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UNIVERSITY OF SAN DIEGO

Hahn School of Nursing and Health Science

DOCTOR OF PHILOSOPHY IN NURSING

THE POST DEPLOYMENT LIVED EXPERIENCE OF U. S. MILITARY TROOPS

AFTER COMBAT-RELATED BLAST EXPOSURE

by

Shirley A. Jett

A dissertation presented to the

FACULTY OF THE HAHN SCHOOL OF NURSING AND HEALTH SCIENCE

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requirements for the degree

DOCTOR OF PHILOSOPHY IN NURSING

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Dissertation Committee

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ABSTRACT

Blast-induced neurotrauma (BINT) is a newly emerging re-occurrence of an old combat-related injury in U. S. military troops returning from deployment in Afghanistan and Iraq. BINT is leading to a silent epidemic of symptomatic troops who face barriers to accessing healthcare and suffer debilitating symptoms in silence. The purpose of this hermeneutic phenomenological study was to discover the meaning of the lived experience of U.S. troops returning from Afghanistan and Iraq after combat-related blast exposure. Eleven service members and veterans ranging in age from 21 to over 30 years old participated in semi-structured face to face interviews. These service members and veterans ranged from a few months to five years post deployment. Audio recorded and transcribed interview data were analyzed to identify essential themes and subthemes. Texts were interpreted guided by hermeneutic phenomenology (Heidegger, 1962) and van Manen's (1990) research activities. Methodological rigor was achieved through validating participants' perceptions and ideas during the interview and confirmations and interpretations from other researchers to validate the researcher's interpretations and connections. The thematic analysis revealed essential themes that fell into two major categories: 1) personal pain and suffering and, (2) pain and suffering associated with using the health care system. The findings revealed high stress levels of long duration caused by the extreme physical and psychological hardships that troops endured to survive their life changing war experience. Stigma was a significant barrier to care leading to coping with or tolerating pain and suffering rather than seeking care or following through on medical treatment. As a result of these changes, upon returning home the participants experienced disruptions in their relationships, work, and other

activities. Re-integration into mainstream society was difficult. Most of the participants perceived themselves as experiencing poor health after deployment. Coping or tolerating symptoms without treatment was the most common health practice. Health system related barriers were described by the participants. The findings of this study provide an understanding of the post deployment health status of U.S. troops after blast exposure in a war zone that suggests the need for further research and have implications for nursing praxis.

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Thanks to my children, Erin and Jared who were cheerleaders in this academic pursuit who I often conversed with about my dissertation experience and my topic. They lived most of their early and school age life in the military culture during the twenty –one years that I served as an active duty U.S. Navy Nurse and gave me insightful comments and helpful suggestions. As an active duty service member in the U.S. Marine Corps, Jared provided technical explanations of various Marine Corps terms that allowed me to adequately describe and understand the participants’ narratives.

Most of all I dedicate this dissertation to the service members and veterans who participated in my study. They shared their stories of their lives even though at times with difficulty so that future “battle buddies” would benefit.

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CHAPTER I

Focus of Inquiry

Phenomenon of Interest

Blast-induced neurotrauma (BINT) in U. S. troops returning from Afghanistan and Iraq is an injury invisible to others, it affects mood, thoughts, and behavior. This invisibility often results in BINT going unrecognized, unacknowledged, and under-diagnosed. Since BINT usually occurs with no outward signs of trauma, service members may not seek medical treatment or may be prevented from seeking treatment due to military stigma, causing access to care barriers for these debilitating injuries.

Many experts have identified BINT as an emerging sub-specialty of traumatic brain injury (Institute of Medicine [IOM], 2008; Tanielian & Jaycox, 2008). This emerging phenomenon is controversial in the medical and scientific communities because the manifesting symptoms, occurring without external injury or structural damage visible on imaging, are not consistent with current medical knowledge. The scarcity of scientific studies on BINT's prevalence, neuropathophysiology, presenting symptoms, and short- and long-term outcomes is problematic for military clinicians and leaders in terms of

diagnosis, treatment, and coordination of care across multiple agencies and specialties.

Experts agree that this emerging phenomenon reoccurrence, if untreated, will lead to future health care costs, long-term disability, and loss of productivity for these young adults and may negatively affect society as well (Defense and Veterans Brain Injury Center [DVBIC], 2006, 2008; Tanielian & Jaycox, 2008).

From October 2001 through 2007, over 1.6 million military troops have deployed to support the wars in Afghanistan and Iraq. The pace of deployments is unprecedented. Deployments are longer; redeployment is common; and breaks from combat are infrequent. Combat-related mild traumatic brain injury (mTBI)/concussion is designated the “signature injury” of these conflicts. The ratio of wounded troops to troop fatalities (7.37:1) is higher than in any previous military conflict due to use of improved body armor and advances in battlefield medical response and evacuation. Many of those wounded would have died in past wars, and new clinical symptoms, such as those related to BINT, are manifesting in this population (Balasco, 2007; Brunner, 2007; IOM, 2008; Tanielian & Jaycox, 2008).

Blast-induced neurotrauma (BINT) injuries are cumulative. If the initial injury does not heal and a second injury occurs, symptoms may worsen and become permanent (Collins et al., 2002). These injuries adversely affect the quality-of- life for military troops and their families. All of the effects noted previously can arise from a single blast exposure. Simply feeling the blast wave is sufficient to cause injury, even without loss of consciousness (Colarusso, 2007; IOM, 2008; Martin, Lu, Helmick, French & Warden, 2008).

The military is a unique culture that treasures strength, resilience, courage and individual sacrifice. The military culture does not embrace illness and it is perceived as a weakness. It is contrary to the notion of an effective fighting force and results in the service member being identified as “different” at many levels and may lead to underlying feelings of failure, weakness or guilt and result in performance problems. Hence, the rationale for the assumption that military stigma imposed by leadership and peers is a barrier to healthcare for those with combat-related blast exposure (Britt, Greene-Shortridge & Castro, 2007).

Taber, Warden, & Hurley (2006) alleged that scientific experts know virtually nothing about the sequelae of exposure to multiple blasts especially when an individual does not sustain severe injuries requiring medical evacuation. According to the IOM (2008) study, limited scientific knowledge on the prevalence of BINT exists. There is ambiguity in the definitions and understanding of the possible long-term repercussions of exposure to blasts. Prompt identification, accurate diagnosis, treatment, care coordination, and management policies and procedures must be developed to hasten the recovery of afflicted troops and restore them to full productivity (IOM, 2008; Tanielian & Jaycox, 2008). These activities, however, can only occur in the context of research that identifies diagnostic features and effective evidence-based interventions for BINT. The service member must begin to overcome the assumed stigma and other barriers to care and present himself to the health care system.

Purpose of the Study and Philosophical Perspective

The phenomenological hermeneutic approach was used to answer the research questions: What is the lived experience of having combat-related blast exposure in the context of military culture? What constructs are used to form their health status perceptions and health practices? The purpose of this hermeneutic phenomenological study was to describe the lived experience of U. S. military troops after combat-related blast exposure while deployed in support of Operations Enduring Freedom (Afghanistan) and Iraqi Freedom and to examine the constructs used to form service members' health perceptions and health practices in this context. The specific aims were to describe: (a) the feelings of these individuals about their war experience; (b) the individual perceptions of their own health and reintegration when they returned home; (c) the individual experiences of getting health care for their perceived personal health problems; and (d) the role military stigma may play in their personal health practices in the context of military culture. This qualitative study used a semi-structured individual interview approach to obtain data from face to face interviews. This study was based on the assumption that qualitative research can add new insight into the real life issues that contribute to personal health perceptions and practices in this population. An individual face to face interview approach was used to enhance the likelihood that more in-depth information would be revealed in a private setting and that the presumed influence of military stigma on health and illness would be reduced. This study's intent was to provide direction for bridging the knowledge gap between health perceptions and health practices in this population. It was further intended to serve as a basis for program

development focused on early treatment and full recovery as well as an effort to prevent permanent disability.

In phenomenology the world of lived experiences and personal perceptions of those experiences is important. Underlying phenomenology is the description of the feelings about and interpretations of those everyday experiences. This philosophy begins with the phenomenon and then examines the clear, deep perception of an experience(s) until a feeling of understanding or grasping the inner nature or essence of the experience(s) is achieved. According to Moran (2000) the roots of knowledge are found in the consciousness of the knowing subject where the knowing actually exists.

Hermeneutic phenomenology is human science that studies persons. Heidegger's interpretation of hermeneutic phenomenology is not purely descriptive but is also concerned with the interrelating and understanding of text. Everyday human interpretation and existence is interpersonal as we live within a network of relationships with others. Individual interpretation of one's existence is an effort to understand and make sense of it. "Preunderstandings" are common themes, such as language and traditional practices, which assists someone in understanding a culture or the external environment of an individual's existence. It is through interpretation that a person lives in the world (Heidegger, 1962). The goal of hermeneutic phenomenology is to try to understand everything that can be understood about an experience(s) to arrive at a deeper understanding of existence through interpretation of the phenomenon under study. A reader should be able to comprehend the phenomenon in a way that enriches one's understanding of that specific everyday life experience.

Significance to Nursing

According to Martin et al. (2008), nursing plays a major role in assessing, identifying, and educating the BINT population. Injured troops affected by BINT, particularly the Reserve Forces, originate from a wide geographic area and will eventually be released from their temporary military duties to seek healthcare in their home communities as they integrate back into their previous civilian existence. It is important for nurses and other healthcare providers in the community to be familiar with combat-related BINT and screen for it in all adult populations who have experienced combat. Many veterans are often told that they are exhibiting signs of post traumatic stress or concussion before they realize they need help. If external trauma is involved these symptoms may become even more invisible. Emergency room physicians, clinic personnel, university professors, employers, loved ones and others who regularly interface with young adult populations should all know these symptoms. Nurses in all settings must be knowledgeable of and watch for signs of cognitive, physical, mood and/or behavioral changes and urge service members and veterans who exhibit them to get a medical evaluation.

Furthermore, the Management of Concussion/mTBI Working Group (2009) contended that, as with other chronic conditions, the focus of management of persistent symptoms resulting from BINT will shift to the psychological and social effects on the patient, the spouse, or significant others and will eventually impact societal public health.

Active duty service members and veterans of Afghanistan and Iraq are predominantly young, healthy, and productive members of society, but 30% of them are affected by PTSD, major depression, and BINT, all of which are difficult to detect. Current literature is limited and studies are in conflict about the long-term outcomes of BINT and whether it translates into any lasting impairment. Another public health implication is the need for a better understanding of the full range of problems associated with this injury (emotional, economic, social, health and other quality-of-life deficits) that confront these individuals. Research regarding the costs and benefits of different treatments and methods to promote immediate treatment for these individuals are paramount for effective public policy formulation (Kennedy et al., 2007).

Nursing leaders, researchers and clinicians have a tremendous opportunity to contribute to the growing body of knowledge on BINT by investigating and describing this injury and using this new knowledge as a basis for creating clinical best practices for effective recovery strategies. This new knowledge may also be used as a foundation for improving the efficacy of current recovery strategies. The nursing profession can take the lead and accept the challenge of filling the knowledge gaps identified in the literature as other health-related disciplines are beginning to do. Nursing leaders and researchers can engage in political advocacy for service members and veterans by disseminating nursing knowledge to develop strategies to promote recovery so that these young adults, who have sacrificed so much, can live as healthy and fully productive members of society.

CHAPTER II

Context of the Inquiry

Introduction

The United States military has been engaged in two wars in Afghanistan and Iraq over the last decade with fewer fatalities and more troops surviving due to state-of-the-art battle field medicine and evacuation. However, with long, repeated deployments to these war zones and repeated exposures to the principal weapons of these conflicts—blasts, troops are manifesting the invisible symptoms of blast-induced neurotrauma also referred to as blast-induced concussion, the “signature” wound of these wars. This chapter will review the most current research and literature available on this phenomenon and will be divided into the following sections: Background, Clinical Manifestation, Current Knowledge and Significance and Gaps in the Literature.

Background

An estimated 320,000, or 19.5% of all U. S. troops deployed to Iraq or Afghanistan, have symptoms related to BINT, which accounts for over 92% of all battlefield injuries (DVBIC, 2006, 2008; Tanielian & Jaycox, 2008). Warden (2006) noted that the number

of TBIs in these wars is higher than in previous wars due to the frequency of blast attacks using large amounts of explosives, estimating that 88% of injuries seen in the battlefield are due to blasts.

The current literature on BINT in U. S. troops serving in Afghanistan and Iraq suggests conflicting views on its cause, pathophysiology, screening, diagnosis, treatment, and subsequent care coordination through multiple specialties and agencies. This phenomenon demonstrates that current medical thought on mild BINT (concussion) is underdeveloped.

Clinical Manifestations

Although invisible to the naked eye, BINT is reported to cause debilitating changes in mood, thought, and behavior. Physical symptoms associated with BINT include migraine, headaches, insomnia, blurred vision, dizziness, vertigo, tinnitus, and exertion- induced nausea and vomiting (Anderson, 2008; Management of Concussion/mTBI Working Group, 2009). Other manifestations of BINT include memory, processing and concentration deficits, verbal and written language and communication dysfunctions, emotional lability, depression, fatigue, light and noise intolerance, anxiety, and irritability (Hosek, Kavangh, & Miller, 2006; Schneiderman et al., 2008; Thompson, Scott, & Dubinsky, 2008). In addition, as indicated in Table 2.1, mild BINT and Post Traumatic Stress have many similar symptoms and are co-morbid in 43.9% of mild BINT cases, complicating diagnosis and treatment (IOM, 2008; Schneiderman, Braver, & Kang, 2008; Tanielian & Jaycox, 2008)

Most of these symptoms of BINT are self-limiting and disappear within three months, barring exposure to a second impact or blast injury in the interim. About 5%-15% of individuals with BINT have persistent symptoms that require neurological evaluation and treatment (DVBIC, 2006, 2008; Management of Concussion/mTBI Working Group, 2009; Tanielian & Jaycox, 2008).

Anderson (2008); DePalma, Burris, Champion, & Hodgson (2005); Okie, (2005); and Taber, Warden, & Hurley (2006) maintained that primary closed brain injury develops over a few hours or days, leading to cell damage, and that associated physical and psychological symptoms can occur as a result of injury to several areas of the brain. Victims may sustain very different injury severities depending upon type of exposure and distance from the deflecting blast waves. According to Collins et al. (2002), mTBI is cumulative, and repeated injuries before initial healing occurs may lead to more severe brain injury and permanent impairment.

Current Knowledge

The current estimated prevalence of Iraq combat veterans with some level of TBI is 10% to 20% (150,000 – 320,000 individuals). Among those veterans with combat-related TBI injuries, over 80% involve BINT without visible physical injuries (IOM, 2008; Tanielian & Jaycox, 2008). However, BINT does not always result in symptoms and long-term neurocognitive deficits but it places the injured service member at risk of additional blast exposures and more severe injury. Diagnosis and treatment are now based on scientific research with significant gaps. The IOM (2008) study indicated that these gaps result in a consequent failure to identify individuals with probable BINT.

