) also noted that veterans reported once being transitioned into civilian life they may internalize negative public views of PTSD and mental illness.

Community Reintegration Post Discharge

Family challenges

One of the most difficult problems facing those who work with service members is how to distinguish service members whose problems are the result of deployment and combat (Danish & Antonides, 2013). Returning service members who cannot successfully integrate may incur serious problems requiring psychological help resulting in difficulty reintegrating into civilian life (Danish & Antonides, 2013). Sayers, Glynn, and McCutcheon (2014) reported the family can be a key partner in promoting the veteran's well-being by encouraging the veteran to seek

treatment options. Serious family challenges may include lack of warmth and intimacy, relationship strain and low relationship satisfaction, interpersonal avoidance, increased conflict, family role confusion, hostility and aggression, intimate partner violence, and difficulty parenting (Perkins et al., 2019; Sayers, 2011; Tinney & Gerlock, 2014).

Family reintegration

Family reintegration is the process of re-entering the family unit and returning to previous roles (Messecar, 2017). PTSD is associated with family and marital instability and higher rates of relationship distress (Carroll, Rueger, Foy, & Donahoe, 1985; Hinojosa, Hinojosa, Nelson, & Nelson, 2010). In some instances, unidentified and untreated PTSD presents a higher risk for maladaptive responses to stress such as alcoholism and family violence, particularly if these problems were present before deployment (Messecar, 2017). Difficulties of family reintegration may be viewed as a traumatized soldier greeting a traumatized family with neither fully recognizing the other (Bowling & Sherman, 2008; Hutchinson & Banks-Williams, 2006). Although there are veterans who can reintegrate into their families without major problems (Freytes, LeLaurin, Zickmund, Resende, & Uphold, 2017; Karney & Crown, 2007; Koenen, Stellman, Sommer, & Stellman, 2008), some estimates indicate at least 50% of the returning veteran population experiences difficulties transitioning back into their families (Danish & Antonides, 2009; Freytes et al., 2017; Tanielian & Jaycox, 2008). When veterans return from deployment, he or she may still be experiencing the stressful effects of deployment and problems may emerge only after “the honeymoon stage” of reunification has passed (Messecar, 2017) causing disruption to the family (Freytes et al., 2017). Veterans who do not receive help while having trouble reintegrating with their family may experience a disintegration of the family unit.

Programs and services focused on the veteran and his or her family unit are needed to help ease the transition to the community.

Reintegration with partner

Partners may experience ambivalence toward the service member as the service member's reentry can cause disruption to their daily routines, requiring shifts in family roles and responsibilities (Bowling & Sherman, 2008). Military veterans' ongoing challenges to adjustment and community reintegration may cause marital instability for a lengthy period of time (Hinojosa et al., 2010; Hosek, Kavanagh, & Miller, 2006). Resnik et al. (2012) and Sayer et al. (2010) also referenced studies where only 42 % of veterans were getting along with their spouse or partner. A study of Vietnam veterans returning home reported a 38% divorce rate versus a 46% divorce rate for Veterans of OIF/OEF. Additionally, there is evidence that wartime deployments lead to increased risk of divorce (Kulka et al, 1988; Negrusa & Negrusa, 2014; Sayers, Glynn, & McCutcheon, 2014). Between 2001 and 2004, divorce rates tripled among active duty Army officers (Bowling & Sherman, 2008) as did domestic violence rates (Bowling & Sherman, 2008; Perry & Flournoy, 2006).

Female veterans

Family reintegration for female veterans can be different than their male peers. Women are the fastest growing veteran segments constituting almost 20% of the total veteran population (Department of Veteran Affairs, 2013). Women veterans have increasingly sought Veteran's Health Administration (VHA) care and are the fastest growing segment of eligible users of the VHA healthcare system (Hoggatt et al., 2015).

Female veteran's outlook on health care may be influenced by military experience, comorbid health conditions, or demographic characteristic (Kimerling, 2015). Female veterans report more distressing PTSD symptoms such as avoidance, reexperiencing and hyperarousal or may report more difficulties with concentration and distress. Leslie and Koblinsky (2017) conducted a study consisting of 29 women veterans who served in OEF/OIF to examine their experiences as they returned to their families. The researchers found common challenges which included adjustments in civilian reintegration, managing anger, and difficulties in interacting with family members. Female service members were found to have a greater likelihood of being their family's primary caregiver; as such they are often expected to readjust quickly to family and parenting roles (Disabled American Veterans, 2014; Leslie & Koblinsky, 2017;). Female veterans face greater reintegration issues regarding relationships with spouses/partners, children, siblings, and aging parents (Leslie & Koblinsky, 2017).

The U.S. Department of Labor (2014) reported nearly 84% of female veterans are of working age compared to 55% of male veterans. However, some groups of women veterans are experiencing high unemployment rates. Joblessness can also lead to poverty which, in turn, results in homelessness. Nearly one in ten women veterans live in poverty (U.S. Department of Veteran Affairs, 2013). According to Vogt et al. (2006), women veterans are less healthy than their nonveteran female counterparts and are in poorer emotional health.

Gradus et al. (2017) found female veterans who had PTSD and substance abuse had an increased risk of non-fatal intentional harm. Additionally, women veterans report being exposed to higher rates of stressful and/or traumatic events. The VA (2018) reports women are twice as likely to experience PTSD, psychological distress and 20% reported military sexual trauma. The

U.S. Department of Veteran Affairs (2018) reports 50% of women veterans are treated for alcohol abuse 20% for cocaine use, followed by opiates, marijuana, and other drugs. Health care systems are not prepared to assist female veterans with PTSD who experience health care disparities.

Kimerling et al. (2015) conducted a study on female veterans across multiple VA sites on patient centered care. The study found veterans of minority race and sexual orientation reported a greater importance to having specialized services for women. The survey participants reported beliefs in belongingness, stigma, or therapist match could vary. Haun, Duffy, Lind, Kisala, & Luther (2016) conducted a qualitative study on female veterans with PTSD who experience health care disparities. The researchers utilized focus groups and demographic surveys to collect data from female veterans. Overall, female veterans felt PTSD impacted their health-related quality of life in social participation, physical issues, cognitive issues, emotional, and substance abuse issues. Female veterans also reported feeling vulnerable and uncomfortable with receiving care services in the Veteran's Health Administration. In general, the availability and options of veteran's health administration does not always meet the specific needs of female veterans.

Self-Efficacy

Individuals will engage in behaviors that will bring the most satisfaction and will lead to desired goals. Albert Bandura (1977) defined self-efficacy as expectancies specific to a behavior or set of behaviors. In his model of self-efficacy, Bandura outlines three basic cognitive mediating processes. These processes include self-efficacy expectancies, outcome expectancies, and outcome value. Bandura also viewed expectancies in various dimensions including magnitude, strength, and generality. Magnitude encompassed a hierarchy of behaviors

related to the difficulty or threat a person believes he or she can perform. Strength is related to persistence when barriers are present and generality is whether self-efficacy expectancy can extend to other similar behaviors (Maddux, 1991).

Experiences can influence self-efficacy expectancies. Examples of self-efficacy experiences may include performance or enactment experiences, vicarious experiences, verbal persuasion, and emotional or physiological arousal (Bandura, 1977). Each one of these experiences can have a powerful influence on self-efficacy. For example, performance experiences are considered one of the most powerful sources of self-efficacy. Performance experiences allows a person to achieve success at a task, behavior, or skill. Vicarious experiences are often observational, learned through imitation and modeling. Verbal persuasion is a presumed to be a less potent source of enduring change.

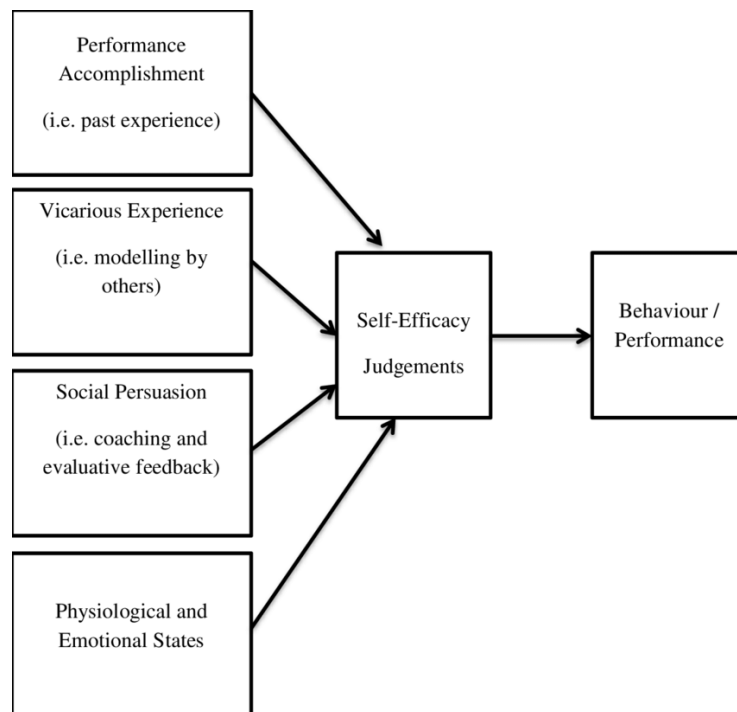


Figure 5: Bandura's Self-Efficacy Theory (Bandura, 1986)

Self-efficacy can play a significant role in adjustment to a different lifestyle especially when veterans are reintegrating into the community. It is important to become familiar with the common psychological disorders in veterans. Problems may arise when individuals become distressed, disengaged, or irritated, and experience other emotional and behavioral problems in adjustment.

As mentioned, self-efficacy can be defined as confidence in one's ability to produce a desired outcome. Researchers are now focusing on resilience and characteristics that may help individuals who encounter traumatic events (Bonanno & Mancini, 2012). It is noted veterans who have a high level of self-efficacy can overcome stressful situations. In addition, Blackburn and Owens (2015) reported research also suggests those with a sense of meaning can protect against PTSD and depression symptoms. The belief is if a veteran has a high self-efficacy then he/she will be able to manage traumatic events or emotional stress after a trauma.

Effective Mental Health Treatment

The VHA is America's largest integrated health system serving 9 million veterans a year (VA.gov, 2019). The Department of Veteran Affairs has prioritized the facilitation of adjustment to life at home and in the community (Dillahunt-Aspillaga & Powell-Cope, 2018). Researchers have taken a significant interest in examining vulnerability and protective factors associated with mental concerns (James et al., 2013). Haun et al. (2016) reported veterans and military personnel are at a higher risk of PTSD which impacts their quality of life.

With the increase in unprecedented levels of combat exposure, many veterans experience transition challenges in health. Hoge et al. (2014) reported at least three studies have been found

which indicate that only a third of the Iraq and Afghanistan veterans treated for PTSD received minimally adequate care; this was defined by the treatment sessions the veteran received.

Stecker et al. (2013) stated veterans reported obstacles in obtaining adequate services through the Veteran's Administration. Obstacles included scheduling, waiting times, paperwork, transportation and navigating the health care system.

The VA offers peer support as a model of care for patients with PTSD. Hundt, Robinson, Arney, Stanley and Cully (2015) reported in a study based on 23 participants, that most veterans reported a positive experience with peer support citing mutual understanding of each other in some way civilians cannot comprehend. However, participants did note potential drawbacks were more personal in nature due to personal personalities.

Stecker et.al (2013) reported the second most common barrier to seeking treatment is emotional readiness. Over 35% of the participants in their study reported discussing their issues would provoke a high level of anxiety creating an impulse to delay or avoid treatment. Avoidance of treatment can lead to maladaptive coping strategies. The VA has implemented innovative approaches to improve adjustment and well-being. One such approach is a high importance on interpersonal support for both the veteran and the spouse. Additionally, the use of internet-based multimedia instruction in both individual and collaborative self-strategies can be integral to preventing the long-term impacts of deployment on their well-being and relationship stability (Kahn, et al., 2016).