Table 1.*Comparison of BINT/ Concussion and Post Traumatic Stress Symptoms*

Blast Concussion & Post Traumatic Stress Similar Symptoms	Concussion Different Symptoms	Post Traumatic Stress Different Symptoms
Insomnia	Headache	Re-experiencing
Memory Problems	Dizziness	Avoidance
Poor Concentration	Nausea/vomiting	Emotional Numbing
Fatigue	Noise/light intolerance	Hyper-vigilance
Depression	Blurred vision	Exaggerated Startle
Anxiety		
Irritability		
Emotional Lability		

Adapted from IOM, 2008; Kennedy, Jaffee, Liskin, Stokes, Leal, & Fitzpatrick (2007); Schneiderman, Braver, & Kang, 2008; Tanielian & Jaycox (2008)

The researchers further asserted that the failure to identify BINT stems from poor documentation of blast exposures, which increase a service member's risk of long term neurocognitive deficits. Of those who reported symptoms suggestive of mTBI in the Tanielian & Jaycox (2008) study, 57% had not been evaluated by a physician for brain injury. These service members' explanation for not seeking medical evaluation included barriers to getting treatment, lack of confidentiality, risk to future job assignments, and risk to military career advancement.

Even though most mild TBI/BINT patients recovered completely, those with poorer short-term recovery outcomes were likely to exhibit depression and anxiety, and 58% reported chronic pain (headache), which was associated with longer treatment and poorer

quality of life (Hoge et al., 2008; Tanielian & Jaycox, 2008). Medication management may be problematic due to memory, self awareness and time management problems, missed doses, and negative side effects from poly-pharmaceutical treatment. In addition, prescribed drugs may be ineffective. An individual's need for treatment and specialty services will involve multiple transitions across Department of Defense, Veterans Affairs and community medical systems that involve extensive travel, making coordination and management of care challenging (Comper, Bisschop, Carnide, & Tricco, 2005; Francisco, Walker, Zasler, & Bouffard, 2007).

BINT's lack of external trauma results in service members not seeking medical treatment or being ridiculed or punished for seeking treatment due to military stigma and clinicians' lack of awareness of this phenomenon. Before service members get needed treatment, their medical problems frequently become critical. If second impact injuries or blast exposure occur, the severity of trauma increases. Experts agree that untreated mild to moderate combat-related TBI will affect healthcare costs, long-term disability, and loss of productivity for these young adults. The influence of untreated BINT symptoms especially co-occurring with post traumatic stress symptoms on societal public health also includes the service member's potential for suicide, criminal violence, and homelessness (McCrea, Kelly, Rudolph, Cisler, & Berger, 2002; U. S. Army Center for Health Promotion and Preventive Medicine [USACHPPM], 2009).

These injuries adversely affect the quality- of- life for military troops and their families. All of the effects noted previously can arise from a single mild blast exposure. Simply feeling the blast wave is sufficient to cause injury, even without loss of

consciousness (Colarusso, 2007; IOM, 2008; Martin, Lu, Helmick, French & Warden, 2008).

Fundamental gaps exist in our knowledge about the mental health and cognitive needs of service members returning from combat. Other knowledge gaps include the adequacy of military and community healthcare systems, the lived experiences of active duty service members and veterans needing services, and the factors related to whether and how this injured population seeks care. Care management and medical treatment of BINT are likely to change drastically over the next several years as more scientific discoveries are made to increase current knowledge and understanding of this silent but potentially catastrophic epidemic.

Significance and Gaps in the Literature

BINT sufferers report cognitive disorders such as short term memory loss, lack of anger and aggression control, and the inability to do simple problem solving, interfering with daily activities, exercise, and work duties. If ignored or not understood by others, BINT symptoms and behaviors may lead to lasting problems in interactions with friends, families, co-workers, and public authorities. This increases the service member's risk for isolation, job failure, depression, substance abuse, further injury, criminal violence, suicide, and homelessness. Increasing incidence of major depression, suicide, and suicide attempts among returning veterans may be related to BINT (DVBIC, 2006, 2008; Martin et al., 2008; McCrea et al., 2002; Roberts 2008). Afflicted individuals may behave inappropriately, or not as expected, because they are unable to receive, store, process, accumulate or retrieve information effectively. Sensory input can be unreliable

and they may have difficulty processing information. This type of brain dysfunction interferes with employment or other performance-based activities. Service members with undiagnosed BINT may exhibit a lack of inhibition that results in difficulty adhering to social rules, inability to perceive interpersonal cues, aggression, violence against themselves or others, or adverse reactions to stressful or demanding situations. Furthermore, the service member may have limited awareness of changes in his/her behavior and/or intensification of some pre-existing problem behaviors.

A recent investigation (USACHPPM, 2009) of 8 homicides perpetrated by 6 soldiers from one unit at Fort Carson over a 12 month period is an example of BINT injuries' societal public health implications. The investigation's goal was to assess the potential impact of military waiver policies on the observed criminal activity and the adequacy of mental health services provided by the military. Most of these soldiers were under 21 years of age when they voluntarily enlisted in the U.S. Army and many had been awarded medals for good conduct during their service. These soldiers deployed to Afghanistan and Iraq multiple times for 12-15 month tours. Although they survived the physical wounds that would have killed soldiers in earlier conflicts, they returned home suffering from invisible combat wounds. Unfortunately, their complaints and symptoms were ignored, neglected, punished, and ridiculed. They failed to adjust to redeployment so the cycle of killing continued when they returned home. This brigade's returning soldiers were also involved in beatings, rapes, alcohol and drug abuse crimes, domestic violence, shootings, stabbings, kidnapping, and suicide after their return to the United States (Philipps, 2009).

These findings are consistent with recent research on combat exposure and subsequent adverse behavioral outcomes. The USACHPPM (2009) report suggested that a combination of many pre-existing personal risk factors and combat intensity/exposure may have increased the risk for these violent behaviors. Military stigma and lack of referral to the Army Substance Abuse Program, a required screening, were barriers to the soldiers' seeking and receiving further medical evaluation and treatment for mental health problems. The IOM (2008) and Tanielian & Jaycox (2008) studies both maintained that preventing or alleviating the short-term consequences of these conditions and early interventions might have a significant indirect long-term benefit and that focusing treatment solely on ameliorating specific symptoms is too narrow.

Some evidence of an association between mild traumatic brain injury (mTBI) and substance abuse has been reported (Walker, Cole, Logan, & Corrigan, 2007). Whether these associations make substance abuse more likely with mTBI is unclear. Martin et al. (2008) reported that at DVBIC, they found that patients with mTBI sometimes self-medicated with alcohol or non-prescribed drugs to manage their symptoms. Substance abuse only worsened cognitive or emotional difficulties for these patients.

Tanielian & Jaycox (2008) described the potential public health consequences of post-combat mental health and cognitive conditions as a surge of negative outcomes that, in the absence of intervention, will impair a broad range of quality-of-life areas over the life span of the afflicted individual. Furthermore, the authors asserted that attention to external events and circumstances, such as the presence or absence of other stressors and support, determine whether or not this negative cascade of events will occur. This

conjecture suggests the possibility that BINT may be impacted by psychosocial interventions.

The Tanielian & Jaycox (2008) study developed a micro simulation model to forecast the economic costs of BINT over time. The researchers maintained that unless treated, long-term and wide-ranging negative consequences could occur. These consequences included diminished work productivity and family and social functioning and relationships (divorce, parenting, and problems with children). BINT increases the risk for violent behaviors, including suicide and violent crime; unhealthy behaviors (smoking, overeating, unsafe sex); substance and alcohol abuse; and physical health morbidity. Based on that premise, annual per-case costs of mTBI associated with cognitive conditions stemming from combat in Afghanistan and Iraq were estimated at \$27,259-\$32,759. Costs were even higher if mTBI was co-morbid with PTSD or major depression. These expenditures do not include the potential costs of substance and alcohol abuse, violent crime, suicide, homelessness, family strain, and military personnel loss. Using the number of cases diagnosed by June 2007 (2,726), Tanielian & Jaycox (2008) projected that the first-year costs of mTBI injuries would range from \$591 million to \$910 million dollars. This expenditure does not include costs for individuals who have not sought treatment or have not been formally diagnosed.

Significance

The likelihood of continued deployments to the Middle East and exposure to blasts by service members into the next decade is high. A continued U.S. military presence in Iraq and a heightened presence in Afghanistan will likely result in an increase

in cases of BINT. Tanielian & Jaycox (2008) also emphasized that loss of productivity to the Department of Defense (DoD) and decline in military readiness from mTBI accounts for 47 to 57% of total costs for this injury. Bennet (8 May 2010) recently reported that military healthcare costs are rising twice as fast as the nation's costs. He stated that the Pentagon estimated that military healthcare costs have risen from \$19 billion in 2001 to \$50 billion in 2010. Public concern over the handling of such injuries is wide spread. Military and government leaders have moved quickly to study how such injuries are currently handled, to quantify the problem, and to formulate policy.

Consequences of BINT may lead to lifelong conditions that require costly, long-standing services and support for individuals, families and society in general. Tanielian & Jaycox (2008) asserted that sufficient resources can act as a buffer. Sufficient resources can protect individuals and minimize the immediate consequences of these disabling conditions. They also asserted that significant vulnerabilities and additional sources of stress can intensify the negative consequences of these conditions. Their study suggested the need for confidential programs to provide injured service members with a supportive environment, since many of them are geographically distant from extended family and friends. Education and support groups, as complements to traditional interventions addressing symptoms, may help these young adults to develop the skills to cope with these potentially enduring conditions. Interventions must be easy to access and confidentiality assured because of the stigma for troops who fear negative career repercussions or ridicule. This strategy will increase total-force readiness and retention

by encouraging individuals to seek needed health care before problems become critical (IOM, 2008; Tanielian & Jaycox, 2008).

Tanielian & Jaycox (2008) asserted that benefits to DoD in retention and increased productivity would outweigh the costs of evidence-based care and related research. Reductions in medical costs, increased productivity, and decreased suicides would result in significant savings to DoD. Other significant implications of BINT include the need to improve service member and family understanding of the injury, treatment modalities, and their high likelihood of recovery. This could be accomplished through educational interventions and the availability of alternative medicine treatment modalities. All treatment modalities must be evidence-based, patient-centered, efficient, equitable, timely and confidential. DoD has already initiated training in evidence-based practices for clinical providers, but efforts are not integrated into a larger system redesign that values and provides incentives for quality of care. Military health systems require wide-spread additional clinical provider training on BINT and its management in deployed settings and in clinic settings. They also need to monitor the providers' client outcomes through performance feedback from patients and other healthcare professionals involved in the care of BINT patients.

In conclusion, the gaps in the literature on BINT are significant that include its prevalence, neuropathophysiology, presenting symptoms, treatment and short and long term outcomes. Other gaps that are ideal for nursing research include this population's lived experience, how they seek care and the effect of military stigma on their health practices.

CHAPTER III

Methodology

Method

A qualitative hermeneutic phenomenological research design was used to conduct this study. Qualitative research examines life experiences in an effort to understand and give them meaning. This usually is done by systematically collecting and analyzing narrative materials using methods that ensure credibility of both the data and the results. Phenomenology is one of many types of qualitative research that examines the lived experiences of humans. Phenomenological researchers hope to gain understanding of the essential "truths" of a lived experience (Richards & Morse, 2007).

Phenomenology is a 20th-century philosophical movement dedicated to describing the experiences as they are lived. Phenomenology is described as a philosophy, methodology, and method. Philosophically, phenomenologist's view the person as an integral part of the environment. The focus of phenomenological research is people's experience in regard to a phenomenon and how they interpret their experiences. Phenomenologists agree that a single reality does not exist and that each individual has his or her own reality. This is true even of the researcher's experience in collecting data

and analyzing it. “Essential truth” results from an interpretation of some phenomenon; the more shared that interpretation is, the more factual it is. There are four aspects of the human experience that are of interest to the phenomenological researcher: 1) Lived space (spatiality), 2) Lived body (corporeality), 3) Lived human relationships (relationality), and 4) Lived time (temporality). All of these aspects are taken into consideration so that it acknowledges that people experience different realities in different situations, in the company of different people and at different times. The broad question that phenomenologists want answered is "What is the meaning of one's lived experience?" The only reliable source of information to answer this question is the person who experienced the phenomenon under study. Understanding, human behavior or experience requires that the person interpret the action or experience for the researcher, and then the researcher must interpret or analyze the explanation provided by the person (Van Manen, 1990).

Phenomenology is sometimes confused with the term hermeneutics, which is the analysis of the written word. Hermeneutic phenomenology emerged from the philosopher Martin Heidegger. Hermeneutics is an interpretative approach to analyzing a phenomenon. Interpretive researchers assume that access to reality is only through social constructions such as language, consciousness and shared meanings. Interpretive studies generally attempt to understand phenomena through the meanings that people assign to them and are aimed at producing an understanding of the context of the phenomenon. Interpretive research does not predefine dependent and independent variables, but focuses

on the full complexity of human understanding as a situation emerges from verbal or written sources (Holloway & Wheeler, 2002).

Hermeneutics can be treated as both an underlying philosophy and a specific mode of analysis. The mode of analysis is the approach used to gather, analyze and interpret qualitative data. The mode of analysis is concerned primarily with textual analysis either in verbal or written form to establish the meaning of a text (Richards & Morse, 2007). From a hermeneutic perspective, the mode of analysis assumes that the researcher's initial assumptions affect the gathering of the data. The questions posed to informants largely determine what the researcher is going to find out. The analysis affects the data and the data affect the analysis in significant ways. As a mode of analysis, it suggests a way of understanding textual data. The basic question in hermeneutics is: what is the meaning of this text? Hermeneutics is an attempt to clarify or make sense of a phenomenon using text either written or verbal (Van Manen, 1990).

As a philosophical approach to human experience, hermeneutics provides the philosophical grounding for interpretivism. Interpretivism is concerned with the uniqueness of a particular situation, contributing to the underlying goal of contextual depth. While interpretive research is recognized for its value in providing contextual depth, results are often criticized in terms of validity, reliability and the ability to generalize, referred to collectively as research legitimization (Kelliher, 2005).

Interpretation aims to make clear an underlying coherence or sense. Hermeneutic analysis looks at the difference between the understanding of the text as a whole and the interpretation of its parts, in which descriptions are guided by anticipated explanations.

The aim of the hermeneutic analysis is one of trying to make sense of the whole, and the relationship between people and their environment (Holloway & Wheeler, 2002).

Martin Heidegger revised many previous phenomenological perspectives. Heidegger believed that as human beings, our meanings are developed through the experience of being born human, our collective life experiences, our background, and the world in which we live. He acknowledged that gender, culture, history, and related life experiences prohibit an objective viewpoint yet enable people to experience shared practices and common meanings. He did not believe it was possible to bracket our assumptions of the world, but rather that through authentic reflection; we might become aware of many of our assumptions. Heideggerian (hermeneutic) phenomenology can be defined as a way to interpret experiences of shared meanings and practices embedded in specific contexts (Heidegger, 1962).

Phenomenological Design

Inductive or qualitative methods involve transcribing material, usually interview transcripts, coding data into essential themes, and drawing conclusions regarding the phenomena based on these essential themes. The phenomenological method must follow an organized approach to answering a research question. First, the researcher must develop the question. Next, the researcher must devise a sampling plan to ensure the appropriate subjects are available and willing to answer questions. Information or data will be obtained by observations, interviews, or written descriptions. Data then are analyzed using a process of coding and categorizing the information. Finally, the findings are confirmed by others to ensure the credibility of the conclusions (Creswell, 2009).

Implementing the Method

The individual face-to-face interviews were audio recorded for transcription and analysis. Researcher designed semi-structured interview questions explored individual experiences and probed into their thoughts, feelings, concerns, and worries during and after their deployment experience, following blast exposure and when they returned home. Individual participant's narratives provided deep and soulful personal descriptions related to this phenomenon and rich detail about their feelings and thoughts while experiencing it. After the tapes had been professionally transcribed, the transcripts were analyzed by the researcher to identify prevailing essential themes by categorizing the critical meanings of each participant's responses using qualitative analytical software, *ATLAS.ti*, and the researcher's interpretation of these responses. The use of direct quotes from participants enhanced the credibility of the findings and conclusions. The use of direct quotes to represent essential common theme categories was meant to support the men's words to portray a deeper understanding of the nature of the experience and insuring that the phenomenon speaks for itself.

In phenomenology, reality is comprehended through embodied experience. Through close examination of individual experiences, phenomenological researchers seek to capture the meaning and common features, or essences, of an experience or event. The truth of the event, as an abstract entity, is subjective and knowable only through embodied perception; we create meaning through the experience of moving through space and across time (Richards & Morse, 2007).

Sampling

Community-based purposive sampling methods were used in this study to recruit participants who had experienced the phenomenon under study (combat-related blast exposure during support of OEF/OIF). In purposive sampling the investigator selects participants because of their specific characteristics. Good participants are those who are knowledgeable about the phenomena of interest, are willing to reflect on the phenomenon, have the time and are willing to participate. The concept or the experience under study is the unit of analysis; given that an individual person can generate hundreds or thousands of concepts, large samples were not needed to generate rich data sets. The exact number of individuals needed, and the number of interviews per individual, depends on the goals and purpose of the study (Richards & Morse 2007).

Phenomenologists are interested in common features of the lived experience. Although diverse samples might have provided a broader range from which to distill the essence of the phenomenon, data from only a few individuals who had experienced the phenomenon and who were able to provide a detailed account of their experience was sufficient to uncover its core elements. Typical sample sizes for phenomenological studies usually range from 1 to 10 people (Creswell, 2009, 1998; Holloway & Wheeler, 2002; Richard & Morse, 2007). Eleven (11) participants were recruited for this study. In the researcher's clinical experience with this population, the sample was representative of the military population seen with BINT.

Data Collection

Qualitative research frequently relies on interviewing as the primary data collection strategy. A researcher designed demographic survey and a semi-structured

interview guide was used to collect data. The interview was audio recorded and field notes were taken during the interview. In a phenomenological study the objective of the interview is to elicit the participant's story. Both the researcher and the participant assumed that their words were understood as spoken and their words spoke for themselves. The researcher was the listener and asked participants to give detailed accounts of their experience of the phenomenon. The researcher asked probing questions to encourage the participants to elaborate on the details to achieve clarity and to stay close to the lived experience. A specific interview process was followed with each participant.

Recruitment of Participants.

A sample of 11 military service members and veteran participants were recruited by a University of San Diego (USD) Institutional Review Board (IRB) approved research recruiting flyer (Appendix A). The flyers were placed in community apartment complexes known to have a large military occupancy. A mailing list without names of occupied military housing addresses was procured from a military base housing office and a total of 600 flyers were mailed over a three month period with only one response. A college student was hired to distribute 200 flyers in the community at locations frequently visited by a heavy concentration of military personnel. Individuals known to the researcher distributed flyers to their military acquaintances and co-workers. The initial three interviews were recruited by individuals known to the researcher with military acquaintances and co-workers. The one response from the mailings who participated in the study resulted in snowball sampling from his unit that culminated in

seven additional participants for a total of 11 participants within one week. There was a very low response to flyers both mailed and distributed over a three month period.

Snowball sampling was the most successful method of recruitment for this study of this specific population. Despite the difficulty in recruiting, based on the researcher's clinical experience with this population, this study's sample is representative of the typical military population seen with BINT.

The interested informants emailed or used a mutual acquaintance to serve as a liaison for gaining more information about the study. The one response from the mailings initially responded by using the email address listed on the flyer. After an explanatory email message response that included a copy of the Research Participant Consent Form (Appendix C) for him to review, the researcher and potential participant followed up subsequently by telephone and text messages.

Overall, the recruitment process with potential participants who were interested in the study contacted the researcher personally by email or telephone, the researcher completed a preliminary telephone screening interview that included: 1) the inclusion criteria; 2) orientation to the purpose of the study purpose; 3) interview procedures; and 4) incentives. The incentives were a helpful recruiting tool. The incentives included a \$25 Visa gift card for travel expenses and \$50 Visa gift card for participation in the study.

The participants read or the researcher read the Research Participant Consent Form content during the screening telephone interview giving potential respondents an opportunity to ask questions prior to commencing any research related activities so that

the researcher was confident the potential participant fully understood their rights and protections. If requested, the researcher emailed a copy of the informed consent form to potential participants to review before setting up an appointment for the screening interview. Once eligibility and the appointment time were confirmed, the participant selected the public location for the interview. The researcher followed up one day prior to the interview to confirm the interview appointment. The participant and the researcher met at the agreed upon time and location for the interview.

Participants.

A purposive community sample of 11 service members and veterans meeting the inclusion criteria were recruited as participants. The inclusion criteria included: 1) male gender; 2) age of 18 years or older; 3) conversant in written and verbal English; 4) located in Southern California; 5) ability to travel to the interview site; 6) history of combat-related blast exposure within the last five years; and 7) ability to access a telephone for the initial screening. The exclusion criteria were simply not meeting the inclusion criteria. The participants consented to participate in one audio recorded interview that could last as long as two (2) hours in a public location in Southern California.

Setting.

The study requirement for the setting was a public location in Southern California. The three initial participants recruited by a mutual acquaintance arranged to conduct the interviews at their personal residences and the remaining participants selected a community park located close to their residence. A small portable digital

recorder was used for the interviews that could easily be utilized and carried in any setting.

Interview Process.

At the scheduled appointment, the participant received a face to face orientation, a printed Research Participant Consent Form (Appendix C), an informed consent determined and approved by the USD IRB prior to commencing the study was presented. The written participant informed consent form requiring the participants' signature explained: 1) the purpose of study; 2) the interview procedures; 3) data use and storage procedures; and 4) the incentive procedures. The participant signed the consent prior to commencement of the interview and it was retained by the researcher. The participant received an identical copy of the unsigned consent form. The participants understood that the incentives were paid only after the informed consent was signed.

The audio recorded interviews were scheduled for a maximum of two hours but the interviews lasted only from 20 minutes to 45 minutes with an average of 35 minutes. A researcher designed, semi-structured General Statements/Interview Guide (Appendix D) was used to collect data and probing questions were spontaneously added during the interview by the researcher to keep the interview on the topic and to elicit detailed responses. Concurrent field notes to record the participants' actions, physical responses and the researcher's responses were taken with the participants' consent to collect data non-verbal data. Incentives were paid at the conclusion of the interview. The IRB approved incentives included a \$25 Visa gift card for travel expenses and a second \$50 Visa gift card for participation in the study.

Mode of Analysis

Phenomenological Reflection.

The general method of interpretive analysis during hermeneutic phenomenological data analysis is an inductive process of decontextualization and recontextualization (Starks & Trinidad, 2007). During decontextualization the researcher separates data from the original context of individual cases and assigns them to categories in units of meaning in the texts. In recontextualization, the researcher examines the categories for patterns and then reintegrates, organizes, and reduces the data around central statements, meaning, themes and relationships drawn across all the cases and narratives to generally describe the experience. The textual data is then placed into a set of categories or concepts from which the final product can be drawn.

Creswell (2009) has described a systematic process for coding data from a phenomenological inquiry in which specific statements are analyzed and categorized into clusters of meaning that represent the phenomenon of interest. Common assumptions are explored, and special attention is given to descriptions of what was experienced as well as how it was experienced. The researcher uses writing to compose a story that captures the important elements of the lived experience. By the end of the story the reader should feel that she has vividly experienced the phenomenon under study and should be able to envision herself (or someone else who has been through the experience) coming to similar conclusions about what it means.

Qualitative analysis is inherently subjective because the researcher is the instrument for analysis. The researcher makes all the judgments about coding,

categorizing, decontextualizing, and recontextualizing the data. In phenomenology the researcher engages with the analysis as a faithful witness to the accounts in the data. Even as the researcher immerses herself in the data, she must be honest and vigilant about her own perspective, preexisting thoughts and beliefs, and developing meaningful themes (Richards & Morse, 2007).

In phenomenology researchers engage in self reflective processes. Self reflexive practices include consulting with colleagues and mentors and writing memos throughout the analysis to help the researcher examine how their thoughts and ideas evolve as they engage more deeply within the data (Finlay, 2002). Memos also serve the function of establishing an audit trail, whereby the researcher documents her thoughts and reactions as a way of keeping track of emerging impressions of what the data mean, how they relate to each other, and how interacting with the data shapes her understanding of the initial thoughts and ideas (Richards & Morse, 2007).

Phenomenological analyses produce rich thematic descriptions that provide insight into the meaning of the lived experience. Phenomenologies are often written as anecdotes or thematic stories, drawing on elements reported from different respondents to create a blended story. Such accounts allow the reader to get a feel for what it is like to have the experience (Finlay, 2002; Starks & Trinidad, 2007). Audiences for these analyses may include clinicians and others whose practice would be enhanced by understanding how individuals live through and make sense of their particular experience.

Conducting Thematic Analysis.

Data was analyzed using comparative analysis of units of meaning in each participant's description of their experience. This began with the field notes by the researcher. Data collection and qualitative analysis occurred simultaneously from the beginning of the study. Numerical coding of participants and pseudonyms were used to ensure confidentiality. Initially audio recorded interviews were compared to written field notes by the researcher. The audio recorded interviews were transcribed into text by a certified transcriptionist after a *Transcriber's Pledge of Confidentiality Form* (Appendix F) was signed. A qualitative software program, *ATLAS.ti* was used to determine, sort and organize categories, themes and patterns of words to identify interrelationships based on the transcribed text of audio recorded interviews. During categorizing, the researcher identified concepts and themes and named them during data analysis using the software's functions for this. Using van Manen's (2007) approaches to uncovering themes from text, the researcher used a combination of these approaches that included the selective or highlighting approach, in which statements or phrases that seems particularly insightful into the phenomenon were identified and the line-by-line approach, in which every sentence was examined for its relevance to the phenomenon. The transcribed text was read once line-by-line while listening to the audio recording to ensure the accuracy of the transcription. Any deviation from the original recording was corrected in the transcription, in an effort to optimize accuracy. The transcripts were then read again for insightful statements that pertained to the experience and highlighted for further consideration. Researcher comments and thoughts as well as field notes were annotated by specific highlighted phrases using the software's function for this. Through

sensitivity to the lived experience of the participant as reported in the words or phrases used by participants to describe a phenomenon or concept were placed in initial categories using patterns, clusters or similar concepts that emerged and were linked to the specific quote. The resulting themes were the interpretive product of the researcher's interaction with the transcript. The concepts or patterns were then grouped together into minor categories or themes. Actions and events observed, recorded, or written in the words of respondents from interviews were compared for similarities, differences and connections. Major themes and subthemes emerged from minor categories and were linked to each other as abstractions or as observed phenomena or themes from the specific data collected. Several core or central themes emerged that linked with several subthemes.

Comparative interpretative data analysis continued until no new information was reported as each piece of data was compared to others. A general description of the experience emerged as essential themes or essential essences of the experience by each participant. Once the themes of the various transcripts were identified, the researcher composed linguistic transformations of the themes. The researcher interpreted the text, and moved the words and phrases to a more collective level of construct, while remaining true to the participant's lived experience by using representative direct quotes for the themes. Interpretation of the relationships and connections among the essential themes and subthemes was formed by the researcher and was threaded into a narrative that vividly described the phenomenon collectively from the each participant's viewpoint.

Determining Essential Themes.

The process of data analysis to determine themes is essential in phenomenological research. An examination of the lived world as experienced as everyday life, van Manen (1997), identified fundamental themes relevant to all human beings so that those themes that are different or incidental can be uncovered. Four of these themes common to all people serves as a guide to the reflective process are: live space (spatiality), lived body (corporeality); lived time (temporality) and lived human relations (relationality). The incidental theme is one that can be removed or altered without changing the phenomenon itself (van Manen, 1997).

To differentiate between the essential and incidental themes during thematic analysis, the researcher used free imaginative variation (van Manen, 1997). The researcher determined if the phenomenon would be the same or essentially altered without a specific theme. By analyzing each emergent theme in this manner, the researcher only selected those themes and subthemes that were essential to the understanding of the phenomenon. These remaining themes were the basis for the phenomenological narrative that was constructed. Direct quotes were used to represent the essential themes to provide a richer and deeper understanding of the phenomenon by using the participants' own descriptive words of that experience.

Methodological Rigor

The procedure used for ensuring internal validity was the comparison of researcher findings with participants' quotes in the analysis section of the study to validate their meaning. Additionally, during the interviews researcher questioning sought clarification of the participant's own descriptions. Since qualitative research is

never wholly replicable, researcher characteristics influence the research so reliability is limited and research instruments were not used. External validity also known as generalizability is the most controversial concept linked to validity. Generalizability has its origin in quantitative research and refers to the ability to apply the findings and conclusions of a study to similar settings and populations. Generalizability is difficult to achieve in qualitative research. The procedure for ensuring generalizability in this study was comparison data analysis, categorizing and linking patterns and relationships of categorized phenomena or themes.