The U.S. Department of Veteran Affairs (VA, 2019) has incorporated health and wellness programs into their healthcare system to promote veteran well-being through body and mind. Nutrition and food programs enable veterans to make healthy choices to help treat neurological

disorders, cancer and diabetes. Licensed nutritionists are available to help with food education and meal plans. Weight management is available for access to dietary and exercise programs such as yoga, tai chi, and meditation. Tobacco health is also available for veterans to inform and educate themselves on the risks of tobacco. In addition, help line counselors are available to assist the veteran with plans to quit tobacco use (VA, 2019).

Harm reduction strategies such as motivational interviewing have been implemented to reduce the misuse and abuse of opioids and alcohol misuse in treatment. Clinical applications of self-efficacy have also been instrumental in focusing on the successes encountered in harm reduction strategies to strengthen the client's sense of self-efficacy (Maddux, 1991). In addition, clinicians are now incorporating a holistic approach where a veteran is evaluated on the specific expectancies of self-efficacy rather than the general competence or effectiveness to incur behavioral or structural changes in the veteran. Most importantly, the VA has a mental health program for treatment and support for PTSD, anxiety, depression and substance use (VA, 2019).

Health challenges post 9/11 veterans face have posed challenges to mental health, therapeutic and other veteran affairs professionals (Fleming, 2015). Professionals are looking for other innovative avenues that address rehabilitation, healing, vocational training, and employment. With the passage of the 2014 Farm Bill, federal legislation recognizes veterans to farmers as an eligible population for health and financial benefits within the agricultural sector. United States Department of Agriculture (USDA) has created veteran to farmer programs where farming is used in rehabilitation, vocational training and career development or redirection to address some of the challenges of transitioning into civilian life (Fleming, 2015).

The Farmer Veteran Coalition (2014) report veterans participating in veteran to farmer programming has addressed their PTSD symptoms as well as their search for meaningful work post military service. Veterans in these programs receive classroom and experiential agriculture education, and obtain information on funding, resources and employment opportunities. Veterans can then consider the benefits of farming for the short-term or long-term including agriculture ownership opportunities (Fleming, 2015).

Summary

This chapter provided a review of literature pertaining to factors that impede veteran wellness in community reintegration. Based on the review of literature, there is not enough evidence to determine the relationship associated with veteran wellness and community reintegration. Current literature varies on the degree of relational factors on wellness and community reintegration. In addition, very few studies were conducted outside the VAMC. This study sampled veterans who reside in Texas. The study identified and examined the relational impacts related to veteran wellness. Chapter 3 will focus on the methodology of the study used to describe the problem and the procedures used in the study.

CHAPTER III

METHODOLOGY

This chapter presents the methodology to be used in the current research, the rationale and research design, data collection tools, sampling and data analysis. Punch (2005) defines research design as the ideas and concepts the study follows. The purpose of this quantitative study was to identify any relational factors that contribute to stigma, veteran wellness and successful veteran community reintegration as well as whether there was a relationship between veteran self-efficacy, substance use disorder, and veteran personal wellness based on gender, theatre of operations, substance abuse history, and discharge status.

The methodology used to collect data for this study are guided by the following research questions:

1. Is there a relationship between treatment seeking and specific veteran demographic factors (gender, theatre of operations, substance abuse history, discharge status) and stigma beliefs?

H₀I: There is no relationship between treatment seeking and specific veteran demographic factors (gender, theatre of operations, substance abuse history, discharge status) and stigma beliefs.

2. Is there a relationship between self-efficacy and specific veteran demographic factors (gender, theatre of operations, substance abuse history, discharge status) and stigma beliefs?

HΦII: There is no relationship between self-efficacy and specific veteran demographic factors (gender, theatre of operations, substance abuse history, discharge status) and stigma beliefs.

3. Is there a relationship between well-being and specific veteran demographic factors (gender, theatre of operations, substance abuse history, discharge status), and stigma beliefs?

HΦIII: There is no relationship between well-being and specific veteran demographic factors and stigma beliefs.

4. What is the relationship between self-efficacy and vocational, financial, health and social well-being?

HΦIV: Self efficacy is not a function of vocational, financial, health and social well-being.

The methods to be used in this study incorporated quantitative data collection. The study collected quantitative data using an online survey created in Qualtrics (<http://www.qualtrics.com>) using a Likert scale. Hopkins (1998) defined Likert scaling as a unidimensional, summative design approach to scaling named after its originator, psychologist Rensis Likert. This scaling method is most frequently used in social science measurement (Rovai, Baker, & Ponton, 2014).

Research Design and Design Appropriateness

The research design used in this study was the non-experimental descriptive survey research design used to: (a) test the null hypothesis or (b) answer the research questions in this

study. Campbell and Stanley (1963) and Gall, Gall, and Borg (2007) described two basic types of descriptive studies: Cross-sectional design and longitudinal or time series design. In this study, the cross-sectional design was used to collect data that reflect the veteran's attitudes toward wellness, social services, mental health, stigma, and community reintegration. A Likert type survey provided by the Endorsed Anticipated Stigma Inventory (EASI) and Well-Being Inventory was utilized to collect data from veterans in the state of Texas. Rovai et al., (2014) stated, "use of surveys is a very popular means for collecting data in descriptive studies (p.50)." The methodology allowed for the statistical analysis of the data. Due to the nature and length of the survey, personal interviews and observations would not have provided a conducive environment for veterans to anonymously answer the questionnaire. In addition, the use of personal interviews and observations would add the potential for bias and inconsistency in the administration of the survey instrument. For this study, the use of an electronic survey through Qualtrics was utilized. Gall, Gall, and Borg (2007) recommended the assurance of anonymity to increase survey response rates.

Population and Sample

Veterans of military service continue to represent a sizable subpopulation of the people who reside in the United States (NCVAS, 2016). The Veteran's Population Model (VETPOP, 2016) predicted minorities to increase from 23.2 % of the total Veteran population in 2017 to 32.8 % in 2037. In Texas, 80% of the total "projected" veterans from 2015-2045 are minorities (VETPOP, 2016). The National Center for Veterans Analysis and Statistics (NCVAS, 2016) report estimates Texas is one of the top state's veterans relocate to after post-military discharge.

According to the U.S. Department of Veteran’s Affairs (VA, 2017), Texas has over 1.5 million veterans. Due to the sizable population, a convenience sampling was conducted for this study. Rovai, Baker, and Ponton (2014) define a convenience sample as one which the researcher relies on available participants. Available participants were identified through the exponential non-discriminative snowball sampling method. The principal investigator identified potential participants through professional and personal connections throughout the state of Texas. As potential participants were identified, the principal investigator emailed the recruitment letter to the potential participants and encouraged them to forward the survey to other veterans around the state. This method allowed for the sampling group to provide multiple referrals until enough samples are received. The use of exponential non-discriminative snowball sampling allowed for the recruitment of hidden participants using digital snowball sampling. Digital snowball sampling included a post on Facebook and other online veteran platforms. The post was shared among various online platforms and garnered multiple referrals from potential participants who would have otherwise not been aware of the study.

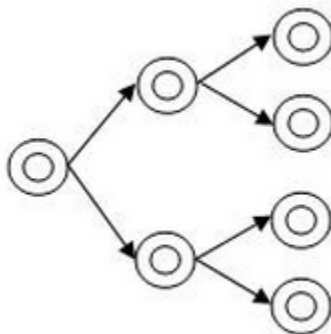


Figure 6: Exponential non-discriminative snowball sampling

The established criteria for participation in the research study included individuals who classified themselves as veterans. A veteran is a former member of the armed forces who is discharged. Furthermore, veterans must have been discharged from the military with a discharge status of honorable, other than honorable or general and reside in the state of Texas.

Sample size. The principal investigator considered how large the sample must be to keep the error to a minimum. A power analysis was conducted using software to determine the effect size for the research study. The number was based on statistical power analyses. The software used to conduct the calculation was developed by Soper (2011). The calculated power for this study yielded a minimum required sample (N=91) for a multiple regression analysis. Below is the formula for a Beta test:

$$B(x, y) = \int_0^1 t^{x-1}(1-t)^{y-1} dt$$

The value returned by the a-priori sample size calculator for a multiple regression included the desired probability level, the number of predictors, the anticipated effect size, and the desired statistical power level of .80.

Data Collection and Research Procedures

Following approval by the Institutional Review Board at the University of Texas Rio Grande Valley the principal investigator (PI) recruited participants by sending out an email recruitment letter with the survey link to personal and professional contacts who are veterans. The PI identified and selected veterans with the assistance of local contacts in the community. The PI sent a recruitment email document explaining the nature of the study with an invitation to

complete the online questionnaire. The recruitment email included a link to the informed consent and online questionnaire created in Qualtrics (<http://www.qualtrics.com>). Qualtrics is an online website used to create online questionnaires. Informed consent was obtained by having the participant read the form and voluntarily choose to participate in the survey. In exchange for their time, the veteran could voluntarily enter a drawing for a chance at receiving one of five \$50 gift cards.

Each participant was asked to complete an electronic survey involving demographic data and brief questions regarding beliefs on mental health, mental illness, treatment seeking behaviors, concerns regarding stigma from loved ones and in the workplace, and substance and drug abuse. There was no time limit on completing the survey.

All surveys were analyzed by the PI and scored based on the Likert sub-scales utilized in the Veteran Well-Being Inventory and EASI. Basic demographic information was acquired from the participant through the online survey.

Instrumentation

The Endorsed and Anticipated Stigma Inventory (EASI) (Vogt et al., 2014) is a 40-item questionnaire that assesses different dimensions of stigma-related beliefs about mental health among military and veteran populations. The inventory used a 5-point Likert-type response format ranging from 1 (strongly disagree) to 5 (strongly agree). No reverse items are included, but positively phrased filler items were included to reduce negativity bias. Scales are scored so that higher scores were indicative of greater stigma in each of the domains assessed in this inventory of scales. The scales include beliefs on mental illness, mental health treatment,

treatment seeking, stigma from loved ones and stigma in the workplace. The inventory takes less than 10 minutes to complete.

The Well-Being Inventory (WBI) is multi-dimensional tool for assessing key components of well-being (Vogt, Taverna, Nillni, & Tyrell, 2018). The WBI consists of a set of scales consisting of 126 questions or statements in four well-being domains. Factors included in the inventory as potential predictors of well-being included military service experiences, exposure to stress and trauma over the life course, social support, and resilience. The four well-being domains consist of vocational, financial, health, and social personal relationships domain. There are 34 items for the vocational domain, 24 for finances, 20 for health and 48 for social relationships. The inventory consists of a response format utilizing 5-point Likert scales. The reading scale is set at 5.8 grade level according to the Flesch-Kincaid Readability Index. The instrument has been deemed acceptable to use for most veterans. Four phases of correlations were conducted to assess the internal reliability and construct validity of the WBI measures. Internal consistency reliability measures were maintained or improved. Cronbach's alphas ranged from .80 to .93 for all scales except one; the financial functioning scale has an alpha of a .70.

Research Variables

Based on the information collected during the review of literature, four sets of independent variables were measured for this study: specific demographic variables (gender, theatre of operations, substance abuse history, discharge status), stigma beliefs, self-efficacy, and treatment seeking. There was one dependent variable based on a measure of well-being based on vocational, financial, health, and social well-being. Prior to implementing the study, the

researcher considered other extraneous variables such as environment or location of the study. Due to the nature of the study, participants were provided information on the study ensuring all responses were confidential on the electronic survey. To avoid limiting the study to a specific military veteran population, the study was open to all veterans who resided in Texas. Below is a list of variables utilized in the study.

Operational Definition of Variables

Stigma. Stigma refers to the elements of labeling, stereotyping, separation, status loss and discrimination co-occur in a power situation that allows them to unfold. The variable of stigma was measured via the Endorsed Anticipated Stigma Inventory (EASI) scale (Vogt, 2014). The items on the inventory refer to beliefs about mental illness, beliefs about mental health treatment, beliefs about treatment seeking, concerns about stigma from loved ones, and concerns about stigma in the workplace. Items from the EASI scale statements such as, “Most people with mental health problems require too much attention” and “Mental health providers often make inaccurate assumptions about patients based on their group membership.”

Self-efficacy. Albert Bandura (1977) defined self-efficacy as expectancies specific to a behavior or set of behaviors. Self-efficacy was measured by utilizing two scales in the Well Being Inventory (WBI). Items such as, “Over the last three months, please indicate how often you went above and beyond in your work” and “Over the last three months of your education or training, the quality of your coursework/training activities was excellent.”

Specific demographic variables. Specific demographic variables included in the demographic section of the study included gender, theatre of operations, substance use history,

and discharge status. Participants were asked for their gender based on male and female and if they had a substance use history. In addition, participants were asked to identify which theatre of operations they participated in and discharge status. Items in the demographic section included questions such as, “What type of discharge status did you receive in the military?” and “Which theatre of operations did you serve in?”

Treatment Seeking. Treatment seeking behaviors refers to the active seeking of remediation by an individual who is cognitively or physically ill, unstable, or disturbed. Treatment seeking was measured by utilizing the EASI belief about treatment seeking scale. Items from the scale include, “I would feel uncomfortable talking about my problems with a mental health provider” and “I would think less of myself if I were to seek mental health treatment.”

Well-Being. Vogt, Taverna, and Nillni (2018) suggest well-being consists of status, functioning, and satisfaction within the key life domains of vocation, finances, health and social relationships. The dependent variable well-being was measured using The Well Being Inventory (WBI). The WBI measures the status, functioning, and satisfaction within the four life domains of vocation, finances, health and social relationships (Vogt, Taverna, Nillni, & Tyrell, 2018). Items from the WBI include questions such as, “Over the past three months, how often have you gotten along well with members of your community?” and “Do you have an ongoing physical health condition, illness, or disability?”

Data Analysis

The quantitative design of the study required the results of the data to be analyzed through an analysis of relationships using a multiple regression and correlation analyses using

the Statistical Package for the Social Sciences (SPSS) version 25 (2017). Descriptive statistics were generated on each of the questions in the survey and divided up by subsections. The descriptive statistics included the mean scores for each section as well as the frequency. The null hypotheses were analyzed at the F distribution and student's t distribution at the .05 level of significance. A multiple regression was used to illustrate the statistical analysis between one factor when analyzing relationships between multiple predictors. In addition, a multiple regression procedure predicts the variance in a continuous dependent variable based on linear combinations of continuous independent variables (Rovai, Baker, & Ponton, 2014). Punch (2005) stated that quantitative, non-experimental research, specifically social, is usually characterized by multiple variables. Hierarchical multiple regression analysis was determined to be appropriate when the data met the assumptions. Hierarchical multiple regression assumptions included: (a) normal distribution of scale scores, (b) reliability of scales, (c) linear associations between the predictor and criterion variable, and (d) homogeneity of variances (cite).

Assumptions were tested by reviewing the raw data for outliers and calculating the skewness and kurtosis values. Rovai, Baker, and Ponton (2014) define skewness as a measure having a lack of symmetry. Values $> +/- 1.00$ suggest a significant violation of the normal distribution of scales. Kurtosis refers to the peak or low tailedness relative to the normal distribution curve (Rovai, Baker, & Ponton, 2014). Kurtosis values $> +/- 2.00$ demonstrate a heavy tailedness or low tailedness distribution of scores around the mean score (Cohen & Cohen, 1983).

Pearson product moment coefficients was conducted between the dependent and independent variables. Normal Q-Q plots, stem and leaf, and scatterplots were computed to

determine normal distribution of data and homoscedasticity. To ensure the dependent variable of well-being did not have variance overlap with the independent variables, the variables were tested for collinearity effects. After analyzing the variance inflation factor it was determined the study did not include multicollinearity. Exploratory and confirmatory data was utilized to increase the integrity of the analyses (Tukey, 1977).

Hypotheses Testing

Regression analyses. Multiple regression analyses were used to determine if a relationship existed between the independent variables (stigma, specific demographic factors, self-efficacy, and treatment seeking) and the dependent variable (well-being).

The following null hypotheses was tested utilizing regression analysis.

H₀₁: There is no relationship between well-being and specific veteran demographic factors and stigma beliefs.

Correlational analyses. The second, third, and fourth null hypotheses were analyzed through correlational analyses. The second null hypothesis determined if there was a relationship between self-efficacy and specific veteran demographic factors (gender, theatre of operations, substance abuse history, discharge status) and stigma beliefs. The third null hypothesis determined if there was a relationship between well-being (dependent variable) and specific veteran demographic factors (independent variable) and stigma beliefs (independent variable). The fourth null hypotheses determined if there was a relationship between self-efficacy (independent variable) and vocational, financial, health, and social well-being (dependent variable).

Assumptions

The following assumptions were made for this research study:

1. The EASI and WBI scales have been proven to be psychometrically accurate in regard to reliability and validity.
2. Veterans who participated responded honestly and to the best of their ability.
3. The researcher computed and analyzed the instrument scales for descriptive information on the study variables. Statistical tests were performed to address any violations of assumptions for hierarchical multiple regression and correlational analyses (Cohen & Cohen, 1983; Pearson & Lee, 1908).
4. The researcher was non-biased, and the interpretation was true testament of the veteran's response to stigma, wellness and reintegration.

Ethical Concerns

It is important to recognize the research proposal responses from the EASI scales and Well-Being Inventory are modestly associated with concerns about social desirability. Rovai, Baker, and Ponton (2014) addressed random selection as a threat to external validity. Generalizability to other groups may not be representative of the target population. It is important to note; the researcher's instrument does not address all mental health beliefs or necessarily represent beliefs based on biased or inaccurate appraisals.

In addition, during the informed consent process, the purpose of the research and benefits of the research to the participants was addressed and informed participants the information would remain confidential. Informed consent was acquired through Qualtrics. Informed consent covered all points required by the Institutional Review Board to ensure the safety and protection of all individuals involved during the study.

Respondent fatigue was also a concern for nonsampling error. The survey, depending on the responses, could take up to 30 minutes long. Withdrawal from the study was allowed and available at any time during the study.

Summary

This chapter provided an overview of the methodology which was used for the exploration of variables. The research design and design appropriateness were defined and provided an in-depth explanation of the overall study. The population and sample size were defined and outlined within the chapter including data collection using a survey instrument. The survey instruments were available online. The survey sample and population were reviewed including the methodologies for the quantitative analysis. The chapter concluded with the ethical concerns the research has complied with. Chapter four will present the results of the research study.

CHAPTER IV

RESULTS

The following study identified relational factors that contribute to stigma, veteran wellness and successful veteran community reintegration as well as whether there was a relationship between veteran self-efficacy, substance use disorder, and veteran personal wellness based on gender, theatre of operations, substance abuse history, and discharge status. The researcher conducted the study among 99 veterans who resided in the state of Texas. Eighty-five surveys were completed in its entirety. Chapter four discusses the sample demographics and a presentation of findings from each research question. The following four research questions were reviewed:

1. Is there a relationship between well-being and specific veteran demographic factors (gender, theatre of operations, substance abuse history, discharge status), and stigma beliefs?

HΦI: There is no relationship between well-being and specific veteran demographic factors and stigma beliefs.

2. Is there a relationship between self-efficacy and specific veteran demographic factors (gender, theatre of operations, substance abuse history, discharge status) and stigma beliefs?

HΦII: There is no relationship between self-efficacy and specific veteran demographic

factors (gender, theatre of operations, substance abuse history, discharge status) and stigma beliefs.

3. Is there a relationship between treatment seeking and specific veteran demographic factors (gender, theatre of operations, substance abuse history, discharge status) and stigma beliefs?

HΦIII: There is no relationship between treatment seeking and specific veteran demographic factors (gender, theatre of operations, substance abuse history, discharge status) and stigma beliefs.

4. What is the relationship between self-efficacy and vocational, financial, health and social well-being?

HΦIV: Self efficacy is not a function of vocational, financial, health and social well-being.

The questions were investigated with a non-experimental descriptive survey research method utilizing an online questionnaire. The questionnaire assessed different dimensions of stigma-related beliefs about mental health among military and veteran populations. It also assessed potential predictors of well-being including military service experiences, exposure to stress and trauma over the life course, social support, and resilience. These predictors encompassed four well-being domains consisting of vocational, financial, health, and social personal relationships domain. The purpose of this chapter is to present the data and the statistical results from the study. Descriptive statistics through multiple regression and correlation analyses were used to describe the sample followed by various statistical analyses used to test each research hypotheses. An alpha

level of .05 level of significance was utilized to test the null hypothesis with an F distribution or student's t distribution.

Sample Descriptive Statistic Information

The study sample consisted of 85 veterans who reside in the state of Texas. The sample consisted of 71 (84%) males and 14 (16%) females. Of the 85 surveyed, 79 (93%) reported an honorable discharge, 2 (2%) other than honorable, and 4 (5%) general discharge. Seventy veterans (79%) completed one tour of duty while the remaining 15 veterans (21%) completed two or more tours of duty. Participants in the study were also likely to have a vocational, technical, some college ($n = 24$, 29%) or a bachelor's degree ($n = 23$, 27%). Fifty-three participants (74%) were also more likely to be married. More than half (57%) of the participants had a household income over \$70,000. Table 1 provides comprehensive demographic information.

Table 1: *Veteran Demographic Descriptive Statistics*

Demographic Variable	N	Percentage
Gender		
Male	71	84
Female	14	16
Total	85	100
Discharge Status		
Honorable	79	93
Other than Honorable	2	2

General	4	5
Total	85	100
Theatre of Operations		
Iraq	30	27
Kuwait	15	14
Afghanistan	19	17
Grenada	3	3
Vietnam	4	4
Other	39	35
Total	110	100
Highest Level of Education		
Less than high school	1	1
High School Diploma/GED	4	5
Vocational, technical training, or some college	24	29
Associate's degree	14	16
Bachelor's degree	23	27
Master's degree	15	17
Professional degree	4	5
Total	85	100
Marital Status		
Never married	8	10
Married-1 st marriage	34	40
	61	

Married-2 nd or later marriage	29	34
Separated	1	1
Divorced	12	14
Widowed	1	1
Total	85	100
Household Income		
Below \$40,000	20	24
\$40,001-\$69,000	16	19
\$70,000-\$95,000	26	30
\$95,001 and over	23	27
Total	85	100

Disability information was recorded by the participants. Participants were more likely to have a physical (75%) or mental health (61%) disability. Since military discharge, forty-six (54%) of veterans have been diagnosed with a mental health disorder. Of the total number of participants, 98% reported having healthcare coverage.

Table 2:

Additional Demographic Data of Participants

Demographic Variable	Yes	No	Total
Disability			
Physical	64	21	85
Mental/emotional	52	33	85

Healthcare Coverage	83	2	85
Substance Abuse	9	76	

The study sample also included questions regarding access to medical care. A total of 73 out of 85 (86%) veterans have sought out VA services. Thirty-seven veterans (43%) are extremely likely to seek medical advice, 33 (39%) are somewhat likely to seek medical advice, 8 (9%) neither likely nor unlikely, 5 (6%) somewhat unlikely, and 2 (2%) extremely unlikely to seek medical advice. Participants were also asked how likely they were to discuss their personal struggles. Thirty-five veterans (41%) percent are somewhat likely to discuss their personal struggles with others besides their family, 20 veterans (24%) were somewhat likely to discuss their personal struggles with others besides their family. Interestingly, 12 veterans (14%) were neither likely nor unlikely to discuss their personal struggles with others, while 12 veterans (14%) were extremely likely to discuss their personal struggles with others besides their family. Only 6 veterans (7%) are extremely likely to discuss their personal struggles with others besides their family. Seventy-two (72%) of participants also reported to be extremely likely or somewhat likely to share their military experience with other military personnel.