Reliability and validity was also addressed using standards such as rigor, truth-value or reproducibility and confirmations. Rigor refers to the soundness of research design by adhering to the purpose of the study and using data collection and interpretation techniques consistent with hermeneutic phenomenological research methodology. Truth-value or reproducibility was maintained by using the comparative method of analysis where each piece of data is compared with others. Confirmations and interpretations from three expert researchers validated the researcher's interpretations. Comparison of the researcher's findings with other researchers' interpretation validated the perceptions, themes, and meaning of the narrative analysis.

Protection of Human Participants

This proposal received a University of San Diego (USD) Institutional Review Board (IRB) review for the evaluation of protection of human subjects and a decision regarding the level of oversight required for the study was made. The IRB application was approved with one revision that was required by the USD IRB. The USD IRB

required that incentives were to be distributed to participants even if the interview was not completed. Protection of the confidentiality and privacy of participants was conducted using the following procedures: 1) Numerical codes were used on all databases, flash drives, audio recordings, transcribed and written notes are password stored in limited access locked researcher files; and 2) Data is being stored for 12 months after the study is completed and then will be destroyed; and 3) Written and signed informed consent was obtained prior to the interview. Participants were not considered a vulnerable population for the purposes of this study because they were not patients and were living independently in the community. No specific ethical considerations were identified such as the inability to make an informed decision about the participating in the study or equitable selection of participants. A minimal risk of disclosure of each participant's personal views and perceptions, anxiety, fatigue was identified as a possibility related to participating in long interviews. No direct benefit to the participants was identified but societal benefits included new scientific knowledge that may enhance the likelihood of full recovery from this injury and prevention of long term disability from combat-related blast exposure.

CHAPTER IV

Findings of the Inquiry

The purpose of this phenomenological analysis was to discover the perceptions and feelings about the health and health practices of male, U.S. military troops after exposure to blasts while deployed to a combat zone in Afghanistan and/or Iraq. The participants provided a window into their lived experience that generated both positive and negative consequences in many facets of their lives when they returned home. Participants described health and illness within the contexts of their particular lives with the meaning unfolding for them in the midst of their everyday reality. They depicted their health practices and the relationship of those health practices to military stigma as well as confidentiality, quality and processes within their health care system that were uncovered as barriers to care. Participants' experiences were not a discrete episode, but, rather now an enduring part of their changed lives. In the participants' new realities, they questioned the very nature of their previous routine experiences and existence. These experiences called into question their understanding of the world, which previously they had been taken for granted or perceived through a different lens.

Demographics

Eleven male service members and veterans consented to participate in this study. Six (6) of the participants were between 20-29 years old and five (5) were 30+ years old. The participants were primarily from two branches of the military during their deployments. Only enlisted (E) ranks were represented in the study with nine (9) participants between the ranks of E-3 to E-6 range but two were in the E-7 to E-9 range. Generally, enlisted ranks range from E-1 to E-9 in all branches of the uniformed services. This is the most junior leadership group and the group mostly likely to support or participate in direct combat-related activities. The ranks in the E-7 to E-9 range represent senior enlisted leadership. Six (6) of the participants had 3-4 years on active duty which usually indicates that they are in their first tour of duty in the military that is usually four years. Two (2) participants had 5-12 years of active service and three (3) of the participants had 13+ years of service and two were among those in the E-7 to E-9 group. One (1) of the participants in this senior leadership group with 13+ years of active duty was medically retired from active duty and one (1) was still on active duty. Overall, eight (8) of the participants were on active duty and are referred to as service members because they are still on active duty. Two (2) participants were medically retired and one (1) had been discharged from active service. These three (3) participants are referred to as veterans since they were no longer on active duty. The participants were nearly evenly divided between having earned a high school diploma or completing some college as their highest education level. Ethnically, seven of the participants were Non-Hispanic Whites but Non-Hispanic Blacks (3) and Hispanics (1) were also represented in this

study's sample. Seven (7) of the participants were married, three (3) were single/never married and one participant was divorced. All of the participants had been exposed to a blast wave while deployed in support of Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF). Six (6) of the participants had been exposed to a blast wave within the last year, two (2) within two (2) years, and one (1) participant was represented in the 3-year, 4-year and 5 year category. So the entire five (5) year range for blast exposure was represented.

Thematic Analysis

Thematic analysis uncovered the following essential themes of the participants' lives in relation to their combat-related and post deployment experiences and these experiences' affect on their values and beliefs, relationships, health and health practices, and identified barriers to care. The overarching theme was pain and suffering. The essential themes fell into two broad categories of pain and suffering: a) personal pain and suffering, and b) pain and suffering associated with using the health care system. The essential themes were expressed as quotes to provide a richer description of the lived experience expressed by the participants. The quotes were not all encompassing but representative of the predominate overall essential themes that were explained more comprehensively in the body of the study.

The essential themes that emerged from analysis of the text and field notes included: a) "It probably was one of the hardest things I've done in my life"; b) "You cannot go back, you've changed and others have, too"; c) "I'm twenty-three years old and I feel like I'm seventy-five"; d) "I just did it the hard way, pushed it through"; e) "I don't

want to be labeled”; f) “They share a lot of the information you shared with them”; g) “They weren’t listening to me”; h) “It was truly impossible to get in there and get an appointment.”

The first two essential themes revealed the participants’ focus on external factors and their own personal meaning of their deployment and reintegration experience after they returned home to express their personal pain and suffering. The sub-themes that emerged from each essential theme reflected the internal factors of these experiences and the impact they had on their lives. The third, fourth and fifth essential themes continue under the broad category of personal pain and suffering focusing on their health, health practices and military stigma. The last three essential themes fell under the broad category of pain and suffering associated with using the health care system. They focused on quality of care, confidentiality and lack of access. The essential common themes expressed as quotes are supported by the participants’ words to portray a deeper understanding of the nature of the experience and to insure that the phenomenon speaks for itself. These essential themes are separated only momentarily for purposes of discussion because, in reality, they became intertwined, interrelated, and overlapping within the structure of the balancing practices between the different themes and their effects on their health practices after deployment. Each essential theme can be viewed and considered only temporarily before it merges with the other themes and makes up the structure. The usual patterns or routines of the participants’ lives were changed by their war experiences and their changed health status and perceptions. New practices had to be embedded in their everyday lives in response to living with their internal changes and

current health status based on their deployment experiences (See Table 2).

Essential Themes

“It Probably Was One of the Hardest Things I’ve Done in My Life”.

Deployment in support of Operations Enduring Freedom (Afghanistan) and Iraqi Freedom (Iraq) was described by nearly all of the participants as a life changing experience. The study participants acknowledged that the old definitions of normal did not hold, because their lives as they had known them were forever changed. One service member shared,

I was over there seven months...it wasn’t easy...you know what I’m saying? It probably was one of the hardest things I’ve done in my life...you know.

One participant acknowledged the constant threat, uncertainty and reality of death:

I saw how really fast life can be taken...you know. I saw where guys were planning what they would do tonight, and you know...you go at nine o’clock...and then they’re not back that night, you know, so...

Another participant explained how his daily life changed:

It’s kind of different...the life, like everything over there is black and white, there’s no gray, either, you know...you’re always go, go, go, or back over here...it’s lots slower, there are a lot of gray areas. Everything was completely different...you’re working twenty-four hours a day over there.

Threaded throughout this essential theme were the sub-themes of fear, danger and suffering. The personal stories with these sub-themes permeated throughout their interviews:

Just make sure you have someone to look out for you and someone that you always know will have your back no matter how bad the situation got. ‘Cause when it comes down to it there’s very few people you can trust out there.

Table 2**The Lived Experience of U.S. Troops After Combat-Related Blast Exposure: Major Categories, Essential Themes and Sub-themes**

PERSONAL PAIN AND SUFFERING		
“It probably was one of the hardest things I’ve done in my life.”	<ul style="list-style-type: none"> • Danger • Camaraderie 	<ul style="list-style-type: none"> • Austere environment • Survival
“You cannot go back, you’ve changed and others have, too.”	<ul style="list-style-type: none"> • Work • Community 	<ul style="list-style-type: none"> • Relationships • Health
“I’m twenty-three years old and I feel like I’m seventy-five.”	<ul style="list-style-type: none"> • General perception of health • Personal Health Status • Affects on their lifestyle and activities 	
“I just did it the hard way, pushed it through”	<ul style="list-style-type: none"> • Coping/tolerating as a health practice • Coping/tolerating as a barrier to care • Affects on their lifestyle and activities 	
“I don’t want to be labeled”	<ul style="list-style-type: none"> • Military stigma’s affect on personal health practices • Military stigma as a barrier to care 	
PAIN AND SUFFERING ASSOCIATED WITH USING THE HEALTH CARE SYSTEM		
“They share a lot of the information you shared with them”	<ul style="list-style-type: none"> • Lack of patient confidentiality’s affect on personal health practices • Lack of patient confidentiality as a barrier to care 	
“They weren’t listening to me”	<ul style="list-style-type: none"> • Poor quality of care • Quality of care’s affect on personal health practices 	
“It was truly impossible to get in there and get an appointment	<ul style="list-style-type: none"> • Lack of access • Healthcare system process problems • Process problems affect on personal health practices 	

They depicted the need for support from each other to face the challenges of staying alive and survival as this service member states:

You never really know and you always gotta keep your eyes open...make sure you got people around you can trust, no matter...you can just tell someone's character, regardless. It doesn't matter, you know...if they're with you or not...you just got to get to know them.

Another participant shared their need to be ready and alert 24/7 and the fast pace of life while deployed:

Everything is follow orders...do this; you want everything on line ready to go.

Greg shared that not all troops are on the front lines while deployed to a combat zone and that being on the front line does affect a service member's behavior differently than those who support from the rear:

I didn't see combat like some Marines who were on the front line...so I didn't have like an edge to me where I was easily provoked or anything like that.

Those who experienced combat are subdivided into categories contingent upon their combat roles- the infantry or foot combatant compared to for example a helicopter pilot. The pilot can initiate and control his combat role. The infantry combatant has no control over his combat role. The psychological trauma of viewing the aftermath of combat from a distance compared to viewing from a position where the sight of dismembered bodies, the smell and taste of death, and the frequent touching of corpses are routine varies significantly the amount of physical and psychological trauma experienced though both are serving in a combat zone.

The participants of this study expressed their experiences with combat casualties and how they individually coped. One service member explained:

A lot of them are seeing a lot of stuff that people shouldn't have to see. Like my buddy had to see a guy get blown up right in front of him, and [you] pretty much go in expecting the worst.

The priority for care while deployed was also very clear; the acute trauma had priority, and may explain why some participants hesitated to seek care while deployed for a headache or cough. This service member reflects:

Once you get out there, medical's there...there's always somebody that can take care of you, but sometimes that's not the highest priority...if there's something going on...if they need to do that... they need to do that.

Jim shared his feelings and concern for his own mental health and described maladaptive coping while he was deployed:

Mentally I knew I was kind of shaken up. Just being deployed two times had its toll on me. I'd have feelings of wanting to kill people...and it would give me a sensation that I liked. It's like; you know...I enjoyed it.

Rascal shared how he coped with these situations: "You just go with the punches."

These young men depicted the environmental hazards that they were exposed to while deployed such as burn pits. All organic and inorganic waste is burned openly in the burn pits. Service members also revealed symptoms they suffered:

Physically, I was not in the best of health...just because of the environment that I was in. I was constantly inhaling fumes which I have a chronic cough. I did have headaches, I don't know if it was from all the stress I was going through. I couldn't tell you why I got these headaches. And I'd have periods in time where I would just go into a state of trance...and I wouldn't think about anything and just daze off, and um...I have a very short temper which leads me to anger control which I have none of...

Charlie relates his experience after a blast concussion when deployed:

While I was out there I did suffer a Grade Three concussion and was knocked out for a couple of minutes, and I was on...like every day I had to go into the medical area and be seen... and they had to run a couple like tests on me and make sure everything was ok with me...because a Grade Three concussion is like the highest level of concussion you can get, I believe. So I was kind of a little loopy...a little out of it for awhile...like a good few weeks until I was able to feel back to normal, I guess...everything from sleeping pattern to balance, and all that.

John's anecdote of his blast exposure conveys the pain and suffering that he endured.

John recalls:

I remember coming to, and I don't remember hitting the floor, I don't remember anything like that. I don't remember if my head hit the back of it, or it could have hit the back of it because the swelling thereafter was very enormous. I remember waking up and just saying my head's about to break. You know, my head's about to split open right now.

The participants told stories of their feelings and the enduring emotional bond that these men had with each other after sharing these life-changing experiences. Brian explains:

We were deployed in a four-man team, so we were like family... You have a camaraderie with them...you have something bigger than a friendship, it's like family... even now that we're back, we still spend a lot of time together even though a lot of us got annoyed with each other throughout the deployment, but, uh, yea...that's one thing that sticks out a lot is serving with those people you form a relationship that you'll probably never lose...it will always stick with you. I almost have a closer relationship with these people that I deployed with than the people I've known since I was four, five years old.

Brian also shared his story of coping with deep feelings of guilt for leaving his battle buddies early who he still communicated with on a regular basis despite being back home. He provided emotional support to his "battle buddies" that he knew was so essential for their survival. He shares:

One of my friends just got shot and he's getting sent home. My buddy, who's in the Helmand Province...the thing is a little north of it...but he's seen a lot of messy stuff. He's gotten into fire fights already...but the unit they're supporting

lost over fifteen people. They're already having to send combat replacements. So his morale is really low.

The accounts of coping with the austere environments of Afghanistan and Iraq depicted its negative effect on their health. Brian also disclosed:

I had more health problems over there, you know...just from different things like...you know...sleeping on the ground or you know...the first two months we were over there sleeping on rocks and you know...in a tent.

Jalen revealed how the austere environment affected his health:

It really did a number to my back. I think the sand... just the atmosphere calls me to go into an asthma attack on a lot of nights. I think it happened for about a month straight.

Chris describes the pain and suffering he endured while deployed:

My knees hurt, my back hurts, my ankles hurt, my arms hurt. As I said, we carry Weight and we walk everywhere. I didn't think...I was always like real flexible, and now it's like its like if I sit down, if I squat down for something...it takes me a few seconds to get back up. I kind of gotta go slow at it; the knees just hurt 24/7. So I think joints are the issue.

These young men told their stories of survival when they were left in combat zones without even the most basic necessities:

We had never been to Afghanistan, I knew everything was popping off there, and it's kind of early...not really early in the war...but with Marines just kind of getting over there...pulling out of Iraq, everything's getting a little crazier so...it's like you're a little bit more on your toes. They don't have nearly the supplies that they had for Iraq. They're still trying to get stuff out there. I mean, the biggest thing out there is obviously water. It's 136 degrees, and you're in full uniform with thirty pounds of gear on you... carrying your weapon, so I know a few times the ANA, the Afghanistan Army, there that would supply us...that were helping on the base supply water, what not like that.. like they kept wanting to go on strike 'cause they felt we weren't paying them enough, I guess...for them to supply us with water so we kept running out of water for a while there. I think at one point, we came to a new place that had absolutely nothing. There was nothing there...there were some walls and that was about it. We started building that place up and we had one supply drop. One supply drop of eight pallets of water for roughly 300 Marines and then plus another 200 or 300 British Marines.