Table 3:

Access to Care Demographic Descriptive Statistics

Demographic Variable	N	Percentage
Discuss Personal Struggles		
Extremely Likely	12	14
Somewhat likely	35	41
	63	

Neither likely nor unlikely	12	14
Somewhat unlikely	20	23
Share Military Experiences		
Extremely Likely	40	40
Somewhat likely	32	32
Neither likely nor unlikely	5	5
Somewhat unlikely	6	6
Extremely unlikely	2	2
Sought Medical Advice		
Extremely Likely	37	43
Somewhat likely	33	39
Neither likely nor unlikely	8	9
Somewhat unlikely	5	6
Extremely unlikely	2	2

Scale Descriptive Data

The descriptive statistics for the Endorsed Anticipated Stigma Inventory (EASI) scale and the Well Being Inventory (WBI) are presented in Table 4.

Table 4:

Descriptive Statistics for Scales

	<i>N</i>	<i>M</i>	<i>SD</i>	<i>Min</i>	<i>Max</i>	<i>Sk</i>	<i>K</i>	<i>Alpha Rel.</i>
Endorsed Anticipated Stigma Inventory (EASI)	85	127.67	28.39	62	191	.294	-.197	.80
Well-Being Inventory (WBI)	85	62.42	5.19	43.71	74.09	-.651	1.107	.76

Note. *M*=Mean, *SD*=Standard Deviation, *Min*=Minimum Score, *Max*=Maximum Score, *Sk*=Skewness, *K*=Kurtosis.

Testing of assumptions. A Cronbach’s alpha was conducted in order to examine the inter-item reliability. The EASI scale consisted of 40 items ($\alpha = .80$) and the WBI consisted of 126 items ($\alpha = .76$). According to Cronbach’s alpha guidelines the alpha level for both instruments is acceptable inter-item reliabilities (Cronbach, 1951). Both scales were also examined to determine whether they violated assumptions of normality. A Kolmogorov-Smirnov test was used to test for normality on stigma and wellness. Rovai et al. (2014) defines Kolmogorov-Smirnov test as a non-parametric procedure that determines whether a sample of data comes from a specific distribution. The stigma scores of $D(85) = .09$, $p < .05$, approximate a normal distribution. The Kolmogorv-Smirnov test for wellness demonstrated a strong evidence of non-normality. However, normality can be assumed since the approximately normally distributed data at $p = .09$. The null hypothesis is retained at the 0.05 level of significance Variables demonstrated skewness or kurtosis values of ≥ 2.00 . In Figures 7-10 normal distribution is validated on the Stem-and-Leaf the Normal Q-Q plots of scales.

Stigma Stem-and-Leaf Plot

Frequency	Stem & Leaf
3.00	0 . 667
11.0	0 . 89999999999
20.00	1 . 00000001111111111111
25.00	1 . 2222222222222222222233333333
13.00	1 . 44444444445555
9.00	1 . 666777777
4.00	1 . 8899
Stem width:	100.00
Each leaf:	1 case(s)

Figure 7: Stigma Stem-and-Leaf Plot

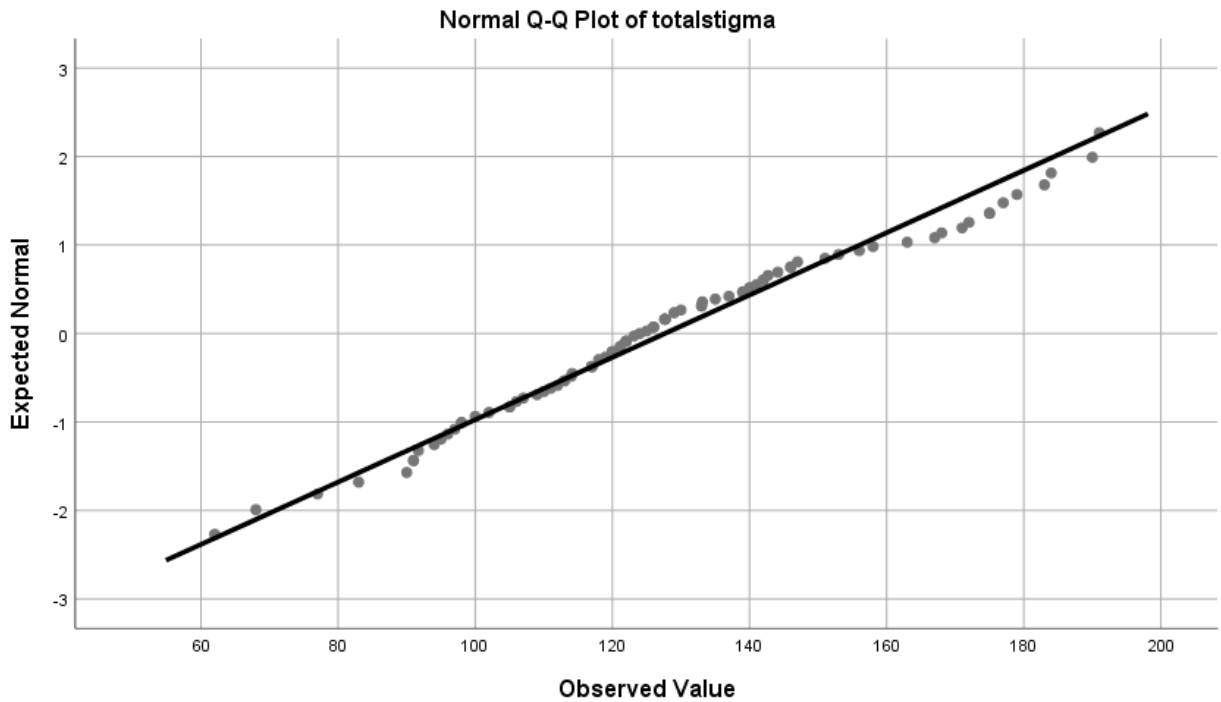


Figure 8: Normal Q-Q plot of Endorsed Anticipated Stigma Scale

Data Analysis for Hypothesis Testing

The analysis of data was conducted using SPSS 25 (2017) and analyzed using regression and correlational analyses. Pearson (1908) defined multiple regression analysis as an extension of simple linear regression to allow for the estimation between one continuous variable and more than one independent variables in one equation. In order to measure the strength of a linear association between two variables, a Pearson product-moment correlation coefficient was performed. The results of the regression and correlational analyses have been included in this section.

Regression Analysis

A multiple regression analysis was conducted to view the estimation between the independent variables (stigma, self-efficacy, and specific demographic factors such as substance abuse, gender, theatre of operations, and discharge status) and the dependent variable (veteran well-being).

The following null hypothesis was tested utilizing the regression analysis:

H₀: There is no relationship between well-being and specific veteran demographic factors and stigma beliefs.

The Model Summary in Table 5 provides information regarding the total variability in the dependent variable that is explained and accounted for by the five independent variables. The

obtained R square of .187 indicates the independent variables (i.e., stigma, self-efficacy, treatment seeking, and specific veteran demographic variables) accounted for and explained 19% of variance on the dependent variable. Table 5 illustrates the significant correlations of the independent and dependent variables.

Table 5:

Model Summary

The Relationship between Well-Being and the Predictor Variables: Stigma, Gender, Self-Efficacy, Substance Abuse, and Theatre of Operations

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.433	.187	.146	4.820

The ANOVA in Table 6 exhibits the obtained p value for this analysis as being .002. Based on this value, the data rejected the null hypothesis at both the .01 and .05 level of significance. Cohen’s f^2 was analyzed using an effect size calculator for multiple regression. Cohen’s $f^2 = .23$ demonstrates a medium effect size measure. Furthermore, in Table 7 the standardized coefficients illustrate total stigma has a significant impact on veteran well-being. The results also exhibited substance abuse and self-efficacy were not statistically connected with veteran well-being.

Table 6:

ANOVA Summary Table

	Model	Sum of squares	df	Mean Square	F	ρ
1	Regression	422.80	4	105.70	4.549	.002
	Residual	1835.53	79	23.23		
	Total	2258.33	83			

a. Dependent Variable: Veteran Well Being

b. Predictors: (Constant), Self-efficacy, stigma, treatment seeking, specific demographic variables

Table 7: Standardized Coefficients

	Model	Standardized Coefficients		
		Beta	t	<u>P</u>
1	Well-Being		17.04	.000
	Stigma	.160	1.10	.274
	Specific Demographic Variables	-.187	-1.83	.071
	Self-efficacy	-.177	-1.741	.086
	Treatment Seeking	.200	1.377	.172

a. Dependent Variable: Veteran Well-Being

Correlational Analysis

A correlational analysis was also conducted to measure the strength of the relationship between and among other primary and covariate variables. The following null hypothesis were tested utilizing correlational analysis:

H Φ II: There is no relationship between treatment seeking and specific veteran

demographic factors (gender, theatre of operations, substance abuse history, discharge status) and stigma beliefs.

HΦIII: There is no relationship between self-efficacy and specific veteran demographic factors (gender, theatre of operations, substance abuse history, discharge status) and stigma beliefs.

HΦIV: Self efficacy is not a function of vocational, financial, health and social well-being.

Table 8 illustrates the strength of associations using the Pearson product-moment correlation which is denoted by the letter r . The Pearson correlation coefficient r is the measure of strength between two variables. The r coefficient can take on values between -1 to +1 with a value of zero indicating no correlation. For example, a positive correlation would be found if a higher well-being score was associated with a higher stigma score. Conversely a negative correlation would be if found if a lower well-being score was associated with a lower stigma score. A positive sign is an example of a positive correlation while a negative sign demonstrates a negative correlation. In order to interpret the r values, Hinkle, Wiersma, and Jurs (1988) suggested values < 0.3 demonstrate little if any relationship, values between $.30$ to $< .50$ demonstrate a low relationship, values between $.50$ to $< .70$ is a moderate relationship, values between $.70$ to $< .90$ demonstrates a high relationship and values between $.90$ and above is a very high relationship. Variables examined included the following: well-being, stigma, specific

demographic variables (gender, theatre of operations, discharge status, substance use), self-efficacy, and treatment seeking.

Table 8: *Intercorrelation Matrix Table*

		Stigma	Well-Being	Treatment Seeking	Specific Demographic Variables	Self-Efficacy
Stigma	Pearson Correlation	1	.316**	.694**	.059	.000
Well-Being	Pearson Correlation		1	.305**	.220*	-.178
Treatment Seeking	Pearson Correlation			1	.073	-.041
Specific Demographic Variables	Pearson Correlation				1	.051
Self-Efficacy	Pearson Correlation					1

**Correlation is significant at the 0.01 level (2-tailed)

*Correlation is significant at the 0.05 level (2-tailed)

Summary

This chapter provided the analysis of data for the relational impacts on veteran wellness and community reintegration. A total of 99 veterans participated in the study. Due to some participants exiting the survey prematurely, 85 participant surveys were included in the data analysis of the survey. The collected determined a relationship between veteran self-efficacy, substance use disorder, and veteran personal wellness based on gender, theatre of operations, substance abuse history, and discharge status. The chapter concluded with an intercorrelation matrix where the data demonstrated relationship between stigma and veteran well-being.

Chapter 5 will discuss the results of the study will include a comparative analysis of previous research, implications on future research and impact to rehabilitation professionals

CHAPTER V

DISCUSSION

This chapter presents the summary of findings, conclusions and recommendations based on the data analyzed in the previous chapter. Limitations were identified in the study. The relational impacts of veteran wellness and community reintegration was assessed to determine if there was a relationship between wellness and stigma, self-efficacy, treatment seeking, and veteran specific variables.

Summary of the Research

According to the U.S. Census Bureau (2017) there are 18.9 million veterans in the United States with approximately 1.5 million veterans residing in the state of Texas. Approximately, 1 in 3 transitioning veterans required ongoing medical and emotional/mental health condition illness or disability (Perkins et al., 2019). Military culture and attitudes about persons with mental illness have become more stigmatizing over the past 30 years (Corrigan & Watson, 2002). Stecker, Shiner, Watts, Jones, & Conner (2013) reported stigma, including self-stigma, public stigma, and stigma within a service member's unit, as a major factor in low treatment utilization.

Forty percent of U.S. military veterans reported alcohol use disorder compared to 30% of the general U.S. population (Fuehrlein et al., 2016). Alcohol use in military veterans may be used as a coping mechanism to palliate stress and negative adverse effects of psychological

comorbidities. In addition, researchers reported veterans with life-time alcohol use disorder also had increased rates of mood and anxiety disorder comorbidities.

The purpose of the study was to determine if there is a relationship between veteran wellness based on gender, discharge status, theatre of operations, substance use disorder, veteran self-efficacy, community reintegration post discharge, stigma and veteran physical and psychosocial factors. The study utilized a combination of two assessments of measurements, the Endorsed Anticipated Stigma Inventory (EASI) and the Well-Being Inventory (WBI).

The background of the study was conducted by reviewing and examining literature on veteran wellness as it relates to reintegration and mental health. The background covers the impact of lengthy deployments on veteran mental health and well-being, the stigma associated with accessing medical care post discharge, and identifies possible factors that may impede veteran wellness. The factors identified in the background of the study may impede the promotion of veteran well-being. The literature review in chapter 2 focused on the research pertaining to veteran wellness, stigma, self-efficacy, substance abuse, and other factors that may impede veteran well-being. The impact of stigma and other veteran specific issues such as military culture, self-efficacy, treatment-seeking, and veteran specific variables.

The research hypotheses of the study are to determine if:

1. Is there a relationship between well-being and specific veteran demographic factors (gender, theatre of operations, substance abuse, discharge status, substance abuse), and stigma beliefs?
2. Is there a relationship between treatment seeking and specific veteran demographic factors (gender, theatre of operations, substance abuse, discharge status) and stigma

beliefs?

3. Is there a relationship between self-efficacy and specific veteran demographic factors (gender, theatre of operations, substance abuse, discharge status, substance abuse) and stigma beliefs?
4. What is the relationship between self-efficacy and vocational, financial, health and social well-being?

A total of 99 surveys were collected from military veterans across the state of Texas. A total of 14 surveys were eliminated from the study. Seven surveys were incomplete and eliminated from the study; four surveys were eliminated due to veteran status and three were not residents of Texas. Participants in the study provided information on socio-economic status, stigma beliefs, mental health, vocational, educational, and financial well-being.

Conclusions

The independent variables (i.e., self-stigma, self-efficacy, treatment seeking and specific veteran demographic factors) accounted for and explained 19% of the variance on the dependent variable (vocational, financial, health and social well-being). The variance illustrates a relationship between well-being and specific veteran demographic factors and stigma beliefs. The outcome of the study indicated, the other variables (treatment seeking, specific veteran demographic factors, and self-efficacy) did not statistically associate with veteran well-being. Subsequently, specific veteran demographic factors and stigma beliefs determined the outcome of veteran well-being, therefore rejecting the null hypothesis.

Research conducted by the U.S. Census Bureau (2016) identifying specific demographic factors such as gender and theatre of operations is closely associated with the current study

whereas, 84% of veterans surveyed were male and 57% served in Gulf War era to the present. Stecker et al. (2013) noted stigma including self-stigma and public stigma can be a major deterrent in accessing medical, mental, and social services to promote well-being. Additionally, military culture can negatively influence the veteran's perception of care (Carrola & Corbin-Burdick, 2015). Personal beliefs about treatment are known barriers to treatment (Spoont et al., 2014). A baseline assessment conducted by Perkins et al. (2019) aligns with the findings in this study whereas, veterans post discharge is being diagnosed with disabilities requiring ongoing mental/emotional health condition, illness or disability. Schell and Marshall (2008) positively correlate with the current study where over half of the veterans having a mental health disorder.

Results demonstrated there were non-significant relationships between treatment seeking, specific veteran demographic factors and self-efficacy. As a result, the research study failed to reject the null hypotheses. Specifically, the sample of female veterans (16%) to male veterans (84%) was too insignificant to decide on well-being. Additionally, there was not variability in discharge status. Seventy-nine (93%) of veterans were honorably discharged while 6 (7%) reported discharge statuses of other than honorable or general. Furthermore, veterans self-reported a low incidence (10%) of substance abuse. Further results illustrated veterans who participated in the study were extremely or somewhat likely to seek treatment, have healthcare coverage (98%), and possessed a college education (93%). Due to the high number of insured and college education participants, these factors did not possess enough variance to impact self-efficacy and well-being.

Implications of the Findings

With 1.5 million veterans residing in the state of Texas, it is important to consider veteran well-being and community reintegration of military veterans. Texas is estimated to be the top state of residential veterans in the next 10 years. Due to the prevalence of lengthy deployments including prolonged exposure to combat and trauma related stress (Zeber et al., 2010), veteran well-being is becoming increasingly important for all service providers in social services. Symptoms of anxiety, poor interpersonal relationships, sleep disorders, camaraderie of military service (Bowling & Sherman, 2008) employability and substance use may all impact a veteran's well-being. In turn, a military veteran may have trouble reintegrating back into their families and communities. The current study of Texas military veterans provided information on the factors that may coincide or increase veteran well-being and improve quality of life. The results of the study have implications that will allow for future professionals to develop interventions and provide ongoing support services to veterans reintegrating into the community.

Of significance is reducing the negative perception of self-stigma and public stigma veterans encounter daily. To improve veteran well-being, stigma (self and public stigma) may be reduced through mentoring, establishing meaningful interpersonal relationships (McDonagh et al., 2018) amongst their peers, family, and friends. Psychoeducation for both the veteran and social service workers would also not only be beneficial but helpful in increasing awareness and understanding of the veteran's needs (Perkins et al., 2019). Additionally, the study reflected Ziven et al. (2015) low unemployment rate of veterans (20%) who access VA services versus

those who did not access VA services. The study was consistent with the findings from the U.S. Census Bureau (2015) where a large majority of veteran's average household income is between \$50,000-\$70,000 and have an educational attainment of a bachelor's degree or higher (52%).

Although research has noted veterans are more inclined to use non-VA primary care clinics due to stigma (Hinojosa et al., 2010; MHAT, 2009), a majority (73%) of the veterans who participated in the study have sought out VA services. Additionally, almost all participants (98%) in the study had healthcare coverage and were extremely or somewhat likely to seek out medical advice (81%). In turn, the veteran's self-efficacy and treatment seeking behaviors were contradictory to research findings (Blackburn & Owens, 2015). In this study, veteran's self-efficacy and treatment seeking behaviors were not significant to make the determination that a high level of self-efficacy would allude to being able to manage any traumatic or emotional stress.

Despite the fact there are awareness campaigns on reducing mental health stigma and the availability of psychoeducation programs, participants (65%) in the study believe stigma is a main deterrent in accessing adequate medical, mental health, and other support services to increase their quality of life. In turn, there is a need to reexamine current mental health awareness campaigns and tailor the programs for veterans. Veterans may carry unique characteristics not all individuals with mental health may experience. Veterans in the study reported they were extremely or somewhat likely to share their military experience with other military personnel. McDonagh et al. (2018) found recovery-oriented programs benefited from having peer specialists on hand to engage the veteran in participating in their continuum of care. Additionally, program training for all social service providers on holistic care approaches,

interpersonal collaboration, and committed staff may help reduce the barriers to increasing a veteran's well-being (McDonagh et al., 2018).

Limitations

There were several limitations to the study. One limitation was the specific population of the military veterans. Military veterans who resided in Texas could only participate in the study. Although, the researcher attempted to collect data from a broader veteran population however, most of the veterans who participated were from the southern part of Texas. A second limitation is the generalizability to the veteran population. Although veterans from the state of Texas were represented, the survey results may not apply to veterans in other parts of the nation. This in fact, limited the number of surveys to analyze in the study. Although the number of surveys acquired was 99, only 85 surveys were analyzed in the research. Additionally, most of the veterans who responded were educated and had a higher socio-economic status. Their responses may not be generalizable to other veterans who have little to no education or have low socioeconomic status. Lastly, the online administration of the survey may have limited the responses of other veterans who have little to no experience with technology. The researcher made every attempt to ensure the population was representative of various theatres of operations.

Suggestions for Future Research

The present study findings allow for future research in the field of rehabilitation. For example, the study could be replicated to include a larger sample population from different geographic locations or nationwide to help identify the relational impacts of community reintegration and veteran wellness. The current study was limited to the state of Texas.

Responses from the survey participants could be indicative of Texas veterans and indicative of the veteran population.

In addition, data could be collected to examine the length of time a military veteran post military discharge accesses services to increase their well-being. Length of time from discharge to survey administration was not captured in the present study. Additionally, future studies may be more focused on women veterans. Although the present study captured gender, the number of women participating in the study was not significant enough to determine any relational impacts of community reintegration and veteran wellness. Women bring their own unique care and support needs post military discharge.

Future studies could be more exploratory and qualitative in nature to obtain additional information on quality of care, support services for employment and/or education and worker satisfaction. A qualitative approach could perhaps include a wider range of veterans from different service eras. Age was not accounted for in the study, service era was reported in this study where a majority (58%) of the participants were from the Gulf War to present. A qualitative approach where a face to face interview with the participant would allow older veterans who may not utilize an electronic device to respond to the survey.

Additionally, branch of service should be included in future studies to identify any similarities or differences in military culture towards well-being. Military branches such as Air Force, Navy, Army, and Coast Guard may have differing views of community reintegration and well-being. In addition to exploring perceptions of a variety of service branches, future studies should evaluate veterans who are low income versus veterans who have a high income. In this study, there were two populations when it related to income, very low income and high income.

An exploratory study on the differing in perceptions amongst the two populations may provide further insight regarding adjustment and improving overall quality of life through wellness.

Veteran wellness is a key component in the quality of life of a military veteran. Researchers should continue to seek alternatives to improve the quality of care, increase positive well-being, and study best practices approaches to treatment modalities for military veterans reintegrating into society.