Yeah, so that kind of ran out and it was drinking well water for a while. You use your water purification the same water you're washing your clothes in right there...you're drinking, that's all we had, but... I don't know...at this point our replacements went out there, so I know we personally built up for them...the guys that was coming to replace me directly...set them up a little bit better, better places to stay, the tents are nicer...they actually have tents.

One service member conveyed experiences and views about coping with family issues while deployed:

If it's your first deployment, be prepared because usually, something bad happens to every person while they're gone. Something happens to the family. If it's not that important...maybe it doesn't need to be mentioned, not...don't lie about it...but maybe it just doesn't need to be brought up...because they're out there, they're dealing with their own stresses...they don't need to worry.

Another participant added in regard to coping with family issues while deployed:

You don't need any more stress while you're out there at all.

The realization of a growing chasm between the American people and the military was voiced by this study's participants. They felt that there was little true connection between the general American public and who they are and what they represented. One recently returned service member shared:

The general public gets a wrong idea of what's going on...I mean, everybody knows what's going on to a sense... but they give the wrong idea of how rough it is, or how the Marines like...they have USO's out there, or they're completely comfortable, like...they make it seem like we're on a camping trip, I guess you could say.

A participant in a leadership role with nearly 18 years on active duty explained his added stressors and his perception of American public's lack of understanding about the military. He shares:

The military can be a very stressful place, 'cause, you know, for the most part, civilian life... they deal with themselves, and themselves only, you know. But as a Marine, especially when you start picking up rank and responsibility, now you

take on like four... you know...four seventeen, eighteen, nineteen year old guys...and it's like now you have their problems and you've gotta deal with them, 'cause you're their mentor, you know... and then, you know, when you deploy, it's like their parents are looking to you to bring them back home...you know, like, so it can be really... put a lot of stresses on you like you may not would have experienced if you were not in the military.

The stories of these service members clearly reveal the abnormality of the war zone environment. As an all consuming 24/7 "job" that takes a significant emotional and physical toll them. With a glimpse into their deployment experiences, it is evident that everyone returns from war wounded. The lived experiences of these troops and veterans provides some understanding that coming to terms with experiences in Afghanistan and Iraq and having peace and closure from that experience is a life changing experience. Reentry into mainstream society requires an understanding of the risky nature of war and repeated deployments and its profound effect on an individual.

"You cannot go back, you've changed and others have, too".

The most common sub-theme of this essential theme about returning home from deployment was that it was "just a relief of just being back home" and happiness for "all the little things, all the little things, like sleep, food." One service member explained:

I didn't really have any expectations when I came back, I was just happy to be coming back...so I didn't even expect anything, I just...I didn't know what to expect.

Another service member revealed:

I was looking forward to being back in the U.S....being grateful and thankful being raised in this country, you know...by seeing the other side of being in Kuwait or Iraq...seeing a different culture and stuff there. I was just looking forward to being back...being back home in the U.S.

The same sub-theme of relief and safety dominates as another service member describes his experience:

It was a huge shock... huge surprise, just an overall feeling of relief...I'm finally back home in the States and safe. It was a little difficult at first, just the adjustment. It took me a couple of weeks to adjust back to normal life here stateside.

Chris provided insight after two deployments:

The first ones are hard because you come back and you're still kind of in that mind set of being out there. Everything is follow orders, do this...you want everything on line ready to go. You're more alert still...you're kind of in that mind set. So, I know from the first ones it's harder to do to get back to where everybody is more comfortable around you. You're comfortable enough to relax a little bit. It took two months just to be really comfortable...and feel like I'm back in the States...because I mean for the first couple of weeks you're still kind of shell shocked that you're back...that the deployment's over with and your back in the States. You don't have to look over...you don't have to watch where your stepping...so I'd say about a month and a half till you're completely comfortable.

Chris also shared that after his second deployment coming home was:

...pretty much the same thing. I knew what to expect and how to prepare for it before I left...how to be ready more before coming back

Health status emerged as a sub-theme and part of the post deployment experience.

Study participants described and were aware of changes in their health and behavior post deployment. One participant shared that:

I need to be up and about. If I sit in one place, I think anxiety will really take effect on me. I can't sit in one place.

Another service member shared that:

I'm just stressing and trying to be more relaxed.

A participant after exposure to a blast shared that:

I couldn't multi-task any more. It was hard to see. I was trying to get used to these things.

And shared his coping strategy:

...Of course I drink, so the more I drink the more blurry it gets. So on and so forth. But I mean... I mean I've adapted.

Another acknowledges his anger control issues and how he manages it:

My temper might still be a little short fused at times, but I know that if I feel that I am going to get upset, I just...I've gotten a lot better. I just relax and I just slowly resolve whatever the issue is.

A veteran shares his symptoms several years post-deployment:

I would have anger outbursts...not would, but still do. I have a very short fuse nowadays, like I'd get flustered really fast...and it's very challenging for me once I click on to turn it off at times...and same with emotionally, you know...I'll watch a commercial and want to break down. It's that both extremes of anger and sadness.

This dominating sub-theme of anger continues to emerge as a change post deployment:

There are times I can get angry. I used to have a real good temper. I don't have that any more... I don't have real good patience anymore...so I get angry at times.

Insomnia was also a very common health change post-deployment and it was threaded as a sub-theme throughout this essential theme. A recently returned service member explains:

Coming back, sleeping was hard...and trying not to think about what actually like... things I saw over there...just kind of like adjusting back to getting used to normal, like...not saying normal human things...but just like American things, you know?

A recently returned service member shared that:

I sleep probably like three or four hours a night, maybe...and then, depending on...like the situation... like if I'm exhausted...that's like exhaustion, or if I have

something to completely distract me...then I can fall asleep.

This participant shares his post deployment story and admits to self-medication:

I can't sleep much. Like I have either...like I've got to like self-medicate to sleep or I just gotta like go completely blank. Otherwise I just sit there and think for hours and I can't sleep at all.

The inability to sleep post deployment dominates as a sub-theme throughout the discussion of health related changes:

My biggest thing is sleep. I don't get a lot of sleep. I'm tired throughout the day. I can sleep by nine, turn off the lights and everything...it takes me a while to go to sleep but I always still wake up at least an hour before my alarm clock goes off.

The more common face of combat-related Post Traumatic Stress (PTS) which is co-morbid with blast concussion nearly 50% of the time is one of depression, melancholy, silence, distance and avoidance of memories (IOM, 2008). These PTS-related subthemes emerged even though the interview questions were focused and re-focused more on physical changes and symptoms rather than PTS. A few years post deployment this service member states:

It was tough because I really wanted to isolate myself because I didn't feel like I can trust a lot of people...so if there was a change, that was the change, it made me a more isolated person and I'm sort of still like that.

Another service member from a recent deployment echoes this subtheme:

...just isolated, you know, just kind of low keyed, not emotional...just accepting things for what they are and how they are and just being more...just low key, even keel, so to speak.

This formerly outgoing veteran several years post deployment reinforces this enduring sub-theme of avoidance and self-isolation:

I tend to avoid people more so often than I ever had before. You know...I love people, I love being around people...being around people typically energizes me.

Detachment or emotional numbness is also expressed:

I don't get as mad about little things. I mean, I'll get mad every now and then, but I just notice I'm more passive in certain situations...

Post deployment changes in relationships were explored and emerged as a sub-theme of this essential theme during the interviews. One participant shared his feelings about his relationships after deployment:

Everybody's different, even the friends and family you had back in the States are different.

A married participant with children shared his feelings about his loved ones:

However, I have avoided most of my friends and my family since my deployment. I just really don't have any interest anymore.

This study participant confirmed changes that friends and family noticed when queried:

I was a little more irritable, easier, more often. They didn't see too much of a difference. They just noticed that I was more irritable and more alert to my surroundings, I guess you could say. Like I was saying before, like when people came up behind me or just walked around the area and I didn't see them, it would scare me.

Other service members shared changes only their families and friends noticed and the participants themselves confirmed their own lack of awareness of these changes:

Just small personality changes, I mean, I can't even say I notice in myself, but other people notice it in me.

Another participant explained changes that only his mother noticed and how she handled it:

I personally don't think I did...but I know my mother thinks I have. She's noticed that I don't smile as much and that I am more timid about things...more alert. I want to know who's in the house and who's not, and always watching always... that's what we do in Iraq...always out and about. She don't really talk about it. She mentions it...but she just knows not to say nothin'.

This participant asserts that:

I was real easy going...I still am. This is coming from my girl friend...she says that I seem more strict. I guess you could say more controlling not to a bad point but I just like things done my way; I guess you could say...so it kind of comes out strict and controlling.

This participant shares this experience with his wife after returning home:

I'm more calm actually mood-wise, like a lot of situations, my wife expects for me to respond, like... kind of like in an anger type of aggressive type of manner, and a lot of times, it's just like... you know what, people make mistakes.

This participant explains how his family copes with their loved one's behavior post deployment:

Now I hear from my wife who would actually tell me that... eh... you know what, you're hard on the boys and you're hard on me... know what I mean. And then there are times like...I don't want to hear it. She knows. She'll just leave it alone and she'll be who she is. So she tries to help out in any way she can, even if it means that, you know, she does everything."

A veteran several years post deployment offered this perspective of service members wanting to shield their families:

She tries to be supportive. I know I don't talk as much as I used to, like I keep a lot of things closed out... like I keep to myself a lot, or I just kind of like daze off into my own space, and it's just, you know... I kind of got used to all this over there, it's just not really having her to talk to and just dealing with the stresses and emotions... like on my own, so now... it like trying to open back up to her. It's not that easy...so I'm still working on that. That causes a lot of problems when she wants me to talk, and everything, and I'm...I don't want to talk about it, you know.

A veteran explains the need to normalize the combat experience to families to aid in post

deployment reintegration:

There needs to be more counseling and more education on obviously not what's going on in the missions, but historically what's going on with the troops that are returning.....that are coming back, not just physical...but also mental complications, and there are just normal stressors that go on in this. And these families are taught, and service members, that these are normal, you know... reactions to abnormal situations.

This participant expressed his gradual awareness of his own aggression and anger a few years after his deployment that interfered with relationships:

I was always trying to pick a fight with somebody. That's the best way to say it. I mean I always thought it was somebody else just talking shit, but it was always myself talking shit.

Some participants shared positive changes in their family relationships after their deployment:

I'm much nicer to my family now than I used to be.

Another attests a positive change in their relationships:

Now I'm much nicer...and I have a good time. I try to enjoy life for what it is, and make the best of it.

This participant shared his opinion on the impact of military duty on the family:

I think the military is a good institution, you know...whether it's for anyone...for people like I was...I had no structure when I was a youngster, so it's a really good institution. But, I just think as far family goes, if you really want to be family oriented...the military takes away from that a lot.

Work related feelings and relationships were discussed by the study participants and emerged as a sub-theme. The responses varied from wanting to deploy again to changes in their personal awareness of the world to disappointment in their leadership.

This participant said:

I was a little displaced. I was depressed too...because I had to leave my team that

I was with. I actually felt happier back there with them, than back here in the States.

Another explained:

I got used to it and in some ways it was better being there than being here.

Service members' shared internal changes:

I see life a little bit more broader.

They pondered:

My purpose of life or the purpose of life altogether... have much more respect for it as... a human, you know...It's certainly not something you take for granted.

Another described feeling:

...more relaxed, I guess. I mean health, you see the world in a different light, but, I used to be one of the people that would be just like, uh, whatever...

This larger life view was expressed by one participant as:

I've grown up and matured a lot, definitely come into realization of what's really going on overseas with our military right now. So it gave me a lot broader outlook other than just being able to watch the news or read the newspaper.

The participants also articulated how they faced moral and ethical challenges, or situations in which leaders fell short:

It's a great fighting force, but the people in charge are ridiculous, they allow some people in charge that shouldn't be in charge.

Another shared his frustration with leadership:

Just the stupid games that they do play. I mean, it's not really the military, but the people who are in it, who are in charge, exactly.

This sub-theme about leadership falling short continues to dominate post deployment:

...'Cause it's people who don't know how to do their job who when it comes down on them...they take it out on the people below them. Then it's an escape route and it's someone to blame it on. So...the military isn't bad, though.

Another participant confirms that leadership is the reason for his departure from active service:

Leadership wise... I mean...the Marine Corps' great. It's just the people that I don't see eye to eye with and right now I can't really do anything about it...and I don't really want to wait. I think I can do better in the civilian world.

Study participants also expressed feelings about personal instances when the military failed to live up to its responsibility to remain apolitical.

I've seen what I thought were really good people do things that were unethical or for all the wrong reasons, so to speak, and I'm like, man...is this what we are about?

Another senior enlisted service member with 20 years on active duty stated:

...its more of an nastiness to it, and I'm like, what is this all about and it makes me really just take a look back, and just evaluate things...some of our leaders in the military are more like the politicians...and it makes me just shake my head at times.

Some of the service members discussed how the change from a 24/7 work day to a more routine work setting affected them in the community that was uncovered as a sub-theme:

Just getting back in the groove, everyday life... everything was completely different. You're working twenty-four hours a day over there and then you come over here and you got so much free time...and you got a lot of time to get in trouble or stay out of trouble, whatever...

A veteran a few years post deployment conveys his transition experience to the community work environment:

The big change now, of course, now too, is I immediately went to work. You know, I got with somebody, somebody tried to hook me up and I became a sub-contractor and I was contracting work out there, and I was doing it and I made a name for myself. But then as competitive as I am, I can't...civilian and military are two different things, and as competitive as I was in the military...civilian life don't like that, and they were looking at me like, whoa, you're too aggressive.

An active service member shared his reaction to and disappointment in his own military work environment:

I didn't expect the people treating me the way they did as if nothing happened.

I'm twenty-three years old and I feel like I'm seventy-five''.

During the interviews, when the participants' general perception of a healthy person was queried the overwhelming consensus was that it was someone who practiced a balanced healthy lifestyle in all domains such as diet, exercise, relationships, high risk behavior, absence of disease and mental outlook. One service member responded:

They get good sleep, they're not sick. You know, regular exercise, healthy mind set, they see the world as what it is. They're positive and they're also personal, all aspects.

A different service member said:

You're eating your proper servings, vegetables, fruit a day, ah, not smoking. I think a healthy person can walk up a hill and not be out of breath and sweating.

Another participant included other characteristics to the list:

Someone who eats well, exercises regularly, has a good relationship with both family and friends overall.

This participant qualified a healthy person more specifically:

A person doesn't necessary have to be a body builder, doesn't have to run eighteen miles every morning. Just being in shape, exercising, thinking about what you eat.