REFERENCES

- Abraham, K.M., Ganoczy, D., Yosef, M., Resnick, S.G., & Zivi, K. (2014) Receipt of employment services among Veterans Health Administration users with psychiatric diagnoses. *Journal of Rehabilitation Research. Dev.*, 51, pp. 401-414
- American Public Health Association. (2014). Removing barriers to mental health services for veterans. *Policy*, (201411)
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: American Psychiatric Association.
- Bandura, A. (1989). Regulation of cognitive processes through perceived self-efficacy. *Developmental psychology*, 25(5), 729.
- Bandura, A. (1986). The explanatory and predictive scope of self-efficacy theory. *Journal of social and clinical psychology*, 4(3), 359-373.
- Bandura, A. (1977). Self-efficacy: toward a unifying theory of behavioral change. *Psychological review*, 84(2), 191.
- Barnes, S. M., Monteith, L. L., Gerard, G. R., Hoffberg, A. S., Homaifar, B. Y., & Brenner, L. A. (2017). Problem-solving therapy for suicide prevention in veterans with moderate-to-severe traumatic brain injury. *Rehabilitation psychology*, 62(4), 600.
- Belmont, P. J., Schoenfeld, A. J., & Goodman, G. (2010). Epidemiology of combat wounds in Operation Iraqi Freedom and Operation Enduring Freedom: orthopaedic burden of disease. *Journal of Surgical Orthopaedic Advances*, 19(1), 2-7.
- Berglass, N., & Harrell, M.C. Well after service: Veteran reintegration and American communities. 2012: 1-45. <https://www.cnas.org/publications/reports/well-after-service-veteran-reintegration-and--american-communities> (accessed 23 August 2018)
- Blackburn, L., & Owens, G. P. (2015). The effect of self efficacy and meaning in life on posttraumatic stress disorder and depression severity among veterans. *Journal of clinical psychology*, 71(3), 219-228.
- Blais R.K, & Renshaw K.D. (2013). Stigma and demographic correlates of help-seeking

- intentions in returning service members. *Journal of Traumatic Stress*, 26:77–85.
- Blevins, D., Roca, J. V., & Spencer, T. (2011). Life guard: Evaluation of an ACT-based workshop to facilitate reintegration of OIF/OEF veterans. *Professional Psychology: Research and Practice*, 42(1), 32-39. doi:10.1037/a0022321
- Bonanno, G. A., & Mancini, A. D. (2012). Beyond resilience and PTSD: Mapping the heterogeneity of responses to potential trauma. *Psychological Trauma: Theory, Research, Practice, and Policy*, 4(1), 74.
- Bossarte, R. M. (2018). Challenges associated with the use of policy to identify and manage risk for suicide and interpersonal violence among veterans and other Americans. *Administration and Policy in Mental Health and Mental Health Services Research*, 45(4), 692-695.
- Bowling, U. B., & Sherman, M. D. (2008). Welcoming them home: Supporting service members and their families in navigating the tasks of reintegration. *Professional Psychology: Research and Practice*, 39(4), 451-458. doi:10.1037/0735-7028.39.4.451
- Campbell, D. T., & Stanley, J. C. (1963). Experimental and quasi-experimental designs for research on teaching. *Handbook of research on teaching*, 5, 171-246 Chicago, IL: Rand McNally
- Carlson, E. B., Garvert, D. W., Macia, K. S., Ruzek, J. I., & Burling, T. A. (2013). Traumatic stressor exposure and post-traumatic symptoms in homeless veterans. *Military Medicine*, 178(9), 970-973.
- Carrola, P., & Corbin-Burdick, M. (2015). Counseling military veterans: Advocating for culturally competent and holistic interventions. *Journal of Mental Health Counseling*, 37(1), 1-14. doi:10.17744/mehc.37.1.v74514163rv73274
- Carroll, E. M., Rueger, D. B., Foy, D. W., & Donahoe, C. P. (1985). Vietnam combat veterans with posttraumatic stress disorder: analysis of marital and cohabitating adjustment. *Journal of Abnormal Psychology*, 94(3), 329.
- Centers for Disease Control and Prevention (CDC). (2015). CDC Vital Signs. Opioid painkiller prescribing. Where you live makes a difference. July 2014.
- Centers for Disease Control and Prevention (CDC). (2011). Vital signs: overdoses of prescription opioid pain relievers---United States, 1999--2008. *MMWR. Morbidity and mortality weekly report*, 60(43), 1487.
- Church, T. E. (2009). Returning veterans on campus with war related injuries and the long road back home. *Journal of Postsecondary Education and Disability*, 22(1),

- Cohen, J., and Cohen, P. (1983). *Applied multiple regression/correlation analysis for the behavioral sciences*. (2nd ed.). Hillsdale, NJ: Lawrence Erlbaum Associates.
- Coll, J. E., Weiss, E. L., & Yarvis, J. S. (2011). No one leaves unchanged: Insights for civilian mental health care professionals into the military experience and culture. *Social Work in Health Care, 50*(7), 487-500. doi:10.1080/00981389.2010.528727
- Corrigan, P. W. (2000). Mental health stigma as social attribution: Implications for research methods and attitude change. *Clinical psychology: science and practice, 7*(1), 48-67.
- Corrigan, P. W., & Watson, A. C. (2002). The paradox of self-stigma and mental illness. *Clinical Psychology: Science and Practice, 9*(1), 35-53.
- Corrigan, P. W., Kuwabara, S. A., & O'Shaughnessy, J. (2009). The public stigma of mental illness and drug addiction: Finding from a stratified random sample. *Journal of Social Work, 9*, 139–147. doi:10.1177/1468017308101818
- Corrigan, P., Schomerus, G., & Smelson, D. (2017). Are some of the stigmas of addictions culturally sanctioned? *The British Journal of Psychiatry, 210*(3), 180-181.
- Corrigan, P. W., River, L. P., Lundin, R. K., Wasowski, K. U., Campion, J., Mathisen, J., ... & Kubiak, M. A. (2000). Stigmatizing attributions about mental illness. *Journal of Community Psychology, 28*(1), 91-102.
- Cronbach, L. J. (1951). Coefficient alpha and the internal structure of tests. *Psychometrika, 16*, 297-334
- Daggett, V., Bakas, T., & Habermann, B. (2009). A review of health-related quality of life in adult traumatic brain injury survivors in the context of combat veterans. *Journal of Neuroscience Nursing, 41*(2), 59–71.
- Danish, S. J., & Antonides, B. J. (2013). The challenges of reintegration for service members and their families. *American Journal of Orthopsychiatry, 83*(4), 550-558. doi:10.1111/ajop.12054
- Daum, A. M., Berkowitz, O., & Renner Jr, J. A. (2015). The evolution of chronic opioid therapy and recognizing addiction. *Journal of the American Academy of PAs, 28*(5), 23-27.

- Dillahunt-Aspillaga, C., & Powell-Cope, G. (2018). Community reintegration, participation, and employment issues in veterans and service members with traumatic brain injury. *Archives of physical medicine and rehabilitation*, *99*(2), S1-S3.
- Disabled American Veterans. (2014). Women veterans: The long journey home. Retrieved from <https://www.dav.org/wp-content/uploads/women-veterans-study.pdf>.
- Dixon, L. J., Leen-Feldner, E. W., Ham, L. S., Feldner, M. T., & Lewis, S. F. (2009). Alcohol use motives among traumatic event-exposed, treatment-seeking adolescents: Associations with posttraumatic stress. *Addictive behaviors*, *34*(12), 1065-1068.
- Exum, H., Coll, J.E., & Weiss, E.L. (2011). *A Civilian Counselor's Primer for Counseling Veterans* (2nd edition). Deerpark, NJ: Linus Productions.
- Farmer Veteran Coalition (2014). Meet a Farmer Veteran. Retrieved April 13, 2019 <http://www.farmvetco.org/farmer-veterans>
- Finley, E. P., Zeber, J. E., Pugh, M. J. V., Cantu, G., Copeland, L. A., Parchman, M. L., & Noel, P. H. (2010). Postdeployment health care for returning OEF/OIF military personnel and their social networks: a qualitative approach. *Military Medicine*, *175*(12), 953-957.
- Fleming, L. L. (2015). Veteran to Farmer Programs: An Emerging Nature-Based Programming Trend. *Journal of Therapeutic Horticulture*, *25*(1). Retrieved from <http://search.ebscohost.com.ezhost.utrgv.edu:2048/login.aspx?direct=true&db=a9h&AN=122818890&site=ehost-live>.
- Fox, A., Meyer, E., Vogt, D., & Deleon, P. (2015). Attitudes about the VA health-care setting, mental illness, and mental health treatment and their relationship with VA mental health service use among female and male OEF/OIF veterans. *Psychological Services*, *12*(1), 49–58. doi:10.1037/a0038269
- Freytes, I. M., LeLaurin, J. H., Zickmund, S. L., Resende, R. D., & Uphold, C. R. (2017). Exploring the post-deployment reintegration experiences of veterans with PTSD and their significant others. *American Journal of Orthopsychiatry*, *87*(2), 149-156. <http://dx.doi.org/10.1037/ort0000211>
- Fuehrlein, B. S., Mota, N., Arias, A. J., Trevisan, L. A., Kachadourian, L. K., Krystal, J. H., ... & Pietrzak, R. H. (2016). The burden of alcohol use disorders in US military veterans: results from the National Health and Resilience in Veterans Study. *Addiction*, *111*(10), 1786-1794.
- Gall, M. D., Gall, J. P., & Borg, W. R. (2007). *Educational research: An introduction* (Eighth ed.). Boston: Pearson/Allyn & Bacon.

- Gradus, J. L., Leatherman, S., Curreri, A., Myers, L. G., Ferguson, R., & Miller, M. (2017). Gender differences in substance abuse, PTSD and intentional self-harm among veterans health administration patients. *Drug and alcohol dependence, 171*, 66-69.
- Gross, R., Neria, Y., Engel, A., Aquilino, C., Hoge, C., Messer, S., & Castro, C. (2004). Combat duty in Iraq and Afghanistan and mental health problems. *New England Journal of Medicine, 351*(17), 1799-1800.
- Harnish, A., Corrigan, P., Byrne, T., Pinals, D. A., Rodrigues, S., & Smelson, D. (2016). Substance use and mental health stigma in veterans with co-occurring disorders. *Journal of dual diagnosis, 12*(3-4), 238-243.
- Hattie, J. A., Myers, J. E., & Sweeney, T. J. (2004). A factor structure of wellness: Theory, assessment, analysis, and practice. *Journal of Counseling & Development, 82*(3), 354-364.
- Haun, J. N., Duffy, A., Lind, J. D., Kisala, P., & Luther, S. L. (2016). Qualitative inquiry explores health-related quality of life of female veterans with post-traumatic stress disorder. *Military Medicine, 181*(11), e1470-e1475.
- Hinkle, D. E., Wiersma, W., & Jurs, S. G. (1988). Applied statistics for the behavioral sciences. (4th ed.). Chicago, IL: Rand McNally College Publishing.
- Hinojosa, R., Hinojosa, M. S., Nelson, K., & Nelson, D. (2010). Veteran family reintegration, primary care needs, and the benefit of the patient-centered medical home model. *The Journal of the American Board of Family Medicine, 23*(6), 770-774.
doi:10.3122/jabfm.2010.06.100094
- Hirsch, J. K., & Cukrowicz, K. C. (2014). Suicide in rural areas: An updated review of the literature. *Journal of Rural Mental Health, 38*, 65-78.
<http://dx.doi.org/10.1037/rmh0000018>
- Hoge, C. W., Castro, C. A., Messer, S. C., McGurk, D., Cotting, D. I., & Koffman, R. L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine, 351*(1), 13-22.
- Hoge, C. W., Grossman, S. H., Auchterlonie, J. L., Riviere, L. A., Milliken, C. S., & Wilk, J. E. (2014). PTSD treatment for soldiers after combat deployment: low utilization of mental health care and reasons for dropout. *Psychiatric Services, 65*(8), 997-1004
- Hoggatt, K. J., Jamison, A. L., Lehavot, K., Cucciare, M. A., Timko, C., & Simpson, T. L. (2015). Alcohol and drug misuse, abuse, and dependence in women veterans. *Epidemiologic reviews, 37*(1), 23-37.

- Hopkins, K. (1998). *Educational and psychological measurement and evaluation* (8th ed.). Boston: Allyn & Bacon.
- Hosek, J., Kavanagh, J., & Miller, L. (2006). *How deployments affect service members*. Santa Monica, CA: RAND Corporation.
- Hundt, N. E., Robinson, A., Arney, J., Stanley, M. A., & Cully, J. A. (2015). Veterans' perspectives on benefits and drawbacks of peer support for posttraumatic stress disorder. *Military Medicine*, *180*(8), 851-856.
- Hutchinson, J., & Banks-Williams, L. (2006). Clinical issues and treatment considerations for new veterans: Soldiers of the wars in Iraq and Afghanistan. *Primary Psychiatry*, *13*(3), 66-71.
- Institute of Medicine (2013). Returning home from Iraq and Afghanistan: Assessment of Readjustment Needs of Veterans, Service Members, and Their Families. *Military Medicine*, *179*(10), 1053-5. doi:10.7205/MILMED-D-14-00263
- James, L. M., Van Kampen, E., Miller, R. D., & Engdahl, B. E. (2013). Risk and protective factors associated with symptoms of post-traumatic stress, depression, and alcohol misuse in OEF/OIF veterans. *Military Medicine*, *178*(2), 159-165.
- Jones, Steve (2014). Perspective. *The United States Army Medical Department Journal*, (4), 1-2.
- Kahn, J. R., Collinge, W., & Soltysik, R. (2016). Post-9/11 veterans and their partners improve mental health outcomes with a self-directed mobile and web-based wellness training program: a randomized controlled trial. *Journal of medical Internet research*, *18*(9), e255
- Kang, H. K., Bullman, T. A., Smolenski, D. J., Skopp, N. A., Gahm, G. A., & Reger, M. A. (2015). Suicide risk among 1.3 million veterans who were on active duty during the Iraq and Afghanistan wars. *Annals of epidemiology*, *25*(2), 96-100.
- Karney, B. R., & Crown, J. S. (2007). *Families under stress: An assessment of data, theory, and research on marriage and divorce in the military*. Santa Monica, CA: RAND Corporation. Retrieved from <http://www.rand.org/pubs/monographs/MG599.html>
- Kehle, S. M., Reddy, M. K., Ferrier-Auerbach, A. G., Erbes, C. R., Arbisi, P. A., & Polusny, M. A. (2011). Psychiatric diagnoses, comorbidity, and functioning in National Guard troops deployed to Iraq. *Journal of psychiatric research*, *45*(1), 126-132.

- Kimerling, R., Bastian, L. A., Bean-Mayberry, B. A., Bucossi, M. M., Carney, D. V., Goldstein, K. M., ... & Frayne, S. M. (2015). Patient-centered mental health care for female veterans. *Psychiatric Services, 66*(2), 155-162.
- Koenen, K. C., Stellman, S. D., Sommer, J. F., Jr., & Stellman, J. M. (2008). Persisting posttraumatic stress disorder symptoms and their relationship to functioning in Vietnam veterans: A 14-year follow-up. *Journal of Traumatic Stress, 21*, 49-57. <http://dx.doi.org/10.1002/jts.20304>
- Kulka, R. A., Schlenger, W. E., Fairbank, J. A., Hough, R. L., Jordan, B. K., Marmar, C. R., & Weiss, D. S. (1988). Contractual report of findings from the national Vietnam veterans readjustment study. *Research Triangle Park, NC: Research Triangle Institute.*
- James, L. M., Van Kampen, E., Miller, R. D., & Engdahl, B. E. (2013). Risk and protective factors associated with symptoms of post-traumatic stress, depression, and alcohol misuse in OEF/OIF veterans. *Military Medicine, 178*(2), 159-165.
- Jones, J. D., Mogali, S., & Comer, S. D. (2012). Polydrug abuse: a review of opioid and benzodiazepine combination use. *Drug and alcohol dependence, 125*(1-2), 8-18.
- Lang, K. P., Veazey-Morris, K., Berlin, K. S., & Andrasik, F. (2016). Factors affecting health care utilization in OEF/OIF veterans: the impact of PTSD and pain. *Military Medicine, 181*(1), 50-55
- Leslie, L. A., & Koblinsky, S. A. (2017). Returning to civilian life: Family reintegration challenges and resilience of women veterans of the Iraq and Afghanistan wars. *Journal of Family Social Work, 20*(2), 106-123. doi:10.1080/10522158.2017.1279577
- Link, B. (2001). Stigma: Many mechanisms require multifaceted responses. *Epidemiologia E Psichiatria Sociale, 10*(1), 8-11. doi:10.1017/S1121189X00008484
- Lunberg, N., Bennett, J., & Smith, S. (2011). Outcomes of adaptive sports and recreational participation among veterans returning from combat with acquired disability. *Therapeutic Recreation Journal, 45* 105-120. Retrieved from http://www.va.gov/adaptivesports/docs/lunberg_pdf.
- Maddux, J. E. (1991). Self-Efficacy. *Handbook of Social and Clinical Psychology* (pp.57-78). New York: Pergamon Press.
- Maguen, S., Skopp, N. A., Zhang, Y., & Smolenski, D. J. (2015). Gender differences in suicide and suicide attempts among U.S. Army soldiers. *Psychiatry Research, 225*, 545-549. <http://dx.doi.org/10.1016/j.psychres.2014.11.050>

- Marek, L. I., & D’Aniello, C. (2014). Reintegration stress and family mental health: Implications for therapists working with reintegrating military families. *Contemporary Family Therapy*, 36(4), 443-451. doi:10.1007/s10591-014-9316-4
- McCarten, J. M., Hoffmire, C. A., & Bossarte, R. M. (2015). Changes in overall and firearm veteran suicide rates by gender, 2001–2010. *American Journal of Preventive Medicine*, 48(3), 360-364.
- McDonagh, J. G., Haren, W. B., Valvano, M., Grubaugh, A. L., Wainwright, F. C., Rhue, C. H., ... & York, J. A. (2018). Cultural Change: Implementation of a Recovery Program in a Veterans Health Administration Medical Center Inpatient Unit. *Journal of the American Psychiatric Nurses Association*, 1078390318786024.
- Mental Health Advisory Team (MHAT), V., Operation Iraqi Freedom 06-08: Iraq. (2008). Operation Enduring Freedom 8: Afghanistan. Retrieved from http://www.armymedicine.army.mil/reports/mhat/mhat_v/mhat-v.cfm
- Messecar, D. C. (2017). Finding their way back in: Family reintegration following guard deployment. *Military Medicine*, 182(S1), 266-273. doi:10.7205/milmed-d-16-00109
- Milliken, C. S., Auchterlonie, J. L., & Hoge, C. W. (2007). Longitudinal assessment of mental health problems among active and reserve component soldiers returning from the Iraq war. *Journal of the American Medical Association*, 298, 2141-2148.
- Mittal, D., Drummond, K. L., Blevins, D., Curran, G., Corrigan, P., & Sullivan, G. (2013). Stigma associated with PTSD: Perceptions of treatment seeking combat veterans. *Psychiatric Rehabilitation Journal*, 36(2), 86.
- Mott, J. M., Stanley, M. A., Street Jr, R. L., Grady, R. H., & Teng, E. J. (2014). Increasing engagement in evidence-based PTSD treatment through shared decision-making: A pilot study. *Military Medicine*, 179(2), 143-149.
- Myers, J., & Sweeney, T. (2008). Wellness Counseling: The Evidence Base for Practice. *Journal of Counseling & Development*, 86(4), 482–493. doi:10.1002/j.1556-6678.2008.tb00536.x
- Myers, J. E., & Sweeney, T. J. (2004). The indivisible self: An evidence-based model of wellness. *Journal of Individual Psychology*, 60, 234-244.
- Myers, J. E., Sweeney, T. J., & Witmer, J. M. (2000). The wheel of wellness counseling for wellness: A holistic model for treatment planning. *Journal of Counseling & Development*, 78(3), 251-266.

- National Center for Veteran Analysis and Statistics (NCVAS) (2016) *Veteran Population Data*. Retrieved from: <https://www.va.gov/vetdata/report.asp>
- National Coalition on Homeless Veterans (2018). Background Statistics. http://nchv.org/index.php/news/media/background_and_statistics/
- Negrusa, B., & Negrusa, S. (2014). Home front: Post-deployment mental health and divorces. *Demography*, 51(3), 895-916.
- Okie, S. (2005). Traumatic brain injury in the war zone. *New England Journal of Medicine*, 352, 2043-2047.
- Pearson, K., & Lee, A. (1908). On the generalised probable error in multiple normal correlation. *Biometrika*, 6(1), 59-68.
- Pedersen, E., Eberhart, N., Williams, K., Tanielian, T., & Scharf, D. (2015). Public-Private Partnerships for Providing Behavioral Health Care to Veterans and Their Families: What Do We Know, What Do We Need to Learn, and What Do We Need to Do? *Rand health quarterly*, 5(2), 18.
- Perkins, D. F., Aronson, K. R., Morgan, N. R., Bleser, J. A., Vogt, D., Copeland, L. A., & Gilman, C. (2019). Veterans' Use of Programs and Services as They Transition to Civilian Life: Baseline Assessment for the Veteran Metrics Initiative. *Journal of Social Service Research*, 1-15.
- Perry, W. J., & Flournoy, M. A. (2006). The U.S. military: Under strain and at risk. *National Defense Magazine*, 90(360), 14-17.
- Petrovich, J. C., Pollio, D. E., & North, C. S. (2014). Characteristics and service use of homeless veterans and nonveterans residing in a low-demand emergency shelter. *Psychiatric Services*, 65(6), 751-757.
- Punch, K.F. (2005). *Introduction to social research: Quantitative and qualitative approaches* (2nd ed.) London, UK: Sage.
- Ray, S. L. (2009). The experience of contemporary peacekeepers healing from trauma. *Nursing Inquiry*, 16, 53-63.
- Renshaw, K. D. (2011). An integrated model of risk and protective factors for post-deployment PTSD symptoms in OEF/OIF era combat veterans. *Journal of Affective Disorders*, 128(3), 321-326. doi: 10.1016/j.jad.2010.07.022
- Resnik, L., Bradford, D. W., Glynn, S. M., Jette, A. M., Hernandez, C. J., & Wills, S. (2012). Issues in defining and measuring veteran community reintegration: Proceedings of the working group on community reintegration, VA rehabilitation outcomes conference,

- Miami, Florida. *The Journal of Rehabilitation Research and Development*, 49(1), 87.
doi:10.1682/jrrd.2010.06.0107
- Riggs, S. A., & Riggs, D. S. (2011). Risk and resilience in military families experiencing deployment: The role of the family attachment network. *Journal of Family Psychology*, 25, 675-687.
- Rittmueller, S. E., Frey, M. S., Williams, E. C., Sun, H., Bryson, C. L., & Bradley, K. A. (2015). Association between alcohol use and cardiovascular self-care behaviors among male hypertensive veterans affairs outpatients: a cross-sectional study. *Substance abuse*, 36(1), 6-12.
- Room, R. (2005). Stigma, social inequality and alcohol and drug use. *Drug and alcohol review*, 24(2), 143–155. doi:10.1080/09595230500102434
- Rovai, A. P., Baker, J. D., & Ponton, M. K. (2014). Social science research design and statistics: A practitioner's guide to research methods and IBM SPSS Analysis. Chesapeake, VA: Watertree Press, LLC.
- Saban, K. L., Hogan, N. S., Hogan, T. P. & Pape, T. L.-B. (2015), He looks normal but ... challenges of family caregivers of veterans diagnosed with a traumatic brain injury. *Rehabilitation Nursing*, 40: 277–285. doi:10.1002/rnj.182
- Saban, K.L., Mathews, H.L., Bryant, F.B., O'Brien, T.E., & Janusek, L.W. (2012). Depressive symptoms and diurnal salivary cortisol patterns among female caregivers of stroke survivors. *Biological Research for Nursing*, 14(4), 396–404.
- Sayer, N. A., Carlson, K. F., & Frazier, P. A. (2014). Reintegration challenges in U.S. service members and veterans following combat deployment. *Social Issues and Policy Review*, 8(1), 33-73. doi:10.1111/sipr.12001
- Sayer, N., Noorbaloochi, S., Frazier, P., Carlson, K., Gravely, A., & Murdoch, M. (2010). Reintegration problems and treatment interests among Iraq and Afghanistan combat veterans receiving VA medical care. *Psychiatric Services*, 61(6), 589-597.
- Sayers, S. L. (2011). Family reintegration difficulties and couples therapy for military veterans and their spouses. *Cognitive and Behavioral Practice*, 18(1), 108-119.
- Sayers, S., Glynn, S., & Mccutcheon, S. (2014). Family court and a review of family services in the department of veterans affairs. *Family Court Review*, 52(3), 371–380. doi:10.1111/fcre.12098
- Schell, & Marshall, T. (2008). Survey of individuals previously deployed for OEF/OIF. In T. Tanielian & L. H. Jaycox (Eds.), *Invisible wounds of war: Psychological*

and cognitive injuries, their consequences, and services to assist recovery (pp. 87–115). Santa Monica, CA: RAND Corporation.