A healthy person to this participant included:

A comfortable mind set, real relaxed, just easy going. Like I said, food, exercise, happy, not the person that sits in their room and eats Ho-Ho's and watches movies all day. One that gets out and enjoys the sun like this... like today.

Another shared more generally:

I think healthy is just, you know...anyone who hasn't anything to complain about.

The interviewees were asked about their perceptions of their own post-deployment health status. One participant explained his view on his health and his health practices:

Now my previous experiences of health care... never had it. I was never in a hospital before, I never had health care. I was living with my dad back in the day; we never went to a doctor. We were sick at one point in time, we got over it the next day and we were good to go.

A few participants reported a positive health status after returning from deployment:

I came back healthier. ...being in better conditioning, you know, as far as losing weight, trimming down, stuff like that, I've focused on getting in better shape while I was there... I've gotten back into the routine of working out every day, and running, and that helps mentally as well. But, no, physically, I'm almost back in top shape.

Another individual shared better health post deployment:

Actually I quit smoking when I came back also...I had the chance to work out and run every day when I was in Afghanistan so I feel like I'm in the best shape of my life right now. Every time I come back I feel much better because we're out there...we're not surrounded by all the junk food and everything like that, sittin' around being lazy as some people do around here in the States. Out there...you're pretty much working out 24/7, carrying all the weight in your packs, you've got your weapons, it's hot, you're running. The food they supply there...they at least try to make sure that it's at least nutritious. It's not just giving you junk food, so...for what you eat, you eat good food. So I always feel healthier when I come back.

However, responses reporting poor health post deployment dominated the interviews. A veteran a few years post deployment recalls his experience right after his blast exposure event:

I have all these other doctors talking to me about suicide. I was... why are you guys even contemplating about suicide. They said, 'you were talking about suicide.' I was like, really. I was like, I don't remember this... I'm getting 30%

for PTSD.

This respondent explained:

I felt uneasy around loud noises and people that were behind me, that people were, like... I don't know...walk up behind me without me knowing, it kind of alert me more than usual, and um... I guess that was the biggest concern with being back.

Another person shared changes in his behavior:

People who like come around me even if they're a few feet and I don't see them at first and I turn around, I jump, I get scared. And that's a big thing. Explosions are the biggest things for me.

Another service member describes changes in his health:

I'm still a little bit more stricter...a little bit more on edge... not like crazy on edge, by any means...kind of like looking around... always still watching.

One interviewee told of behavior changes he noticed:

I like more order to things. Like I cleaned my room before I came over here. I used to really never care if there was dirty laundry on the ground, whatever, I'll take care of it. Now, it's kind of like an OCD thing, everything has to be in its place. I need to know where everything's at, where it's at, why I have it there, and, just order and structure.

Another participant reported cognitive deficits post deployment after his blast exposure event:

I'm thinking, how come I can't remember this, or how come I can't remember that?

This participant also shares cognitive changes and insomnia he noticed post deployment:

Physically I'm good... mentally probably a little bit slower than I was before. I think sleep has to do with that.

Sleep and fatigue was another strong sub-theme that emerged regarding post-deployment health status. One service member explained:

... 'Cause normally it would take me hours just to go to sleep and I would wake up numerous times throughout the night, where now... even though Ambien is supposed to have these side affects where people are known to sleep walk, hallucinate... all that, wake up groggy... I could actually take an Ambien... get four, five hours of sleep and wake up more alert than if I were to not take anything at all.

Another participant shared his sleep disturbances:

But it wasn't until later on still I started noticing that I was having some issues like nightmares or fatigue... things like that.

Pain and suffering was the strongest sub-theme related to health from those returning from deployment. One service member shared:

My knees are all messed up. I finally just got a specialist, so I'm waiting to get a consultation from them, 'cause I can't run any more. I can't do any of that. When I first came back, I actually got into trying to get in shape, so I was going for runs and all that, and then something happened to my knees so I could barely walk on them. So actually I haven't been on them for the past two months now, running. Um, my back, I actually have, I forget what it's called... um... well, one of my disks in my back are a little messed up. So there's nothing they can do for that. I can't do a lot, especially with my son, like bending over and everything really gets to me. I feel like an old man. But... uh, yea... that and my breathing is a little messed up too. I'm sure that if there is anything else from the deployment, like being around burn pits and everything, I'll probably see later... I'm twenty-three years old and I feel like I'm seventy-five.

Tales of pain and suffering continue to permeate the responses from another participant:

My knees hurt, my back hurts, my ankles hurt, my arms hurt. As I said, we carry weight and we walk everywhere. I didn't think... I was always like real flexible, and now it's like it's like if I sit down... if I squat down for something, it takes me a few seconds to get back up... I kind of gotta go slow at it, the knees just hurt 24/7. So I think joints are the issue.

Another service member explains his reasoning for his post deployment health problems:

You just had to set up where there was room and there could be rocks underneath it... and you'd just sleep in a sleeping bag, so it was very uncomfortable. I actually have back problems and knee problems now that I'm back that I didn't have before.

This participant confirms that the pain interferes with daily activities:

I had back spasms which got really bad. I wasn't able to work without being in pain which had its toll on me.

Interestingly, respiratory problems emerged unexpectedly as a health problem post deployment by the study's participants. Exposure to burn pits was reported by several of the service members. Burn pits are shallow excavations where refuse, from discarded plastic to human waste, is incinerated near military bases in Iraq and Afghanistan. The use of burn pits has triggered federal lawsuits from veterans. A recent report from the New York office of the U.S. Department of Veterans Affairs said the department is very concerned about the effects of exposure to toxins produced by burn pits by U.S. military troops (Ramos, 2011). Responses from this study's participants describing their respiratory symptoms post deployment include:

Right now I'm still getting seen for like...my lungs.

Another service member states:

My lungs and my back...they like to spasm on me.

The respiratory complaints continue:

I like running, I just...it hurts so bad now in my chest. I smoke Newport's, it doesn't help.

This service member confirms exposure to burn pits:

I smoke, and I know that's the problem, and it's not like I'm submerged in the burn pit. I mean...we were near them.

Jalen stated his post deployment health problems:

It really did a number to my back. I think the sand... just the atmosphere calls me to go into an asthma attack on a lot of nights. I think it happened for about a month straight.

Another participant pessimistically states:

But...uh...yea that and my breathing is a little messed up too. I'm sure that if there is anything else from the deployment, like being around burn pits and everything, I'll probably see later.

Another service member admits to returning to unhealthy habits post-deployment:

I'm not as healthy as I was...I enjoy McDonald's with a passion, and I smoke.

Joe said it took, "Maybe a few months" to start feeling like himself again after his deployment.

Overall, the study's participants reported both mental and physical health problems post deployment. Many did not seek healthcare and just tolerated the symptoms. These symptoms persisted for several years for a few of the study participants. Other participants did not follow through with their health care treatment regimes due to stigma. Stigma and tolerating/coping were very intertwined with responses about poor health post-deployment as the interviews became more detailed about their health practices

"I just did it the hard way, pushed it through".

Coping or tolerating symptoms as a health practice emerged as an essential theme in an effort to deal with the study participants' reported pain and suffering. Although coping has a more proactive connotation than tolerating, both terms were used to describe this health practice because the participants actually used the term coping frequently in their responses although their actions were not proactive and actually reflected tolerating and denial. This health practice was also identified as a significant barrier to care. This

health practice included discussions about self medication and an increase of alcohol use by some participants' in an effort to help them cope with or tolerate their poor health and their symptoms post-deployment.

Coping/tolerating as a common health practice and barrier to care had sub-themes that were frequently expressed. One participant described his health belief to explain his rationale for and other service members' common use of coping/tolerating as a health practice even though they have access to quality healthcare at no cost. One service member stated:

Pretty much, unless it's like real serious pain, a sharp pain that really hurts at the time, most of us don't go in, don't worry about it.

Another participant confirmed the common use of coping/tolerating for health problems:

We just kind of tough it through because we're all...everybody's in the same boat, everybody's knees hurt, everybody's shoulders hurt.

Another respondent reflects the warrior ethos in his response:

I wanted to...in the beginning I wanted to see how I could achieve without anybody's help...so I was doing everything on my own.

These responses describe the fundamental and distinctive character of military culture that is implied in their expressed attitudes, habits, and beliefs about their post deployment health practices.

This veteran describes the warrior ethos and the coping/tolerating health practice even when he was seriously wounded after a blast:

I was refusing narcotics, and I told them, hey... look it I don't want to do narcotics. I don't want anything, and they kept giving me this stuff. And I says, I don't want it. If you don't have standard pain killer, I told the nurse, I can take the pain. I understand I'm wounded. I can take pain. Just give me some pain

relievers to help me cope, not give me narcotics. There are just too many things about narcotics I don't want to handle.

This veteran's story depicts coping/tolerating as a barrier to care even after they leave the military:

I get 30% [disability] for PTSD. [His family says] But you're not seeing anybody. What are you going to do? [He explains] I keep fighting about it... I'm able to control it.

This active service member describes his health practice of coping/tolerating after recently returning from deployment:

I've got back problems and I have knee problems, but other than that... I mean...I can kind of push through it. I mean, they couldn't do anything for me out there...without transporting me to another base so I just kind of deal with it.

Joe, an active duty service member with nearly 18 years in the military reveals that post deployment:

We were afforded help which... was the part that didn't go well as being in the Marine Corps. I didn't want the help. I just ...did it the hard way, pushed it through."

Joe talks about "it". "It" pertains to PTSD but he never really defines it but believes he suffers from it. It's as if he is afraid to actually say PTSD. Joe continues to describe his experience:

I just be sitting and I'll choke on my saliva. Other than that, my patience is still not the best... but I know what it is...so I just know how to handle it. Like anger, like I said my patience, and it took me...something else that I just did on my own and just coped with it. I think it came from the stress...which I dialed out. I don't want to be a part of that...it is what it is. I think I'll get it evaluated in another year, when I get my eighteen year mark.

Joe offers a solution for ensuring future service members are identified with post-deployment health problems:

I would recommend just for the military in general to make it mandatory for a Marine or military personnel to get checked up. They should make it mandatory after you've done a deployment to be evaluated and checked out... because a lot of people at first don't know what it is. People like ...think that they have to be in combat arms to get PTSD. They think if you're literally in combat that you get it. It could be just a regular legal clerk...or anybody can get it and they don't know that.

Joe believes other service members should get help but he personally prefers

coping/tolerating:

If they see a change in themselves. I think they just need to go get it checked out. That's it, I mean, I did... I didn't do it. I just know how to cope with things, and I don't let myself take control over me or anything like that.

Another service member explains:

When I first came back that was the first time I complained about it...even though you know I told them it was from a while back. They just never... you know. I figured it would just heal on itself which it never did and then they kind of got mad at me because I never came in and I never expressed the pain and they lost my records. 'Cause I actually went before that and they never believed me... 'cause I went when I was in the school house... and I didn't want to deal with it...otherwise they'd drop me and I'd have to stay in the school house longer. So I got to my unit, deployed and came back with my complaint.

Another explanation for the health practice of coping/tolerating:

I just kind of tough it through because we're all...everybody's in the same boat, everybody's knees hurt, everybody's shoulders hurt. Get it documented, but do we follow through any more past that, maybe not...maybe so, it depends on really how much pain there is from it.

Lifestyle, behavior or daily activities disruptions emerged as a sub-theme.

Participants provided descriptions of their strategies for coping with or tolerating their post deployment health problems. This was offered as an approach to anger management:

If you feel as if you are in a situation that's going to aggravate you, you know...walk away. If somebody's there talking and there's a problem and you're

starting to get frustrated with it...excuse yourself. It's like the 10-second rule, which doesn't work for me...but take a breath. Count to ten in a sense or disengage and then come back. I think the biggest problem with service members is they are frustrated that nobody understands what's going on...what's gone on with them and that includes family, friends and even people within the communities especially the larger military communities need to be educated on this as well.

Isolation as a health practice was described by a participant:

Take 'me' time, do something by yourself, whether it's getting a hotel room, just isolating yourself in there, and just take "me" time. Family will understand, if they don't, I'm sure they will afterwards as if you didn't take it. That's the biggest thing, "me" time.

Another service member recommended:

Kind of relax and get back into, you know...a normal way of living, you know...and kind of relax, take it easy, don't go out and try to make up for seven months in one day, and gradually just try to progress into how you were...if you liked how you were or take a new start and try to become a new person, you know...

A veteran several years post-deployment who continues to suffer chronic symptoms explains:

What stands out [post-deployment] probably my alcohol consumption has gotten worse over the years. Alcohol is not the way. It doesn't hurt, you know, you take the edge off.

An active duty service member explains:

When they get back and start drinking a lot...'cause you missed it, get DUIs... fights, so I would tell them to stay away from alcohol.

"I don't want to be labeled".

Stigma was identified as the most significant essential theme driving health practices that were barriers to care. The participants described denial of symptoms, increased refractoriness, self-medication, delays in seeking help and poor treatment

adherence. Several participants acknowledged that they needed to take care of themselves and to embrace the notion of wellness by overcoming the stigma to seek health care for their health problems despite the obstacles. Many were reluctant to seek help for fear that it would be on their military record and would adversely affect their military career.

Stigma as a barrier to care is explained by John:

If I lost an arm, leg or I can't do anything, I'm just not here no more, you know, I'm not going to be around anymore, I'm not going have somebody care after me if I can't do it myself.

Another participant explains his reluctance to expose his mental health problems that is now a barrier to care for him:

I'm not going to go to group therapy. You crazy? So I said, forget it, I'm not doing it. I mean I could talk like this. Put me in a group of nine other people talking...I'm not going to do nothing. Are you crazy? I'm not going to talk about it. I'm not going to go.

Joe, an active duty service member with nearly 18 years of service in the military, reveals stigma straightforwardly as a barrier to care that drives the health practices of service members:

I didn't want to be labeled. I didn't want... I didn't know if I got the help whether or not I'd get in trouble...if I'd get kicked out. I don't want to be diagnosed with what is it... PTS. They kick Marines out for it medically. I don't want to be a part of that...it is what it is! I think I'll get it evaluated in another year, when I get my eighteen year mark.

Joe also offered these recommendations as a way to circumvent stigma so service members including him could get the health care they need to recover:

I would recommend just for the military in general to make it mandatory for a Marine or military personnel to get checked up...after you've done a

deployment... instead of given the option. When a unit comes back and they all get evaluated. I think they need to physically go through it instead of with an HM [hospital corpsman]; they need to go through it with a doctor. They're just afraid to come forward because of their career.

Joe reflects and expands on his recommendations for circumventing military stigma so that service members get the care they need:

I think it needs to happen before they come back...it needs to happen out there before they come back...so when they do come back they can go and get taken care of before they go on leave.

Joe believes that learning and increasing troops' awareness of blast-induced concussion and PTSD will break down the barriers caused by military stigma:

In the Marine Corps we do our annual training, everybody does it, sexual harassment and things like that, it should be a part of that.

Another participant shares his experiences with military stigma:

There were leaders out there that should not have been leaders...that got people hurt and ruined many Marines' morale...mentally. It was like they would badger them verbally over and over and over until they seemed like they'd been weakened and they would just use them as a punching bag constantly. And I knew, just by seeing it that it really had effects on them, and that actually lead to illnesses and weakened lots of Marines and our unit because they were not fit for their duty.

Another service member shares:

I wasn't able to get help mentally because I didn't want anybody to know ...because I was told that it would keep me in the Marine Corps longer by pushing my EAS (End of Active Service) date back because I'd have to get screened through Mental Health and some other doctors, and I just wanted out, so I didn't get help for that...

Another active service member explains how stigma affects him and made it difficult for him to even go to his medical appointments:

So I...I tried to get help and I kept on asking can I go to my appointments now, can I go to my appointments, I gotta leave for an appointment and sometimes...I

tried to only talk to one guy who had the authority to say go...you can go to your appointment, but sometimes other guys that I talked to, they'd ask me why are you going, and I didn't feel comfortable talking about it and telling them why. I didn't...it's really weird when someone asks you what appointment are you going to and you say I'm going to a therapist. They ask you why you're going to a therapist and it's kind of like if I wanted to tell you...you would be my therapist. They use it kind of like a weapon to hurt me. They would bring it up, make jokes about it...anything they think that would get under my skin they would use, and that definitely would get under my skin if they knew about it.

A veteran admits that military stigma caused him delay seeking care for health problems until after he left the military that was five years after his last deployment:

I truly didn't start seeking any type of physical...or mental health assistance until I retired.

Brian admits that military stigma made him not adhere to his medical treatment plan even though he knew he needed treatment:

When I did want to see a therapist, they wanted me to get some kind of anti-depressant medication, and the military really frowned upon it, and they gave me a lot of crap that pretty much made me feel like...if I wanted to go into the civilian world I wouldn't be able to get a normal job because of it. I wouldn't be able to put in any kind of reenlistment package because I was wanting to take that medication and I wouldn't be able to be up for promotion because of all this...so they pretty much told me if I wanted any kind of help medically because I've already tried everything without medication but it wouldn't work...so I figured I'd try the medicine route anyway and I got a lot of ...negative input from that. There's problems of leadership and that's what makes the military...that's what can make the military like good or bad...leadership...so its people like that. I'm sure if there was somebody else in charge, they could have perceived it differently...and it could have been a lot better but that's the reason why I didn't stay with the medication. I pretty much took myself right off...was because of them.

Brian recommends to other service members facing stigma as a barrier to care based on his personal experience:

If they're having difficulties adapting...seek some kind of help...don't be afraid. No matter what anybody says... because the only person you're going to be hurting is yourself and the people around you.

A different participant describes frustration and feelings of isolation at work due to health problems and how stigma was a barrier to care:

I couldn't work out. Sometimes, like I wouldn't be put on certain jobs. Like I'm a heavy equipment operator...I want to be able to do work on a regular basis...it's just... they put me in the office pushing papers. I've seen civilians like out in town and then you've got to deal with Tricare and all that shit...and it's an even bigger pain...and they're like why'd you go there, and they give you crap for that.

Stigma that drives these types of health practices and beliefs may be one explanation for many of the problems that lack of health care may result in, such as the high rate of suicide currently being experienced in the military.

“They share a lot of the information you shared with them”.

The lack of confidentiality of personal health information was closely related to military stigma and the desire on the part of the participants to not have their health status or treatment shared with their military superiors or co-workers. Participants explained that they are treated differently or that it threatened their military career. Some of the participants preferred seeing civilian health care providers anonymously rather than military-based providers due to its perceived lack of confidentiality. Lack of confidentiality was identified as a barrier to care and affected their health practices. This emerged as an essential theme.

In regard to lack of confidentiality being a barrier to care. One participant shared:

It's been pretty easy to...use resources like OneSource; you know...I had them myself. I dialed up so definitely a great tool or asset to use if you're in the military and I've used that and referred it to a lot of people...vice going to counseling on base. Military OneSource, obviously you're going out in town, paid professionals who are confidential on a lot of that stuff that you discuss which was great. Unlike the military it's on base...they may say there's certain things that's between you and them...but I've seen the situation where they share

a lot of the information you shared with them to your superiors which is why I've always told people to go to OneSource off the bat...because I've seen counseling on base actually make things worse...and it did for me and I'm just speaking about myself. It did for me...going through my divorce...and I initially volunteered to go to counseling...I'm a big believer in that and so I think it's a great thing...but I've seen going on base how that can make things worse and I've been through once where it was great and I got the help that I really, really needed... vice...you know...all the extra stuff with the work and that the military counselors you know...could really make things worse. If you see signs where you need counseling or your family or your kids' needs counseling...you know...call OneSource immediately.

Military OneSource is a web-based 24/7 referral service that is endorsed by the military but is 100% confidential. Tricare is the name of the military – civilian preferred medical provider network system.

Another participant shared that:

In the Marine Corps nothing's a secret because you tell one person and they most always open their mouth and...whatever you tell them spreads like wild fire. So I...I tried to get help and I kept on asking can I go to my appointments now...the making and getting appointments wasn't hard. It was quite easy. I was able to make a lot of appointments but trying to go to your appointments...by then your unit knows...is the difficult part 'cause of how much information they require to let you go to your appointments.

“They weren't listening to me”.

Quality of care emerged as an essential theme and a barrier to care during the analysis of the findings of this study. The perception that the health care system did not listen to them about their pain and suffering reflected negatively upon the resulting care they received. It was given a voice with participants recalling its affect on them personally through polypharmacy and alcohol abuse. A military study recently found that substance and prescription-drug abuse was increasingly a contributing factor to the suicide epidemic in OEF/OIF troops and veterans (Youssef, 2009). According to Keyes

(2010), The Defense Department's Medical Surveillance report from November 2010 stated that in 2007, 2008, and the first two quarters of 2010 the incidence rates of new diagnoses of alcohol dependence in the Marine Corps were the highest of all the Services. This study's participants included Marines as well as other uniformed services, interestingly, alcohol dependence emerged as a subtheme as well a polypharmacy.

Quality of care uncovered itself as a barrier to care. One participant described his experience with his treatment with prescribed drugs and the military healthcare system's lack of attention to his voice and rights as a patient:

They were supplying me drugs... they were just giving me drugs after drugs. I was refusing narcotics, and I told them, hey, look it. I don't want to do narcotics.

The current treatment for BINT and co-morbid PTSD is the use of multiple medications to treat the complex symptom clusters that occur but it is especially risky. According to Hammer & Sauv (2011) inadequate communication among different disciplines to reconcile or reduce the number of drugs used to treat these patients may be leading to prescription drug abuse.

John shared his personal story about the military healthcare system's treatment after his blast injury:

It was five or six days after, you know...that's when they finally said, ok, what happened? What do you mean, what happened? You don't know what happened?

John goes on to share a family member's conversation with his military physician after his blast injury:

You can get so sued right now for...whatever the term was...you know... malpractice or this and this and that. You didn't even keep him for observation, you didn't do no tests on him, you just thought he was a swollen head and you let

him go.

John more bluntly states:

The health care I'm receiving now sucks.

John about two years after his blast injury was medically retired and expresses his opinion and frustration of still not being heard by his clinicians:

VA sucks. They weren't listening to me. I was sending e-mails, and I tried calling and get the voice messages and leaving the voice messages about it telling exactly what I need...and it wasn't until recently where I had a every six months I'm supposed to see a doc...you know...just to get my physical, see if I have any complaints that I know of, anything like that. And then they want to try to tell me what's going on. And at that point in time, the doctors are like, hey...I know you say you don't need health care but you need to do it. I have an assessment here that you need to do it. I have this doctor I have right now. She's pushy as shit. I hate her so bad. And the fact that I have to go see her is just ridiculous. Because she doesn't even let me explain anything. She just...what do you want? Are you six months? What do you want? What are you doing? Hey, I'm going to say you go to therapy. I'm going to rat on you thing. She's like giving ultimatums instead of just listening to what I have to say about everything. I come in with maybe a little list...and by the time I start even talking to her for the first minute, I can't wait to get out. So everything I might come to try to ask her about...get her opinion of some sort...I just want to get out. But she has no care in the world. She just wants to hurry up and get out. If I know I'm not going to win or even get heard...why am I going to waste my time?...get all this emotion out...let her see this and then be denied for her pleasures...so no...I'm not going to say nothing. So, it's like I just walk out.

Chief, five years post deployment and retired with a disability, shares his story about his care after leaving active service in the military:

They had services that...like the mental health and the occupational health services...but it was truly impossible to get in there and get an appointment...and...uh...and again when you go in there and you talk to these people they just truly don't understand. You know...they've never been that or done that...so they don't...I think, have a real good grasp on what it's like being in the military...what it's like to be able to talk the lingo, and be more comfortable. In the Navy mental health scenarios...providers...not all the providers are as good as they should be, you know. I think our providers should be military folks or retired military folks...or have some type of military background. It doesn't

always have to be deployment...just a military background. 'Cause they just don't understand.

Chief explained his perception about health care:

So I think for service members... and even for family members having somebody within the group that has that military background and deployment background and the expertise of the military in whatever form that the counseling is being provided is very important.

An active service member who had returned from OEF just a few months previously described a perceived lack of caring from military medical personnel:

If you need help and you kind of look at someone...and they're like...they give you that look like I don't want to help you but they know...and you're like so do you job. Everyone does this...I mean...it's just a pain in the ass. I understand they're busy but it still shouldn't push anything to the side. I mean...deal with their daily duties...I mean tending to the sick.

This same participant explains why he believes civilian health care is better than military health care:

I mean their job is always in jeopardy...and can always get replaced by somebody younger or better or anything. I mean like in the military...they can't really fire you.

Another service member shares an experience:

They kept just thinking that I twisted my ankle. All the time...all that just happens...and here, I tore some ligaments and all that. So it took awhile [to get seen].

A service member in response to a question about how to make the military health system better was:

Be more open minded. Like I know there are lots who go in there to get out of training...but then again...there also are a lot of people who are sick or hurt who get treated the same as the person faking it. And I wish they could be more understanding...like actually do their job and be more into it...instead of just assuming that everyone is faking.

“It was truly impossible to get in there and get an appointment”.

Lack of access to care also emerged as an essential theme but was very closely linked to quality of care. These two essential themes fall under the major category of pain and suffering associated with use of the healthcare system. An active service member shares his lack of access to care anecdote:

Like...you know...the BAS [Battalion Aid Station] medical...that's just like the corpsman...and actually in each battalion...you know...it's too hard get in with those guys. Their schedule...like they only work only two hours a day and the rest is like paperwork all day... and I'm like you know...you only see me two hours a day...and like you do twelve hours of paperwork...you know. I don't really know what that's all about. But, it's like, I don't know... it too...you know it's like coming up from sick call from eight to ten and then after that there has to be an appointment between eleven to one or something.

A Battalion Aid Station (BAS) is a small unit-based field medical facility with few resources used for receiving casualties, triage, stabilization, minor treatment and evacuation in the Marine Corps. Marine Corps and Navy clinics hold “sick call” hours which is a walk-in clinic for anyone who wants to see a provider with a health problem. Most see a hospital corpsman/medic for screening and may be referred to a medical provider if deemed appropriate by the corpsman/medic. They serve as the gatekeepers of health care in these field clinics.

A veteran shares his experience with lack of access in the veteran's healthcare system:

I did a assessment test, and then they said ok...well we can't take you in because we're packed. Says...well we don't have any more space for taking in members right now...so we're going to make a consultation so you can see somebody outside.

John shares his dissatisfaction with the long timeframe and distances needed to travel to get a prosthesis as a veteran:

So I'm getting upset...I get frustrated, and then I said, look...I need the prosthetic. So I'm going to do the prosthetic. So I gotta take the time. Now this one took me a year and change. I was upset. I didn't want to have to go all the way to Tustin all the time to do it, and the prosthetic I was using before would be this old beat up one the Navy gave me once upon a time.

John describes how this barrier to care directly affected his health practices:

I'm not even worried about having to go see those counseling sessions, but in the beginning...I was always like if I was pushed into it, I'd probably do it. You know...talk about it...go through the procedures...do everything I have to do. And I think that would have helped me back then but looking at it now, I'm like; no...I care about what people think a lot. So, I like...if I go back they're going to say...oh, you're faking it...or you're doing something now?

Another service member shares his inability to access military care:

For inhaling the fumes and having my cough problem, I did try to get help with that.

Chief, a veteran, describes his frustration with lack of access to care due to lack of follow-up as well as the distances required to access health care:

I went to the VA...first I had tried to call them...tried to get an appointment and you could never get through to a real person...and so I just went down there in Yorba Linda... and I just needed to speak to somebody...and nobody was there at that time...so they were going to call me back. And, you know...it was like a month, you know...and nobody had called me back so I ended up going back there and speaking with the director...and he apologized for it and I gave him the names of the people that said they would call me back... and the VA just to me is still not really there as much as they say they are. Very frustrated over the VA system. It was truly impossible to get in there and get an appointment.

Another service member explains his perspective about lack of access:

We pay for it each month, and it's like...you know...I feel like they should just get affiliated with hospitals like the local hospitals surrounding the base at least...you know...because just getting into to that one hospital...even like going to the ER there. You have to slot like 24 hours, you can't plan to do nut' tin else, 'cause, I mean...we went in there...just the ER, we just went in there...you know...you go in there at 8 in the morning and you're just now like getting seen at like...you know...10 at night or something like this. You being in there all

day, but...I mean... their service is pretty good. I think the doctors out there are pretty good. They're knowledgeable in what they do...it's just really crowded.

This service member shares his feelings about the military health system:

They kind of push it aside or they say, oh...you gotta go see this person and then you gotta go see that person and they give you a run around.

Yet another service member shares his frustration with lack of access to care:

I think it would be easier to see civilians. The people who do go in there and they do have problems...it's a lot longer...it's a lot harder to just to get through that stage and before you know it...you're like...fuck it, I'll just deal with the pain. And then people are upset with you for being slow or whatever.

A similar theme from another service member:

If you don't have any record of it...and you need to see a provider then...at that point...the provider only comes in maybe...or at that time...I don't know about now...but maybe once or twice a week...if that...or a month even. Like I never once seen him other than like for a PDHRA. And it was just a pain in the ass.

The Post Deployment Health Re-Assessment (PDHRA) is part of the force health protection program. It extends the continuum of care for service members' deployment-related health concerns by providing education, screening, assessment and access to care for a wide variety of questions and concerns that a service member may have about their health after they return from deployment. It provides for a second health assessment during the three- to six-month time period after return from deployment.