- Schlenger, W. E., Kulka, R. A., Faribank, J. A., Hough, R. L., Jordan, B. K., Marmar, C. R., & Weiss, D. S. (1992). The prevalence of posttraumatic stress disorder in the Vietnam generation: A multimethod, multisource assessment of psychiatric disorder. *Journal of Traumatic Stress, 5*(3), 333-363.
- Shane, L. (2018, September 26). VA: Suicide rate for younger veterans increased by more than 10 percent. *The Military Times*. Retrieved from <https://www.militarytimes.com/news/pentagon-congress/2018/09/26/suicide-rate-spikes-among-younger-veterans/>.
- Shelton, K. H., Taylor, P. J., Bonner, A., & Van den Bree, M. (2009). Risk factors for homelessness: evidence from a population-based study. *Psychiatric Services, 60*(4), 465-472.
- Sheng, T., Fairchild, J. K., Kong, J. Y., Kinoshita, L. M., Cheng, J. J., Yesavage, J. A., ... & Adamson, M. M. (2016). The influence of physical and mental health symptoms on Veterans' functional health status. *Journal of Rehabilitation Research & Development, 53*(6).
- Smith, H. (2001). Professional identity for counselors. *The handbook of counseling, 569-579*.
- Soper, D. S. (2011). A priori Sample Size Calculator for Multiple Regression. Statistics Calculators [Online Software]. Retrieved from: <http://www.danielsoper.com/statcalc3/>.
- Spelman, J. F., Hunt, S. C., Seal, K. H., & Burgo-Black, A. L. (2012). Post deployment care for returning combat veterans. *Journal of General Internal Medicine, 27*(9), 1200-1209.
- Spoont, M. R., Nelson, D. B., Murdoch, M., Rector, T., Sayer, N. A., Nugent, S., & Westermeyer, J. (2014). Impact of treatment beliefs and social network encouragement on initiation of care by VA service users with PTSD. *Psychiatric Services, 65*(5), 654-662.
- Sporner, M. L., Fitzgerald, S. G., Dicianno, B. E., Collins, D., Teodorski, E., Pasquina, P. F., & Cooper, R. A. (2009). Psychosocial impact of participation in the national veterans wheelchair games and winter sports clinic. *Disability & Rehabilitation, 31*(5), 410-418. doi:10.1080/09638280802030923
- Statistical Package for the Social Sciences (SPSS, 2017). (Version 25.0) [Computer Software]. Armonk, NY: BM Corp.

- Stebnicki, M. A. (2015). Military Counseling. In Stebnicki, M.A. and Marini, I. (Eds.), *The professional counselor's desk reference* (Second ed.) (pp. 499-506). New York, NY: Springer Publishing Company, LLC.
- Stecker, T., Shiner, B., Watts, B. V., Jones, M., & Conner, K. R. (2013). Treatment-seeking barriers for veterans of the Iraq and Afghanistan conflicts who screen positive for PTSD. *Psychiatric Services, 64*(3), 280-283.
- Taft, C., Schumm, J., Panuzio, J., & Proctor, S. (2008). An Examination of family adjustment among operation desert storm veterans. *Journal of Consulting and Clinical Psychology, 76*(4), 648–656. doi:10.1037/a0012576
- Tanielian, T., & Jaycox, L. H. (2008). *Invisible wounds of war*. Santa, Monica, CA: RAND Corporation. Retrieved from <http://www.rand.org/pubs/monographs/MG720.html>
- Taylor, J. G., & Baker, S. B. (2007). Psychosocial and moral development of PTSD-diagnosed combat veterans. *Journal of Counseling and Development, 85*, 364—369.
- Tinney, G., & Gerlock, A. A. (2014). Intimate partner violence, military personnel, veterans, and their families. *Family court review, 52*(3), 400-416.
- Treatment seeking. (2019). Psychology Dictionary.org. Retrieved from <https://psychologydictionary.org/treatment-seeking-behavior/>
- Tukey, J. W. (1977). *Exploratory Data Analysis*. Addison-Wesley, Reading.
- Ullman, S. E., Townsend, S. M., Starzynski, L. L., & Long, L. M. (2006). Correlates of comorbid PTSD and polysubstance use in sexual assault victims. *Violence and victims, 21*(6), 725.
- U.S. Census Bureau. (2012). *Memorial Day: Honoring America's wartime veterans*. Retrieved from http://www.census.gov/how/pdf/memorial_day.pdf
- U.S. Census Bureau. (2015). *Veteran Statistics: Texas*. Retrieved from <https://www2.census.gov/library/visualizations/2015/comm/vets/tx-vets.pdf>
- U.S. Census Bureau (2016). *Who are our veterans? American Community Survey 2016*
- U.S. Census Bureau (2017). *2013-2017: Related statistics about U.S. veterans, American Community Survey 5-year estimates*. Retrieved from <https://www.census.gov/programs-surveys/acs/>
- U.S. Department of Housing and Urban Development (2018). AHAR Reports. <https://www.hudexchange.info/homelessness-assistance/ahar/#reports>

- U.S. Department of Labor (2014). Five facts about women veterans. Retrieved from:
<http://blog.dol.gov/2014/11/22/five-facts-about-women-veterans/>
- U.S. Department of Veterans Administration, Supportive Services for Veteran Families Program. (2017). *Supportive Services for Veteran Families Program Guide*. Retrieved from
https://www.va.gov/HOMELESS/ssvf/docs/SSVFProgramGuide_October2017.pdf
- U.S. Department of Veteran Affairs. (2011) *America's Women Veterans: Military service history and VA benefit utilization statistics*. Retrieved from
http://www.va.gov/vetdata/docs/specialreports/final_womens_report_3_2_12_v_7.pdf.
- U.S. Department of Veteran Affairs (2013). FY2014-2020 Strategic Plan, retrieved from
<http://www.va.gov/op3/docs/strategicplanning/va2014-2020straegicplan.pdf>
- U.S. Department of Veteran Affairs (2016) Office of Suicide Prevention. (2016). Suicide among Veterans and other Americans 2001–2014. Retrieved from <https://www.mentalhealth.va.gov/docs/2016suicidedatareport.pdf>
- U.S. Department of Veterans Affairs. (2016). Suicide among Veterans and Other Americans. 2001–2014. Retrieved from
<https://www.mentalhealth.va.gov/docs/2016suicidedatareport.pdf>
- U.S. Department of Veteran Affairs, National Center for Veterans Analysis and Statistics. (2016). Veteran Population Model. Retrieved from
https://www.va.gov/vetdata/docs/Demographics/New_Vetpop_Model/Vetpop_Infographic_Final31.pdf
- U.S. Department of Veteran Affairs (2017) *State Summaries Texas*. Retrieved from
https://www.va.gov/vetdata/docs/SpecialReports/State_Summaries_Texas.pdf
- U.S. Department of Veterans Affairs. (2017). VA REACH VET Initiative Helps Save Veterans Lives; program signals when more help is needed for at-risk veterans. The Reach Vet press release.
<https://www.va.gov/opa/pressrel/pressrelease.cfm?id=2878>.
- U.S. Department of Veteran Affairs Office of Public Affairs. (2018). *VA Programs for Homeless Veterans*. January 2018. Washington, DC. Retrieved from
<https://www.va.gov/HOMELESS/docs/Homeless-Programs-General-Fact-Sheet-JAN-2018.pdf>.
- U.S. Department of Veteran Affairs (2018). *Women Veterans Health Care: Substance Abuse and Treatment*. Retrieved from

https://www.womenshealth.va.gov/WOMENSHEALTH/outreachmaterials/mentalhealth/substance_abuse.asp

- U.S. Department of Veteran Affairs (2019). *Veterans Programs for Health and Wellness*. Retrieved from <https://www.va.gov/health-care/wellness-programs/> (accessed 19 April 2019)
- U.S. Government Accountability Office. Military Veteran Support: DOD and VA programs that address the effects of combat and transition to civilian life (GAO-15-24). 2014. <http://www.gao.gov/assests/670/666801.pdf> (accessed 22 August 2018).
- Veteran Population, U.S. Department of Veterans Affairs, 2016, https://www.va.gov/vetdata/docs/Demographics/New_Vetpop_Model/Vetpop_Infographic_Final31.pdf
- Vogt, D., Di Leone, B. A., Wang, J. M., Sayer, N. A., Pineles, S. L., & Litz, B. T. (2014). Endorsed and Anticipated Stigma Inventory (EASI): A tool for assessing beliefs about mental illness and mental health treatment among military personnel and veterans. *Psychological Services, 11*(1), 105.
- Vogt, D., Smith, B., Fox, A., Amoroso, T., Taverna, E., & Schnurr, P. (2017). Consequences of PTSD for the work and family quality of life of female and male U.S. Afghanistan and Iraq War veterans. *Social psychiatry and psychiatric epidemiology, 52*(3), 341–352. doi:10.1007/s00127-016-1321
- Vogt, D., Perkins, D., Copeland, L., Finley, E., Jamieson, C., Booth, B., Lederer, S., et al. (2018). The Veterans metrics initiative study of US veterans' experiences during their transition from military service. *Bmj Open, 8*(6), e020734. doi:10.1136/bmjopen-2017-020734
- Vogt, D., Taverna, E., Nillni, Y., & Tyrell, F. (2018). Manual for the Well-Being Inventory (WBI): A multidimensional tool for assessing key components of well-being. Boston, MA: National Center for PTSD.
- Weiss, E., & Coll, J. E., (2011). The influence of military culture and veteran worldviews on mental health treatment: Practice implications for combat veteran help-seeking and wellness. *The International Journal of Health, Wellness, and Society, 1*(2), 75-86. doi:10.18848/2156-8960/CGP/v01i02/41168
- Wisco, B. E., Marx, B. P., Wolf, E. J., Miller, M. W., Southwick, S. M., & Pietrzak, R. H. (2014). Posttraumatic stress disorder in the US veteran population: results from the National Health and Resilience in Veterans Study. *J. Clin. Psychiatry, 75*(12), 1338-1346.

- Women Veteran Profile, U.S. Department of Veterans Affairs, 2013,
http://www.va.gov/vetdata/docs/SpecialReports/Women_Veteran_Profile5.pdf
- Woolsey, L., & Naumann, M. (2015). A Review of the literature related to homeless veteran reintegration.
- Ysasi, N. A., Silva, I. & Becton, A. D. (2016) Counseling families of active duty military and returning veterans. In *The professional counselor's desk reference* (Second ed.). New York, NY: Springer Publishing Company, LLC.
- Zeber, J. E., Noel, P. H., Pugh, M. J., Copeland, L. A., & Parchman, M. L. (2010). Family perceptions of post-deployment healthcare needs of Iraq/Afghanistan military personnel. *Mental Health in Family Medicine*, 7(3), 135.
- Zedler, B., Xie, L., Wang, L., Joyce, A., Vick, C., Kariburyo, F., ... & Murrelle, L. (2014). Risk factors for serious prescription opioid-related toxicity or overdose among Veterans Health Administration patients. *Pain medicine*, 15(11), 1911-1929.
- Zivin, K., Yosef, M., Levine, D. S., Abraham, K. M., Miller, E. M., Henry, J., ... & Valenstein, M. (2016). Employment status, employment functioning, and barriers to employment among VA primary care patients. *Journal of Affective Disorders*, 193, 194-202.

BIOGRAPHICAL SKETCH

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