This service member describes his story of lack of access which is closely tied to quality of care:

Our local BAS [Battalion Aid Station] for our unit...they're not really understanding...because you have to get referrals to go to the hospital if something's wrong with you...and if you go in...they'll give you some Ibuprofen and water and say 'rest up'. That's all you get...then you have to keep on going before they finally let you go to the hospital.

This service member describes the challenges of getting past the gatekeeper:

After my first of like two months of going there...then I finally got to see a doctor. The corpsman just put me on light duty and said ok...you're on light duty for so many days until your ankle gets better... It took me almost a year just to be able to get in and get an MRI done.

This service member depicts his experience of how to successfully break through the barriers to care:

Keep complaining, I guess. Just keep going in...keep bugging them...pestering them until you see...who you want to see.

Conversely, two of the study participants did not perceive any barriers to care.

One participant offered:

Access to health care has been easy. Yes, it's been easy. I've recently went to therapy with my daughter...you know...it was joint therapy.

Another service a member asserts once you get in the care is high quality:

It's a good system, especially at the hospital...It's packed, so you...I mean you might be waiting for a little while, but that's the same in any hospital. But they really do a good job, they focus on you when you get in there...what's your problem, what can they do to help, maybe give you a pamphlet on something to exercise, workouts or just something that might help. They're really good about it. If the pain's insane they treat it different than if it's just a mild twinge in your leg. They know what to do...they know what they're doing and they do a good job for it.

CHAPTER V

Discussion

The findings from this hermeneutic phenomenological study expands our current view of U.S. service members who have been deployed to two wars for nearly a decade and how deployment affects the health of the all-volunteer force. Few studies have focused on the lived experience of U.S military troops who have served in Operations Enduring Freedom (OEF) [Afghanistan] and Iraqi Freedom (OIF). The participants of this study volunteered to describe and depict their experiences after blast exposure while deployed in support of OEF/OIF and give a picture of its physical and mental affect on them. This study focused on a community-based purposive sampling of troops who predominantly had not been diagnosed with or even sought care for blast-related symptoms in order to explore the physical and mental aftermath of blast exposure in a combat zone from their perspective and to investigate their health practices. The findings of this study gives us a glimpse into the rationale for the reason many of these participants do not seek healthcare even though they are suffering and in pain. This study confirms as currently postulated that stigma and military culture is a barrier to care even though healthcare is readily available at no out of pocket cost.

Conversely, lack of confidentiality and access, the perception of poor quality of care and the common health practice of coping with or tolerating symptoms also emerged as barriers to care. These service members and veterans some as long as five years post-deployment and no longer on active duty continued to share common responses with their active duty peers regarding their experiences post deployment from OEF/OIF.

There is no good war, and there is no victor, everyone loses. The study participants confirmed that there is no victor in war; everyone loses by sharing how they brought the war home into the hearts of their families which was the cruelest aspect. They were not able to protect that which they held most dear- their family. Many of the participants expressed feeling disconnected and detached from loved ones. This study's findings may help strengthen the relationship between members of the armed services and the general American public whose daily lives are never touched by the war or the military resulting in a lack of awareness of what only about 1% of the U. S. population ever experience. This study may assist those not affiliated with the military to understand that experience and find ways to help service members and veterans with reintegration or when they are encountered in community hospitals and clinics.

Military service members have an attitude that if something is broken, they have to fix it. This study revealed insight into service members' and veterans' understanding that they were not the same person anymore. These young men went through a major, earth shattering event that has changed their lives forever both in positive and negative ways. Many voiced an understanding that they have to cope with or tolerate what they have and concentrate on management of pain and other issues that now interfered with

their daily activities. These young men also expressed never feeling more alone until they were surrounded by people back home who didn't understand. What the researcher observed consistently was that they not only spoke more maturely but looked older than their years. The researcher was consistently surprised when she learned their actual chronological age. Overall, the findings of this study confirms the role of stigma that drives their health practices and the challenges with reintegration and the long periods of time needed to adjust to mainstream society after deployment. Pain and suffering is the over arching theme of the essential themes identified in this study. The first five essential themes fall under the major category of "Personal Pain and Suffering" and the next three essential themes fall under the major category of "Pain and Suffering Associated with using the Health Care System".

"It probably was one of the hardest things I've done in my life".

The predominant sub-themes revealed in this essential theme focused on fear, danger, and the austere environment in which they struggled and suffered to survive. Stress, pain and suffering were threaded throughout all the essential themes. The emotional and mental stress of observing the casualties of war as well as the physical stress of survival over several months with the barest of basic necessities took its toll on these study participants' health and psyche. Some of the participants described survivor's guilt for leaving their battle family even though they themselves were injured or had served their time. New health hazards emerged such as exposure to toxic fumes from burn pits that caused enduring symptoms. It is not difficult to understand that a long transition time is needed to turn off the physiological and emotional distress and the

automatic responses to certain situations when these troops return home after enduring such an experience.

Some of the study participants reflected on their disappointment in leadership and their frustration and sadness that the American public fails to understand the impact of war on those who serve. This lack of understanding was seen as a barrier to their successful re-entry into mainstream society and sometimes even a barrier to seeking care from health providers who “don’t understand or listen to them.”

The participants tell of the strong bond that developed among their “battle buddies.” The camaraderie that developed as they supported each other to stay alive was described as “family” and a bond stronger than that of the friends and family they left behind. This camaraderie later emerges as an impediment to transitioning back with their parents, spouses, and children post deployment. They also asserted that a provider’s ability to heal or help them is based on the provider understanding or having experienced military culture. These providers were sought out to help them heal from their guilt for killing; betrayal by their leaders; indiscriminate anger; emotional shutdown; alienation and their physical ailments. These experiences were reluctantly shared by the study’s participants.

Recent military operations in Afghanistan and Iraq represent the most sustained ground combat operations involving Americans since the Vietnam era. The majority of military personnel experience high-intensity guerrilla warfare and the constant threat of roadside bombs and improvised explosive devices. Many service members have served

multiple tours of duty, experienced traumatic injury, and more of the wounded have survived than ever before as part of the first all volunteer force to experience this. Blast induced mild traumatic brain injury, commonly referred to as blast concussion, and has been estimated to have occurred in nearly 20% of the troops returning from OEF/OIF (IOM, 2008).

From a historical point of view, Alexander (2010) suggests that perhaps this is not so much an emerging new phenomenon but an emerging new occurrence and established strong evidence that we have not learned anything new about this injury over the last 100 years from past war injury experiences. In World War I (WW I) the term coined “shell shock” was described with similar symptoms: headaches, tinnitus, dizziness, poor concentration, loss of memory and insomnia. WW I ground troops were also exposed to exploding shells clearly damaged but without visible wounds. Medical officials at that time described shell shock as “a state of shock cause by the blast force” (Alexander, 2010 p. 59). They also describe soldiers with similar symptoms who were not near exploding shells that they diagnosed with emotional collapse due to unprecedented horrors of trench warfare. This is hauntingly similar to what is being reported by OEF/OIF troops who are exposed to blasts. These WW I medical officials noted the same dichotomy of “shell shock (wound)” an organic injury from blast force and “shell shock (sick)” for troops who had not been close to an explosion that exhibited similar symptoms (Alexander, 2010). Early medical officials were as confused with the differential diagnostic complexities of blast concussion (shell shock-wound) and PTSD (shell shock – sick) as they are now for the combat casualties of Afghanistan and Iraq. An important finding in

the Tanielian & Jaycox (2008) study was that blast exposed brains were structurally intact but injured by low levels of brain inflammation. Alexander (2010) quoted Colonel Geoffrey Ling, the director of the Tanielian & Jaycox (2008) study as saying that someone with a brain injury could look as if they had PTSD. The differentiation of PTSD “emotional” and BINT “commotional” puzzled WWI medical officials as much as military medical officials are puzzled today. In WW1 spinal fluid drawn from men who had been “blown up” revealed protein changes. Ling was quoted as saying that early medics were ahead of their time. He explained that your proteins, by and large, are immunoglobulins, which are basically inflammatory cells. Is blast concussion, an organic injury, being diagnosed as PTSD, an emotional injury, because it is cannot be diagnosed accurately due to the lack of research-based diagnostic criteria and clinical practice guidelines? Are organic injuries being treated as psychological injuries that may be leading to the epidemic of suicides and long term disability in the military today? Is prevention the only means left to treat these injuries until scientific research catches up with the occurrences of this blast concussion phenomenon?

Military TBI Case Management Quarterly (Fall 2010) reported that estimates including the 1st quarter of 2010 were that 178,876 cases of TBI of all severities have been diagnosed and nearly 80% were mild. If the Tanielian & Jaycox (2008) study’s estimates of more than 300,000 service members who have suffered blast-induced mTBI are correct then nearly half of these service members have yet to be diagnosed or identified. It is quickly becoming clear that our society cannot afford to ignore these

invisible wounds as more OEF/OIF veterans leave the military and the public health impact is felt by the American people.

“You cannot go back, you’ve changed and others have, too”.

The participants of this study were relieved and happy to return home alive post deployment. They described an “adjustment period” of a few months that was needed to transition back into mainstream U. S. life. Most of the participants admitted that they were no longer the same person who had left on deployment and that even their friends and families no longer really knew them. Some service members preferred being with their battle buddies and admitted missing that camaraderie because their battle buddies understood them.

The participants shared their difficulty in transitioning from a stressful, dangerous combat-related lifestyle to mainstream U.S. society. The study participants explained how they gradually became aware that the world did not stop at home as it did for them over the timeframe of their deployment and that everyone had changed including their friends and family which made re-integration even more challenging.

Stress was a notion that was expressed throughout this essential theme. The post deployment stress these service members described was not that of survival or the life threatening tension of combat but more emotional distress due to the emotional impact of changing gears to a different lifestyle and coping with their changed health and emotional state in the domains of relationships, work and the community. To understand the immensity of this transition, one must understand that any direct personal experience of an event involving actual or threatened death, serious injury or threat to one’s physical

integrity or of another person, unexpected or violent death, and serious harm of a close associate is a daily occurrence in a war zone over a period of months and even years. These experiences result in intense fear, helplessness or horror of the person experiencing it.

Killing another human being is an unnatural act in the civilian environment. However, in the military environment killing is viewed differently, it is a more natural act of survival and improves the possibility that the military mission will succeed. A good soldier's principles in a war zone are not acceptable or advantageous in mainstream society. These service members may have a kill count, may have been in a vehicle struck by a land mine, worn the blood of their friend or had a friend killed beside them. A high level of discipline is required to survive and complete their military mission. Endless and repetitive training occurs until reactions become second nature and automatic in certain situations. The enormity of the transition from the military lifestyle in a war zone to mainstream society in the U.S. requires education, health resources, time and an understanding of this environment by those who interact with them back in the U. S.

We know that many of the difficulties that service members suffer result in increased social isolation and diminished interest in getting outside the home and interacting with other people. To increase the chances that service members seek help once back home they and their families must be aware that they are not "crazy", they're simply experiencing the inevitable psychological and physical aftermaths of war. The service member, friends and family need to be able to normalize these symptoms. The attitude of health professionals that provide services to these service members and

veterans must include encouragement that they can recover and cope with these changes in a healthy manner with their assistance and appropriate resources.

Peer and family support was reported by participants as particularly helpful in transitioning from the battlefield. A recent study's key finding was that support from significant others specifically family and military peers related to lower PTSD symptoms and had a protective effect (Wilcox, 2010). Battle buddies, as was confirmed by this study's findings, share a particular kind of bond that acts as a bridge because of their common experience. A few participants voiced a yearning to return to battle because they missed the camaraderie after they returned home. The military is a culture wherein members are trained to take care of one another. Peer support, assistance provided by a person who shares commonalities with the target population, based on the notion that shared experiences, especially combat, bind individuals in ways that foster trust and credibility-camaraderie. Those two attributes, of course, are central to developing relationships in which individuals can open up and discuss their problems comfortably. Peer support, widely used in formal and informal programs, has been found to have a positive effect on individuals with other types of shared diseases, conditions, and situations (Wilcox, 2010).

Anger and anxiety-related behavior was described by most of the participants as a major change they noticed post-deployment. Study participant discussed self-medicating and using alcohol to "take the edge off" or to sleep. Most of the participants expressed great difficulty controlling their anger even without a prior history of lack of impulse

control. The veterans that were interviewed confirmed that anger and lack of anger control continued over the years. Insomnia was another key health-related subtheme. Participants told of only getting 3-4 hours of sleep at night and experiencing chronic fatigue upon their return from deployment.

Anger and insomnia are symptoms that overlap in blast concussion and PTS making a differential diagnosis difficult. However, sleep deprivation alone can also lead to irritability, lack of anger control and chronic fatigue. The overriding researcher observation was that few of the study's participants had sought care for these symptoms regardless of the etiology even though it was available with no out of pocket cost. A recent study confirmed that insomnia is the most frequent and most persistent symptom reported by service members immediately following deployment (McLay, Klam, & Volkert, 2010).

Interestingly, study participants confirmed that many behavioral changes were brought to their attention by their family and close friends and that they were not aware of or even noticed these changes. A blast concussion injury may cause impaired self-awareness due to an injury to the frontal lobe. This study helps to confirm the widely held assumption that family members and close friends are the first to notice subtle changes in service members' behavior and mood. A possibility of impaired self-awareness reinforces the need for families to be educated on blast concussion and PTS symptoms post deployment. Family education must also include a guide to resources that are available and how to use them should they observe these symptoms. Counseling for the family and couples is important and should be readily available post deployment to

deal with any issues that may arise. Part of the medical evaluation for blast concussion should include a history from a family member or close friend to ensure all of the symptoms and changes are gathered in case the service member suffers from impaired self-awareness. Health care professionals must also be aware that family members may start to observe those the initial signs and high-risk behaviors that the service member may not be cognizant of.

Emotional detachment, self-isolation and passivity were frequently expressed by the study participants even though the interview questions were more focused on the physical symptoms associated with blast concussion. Many of the participants described experiencing PTS symptoms. Service members shared that it was difficult for friends and family to adjust to these changes in their mood and behavior. They explained that they felt disconnected from their loved ones and withdrew within themselves for comfort. Personal accounts of family dynamics portrayed family members walking on egg shells and using avoidance to cope as they struggled to adjust to the new and different person who returned from deployment. Family focused re-integration education is a vital resource to successful transition of service members.

Several of the study participants reported work related problems and lack of patience with the rules and regulations. An awareness that they had matured from their experience emanated from the interviews. Several expressed a perception that many of the problems that the military is facing is now are due to leadership. This finding confirms the widely held assumption that leadership must change their attitudes and

beliefs before service members will step forward to access care for symptoms that interfere with their daily activities, quality of life and work performance.

“I’m twenty-three years old and I feel like I’m seventy-five”.

The general perception from the interviewees when asked about their perception of a healthy person was overwhelmingly someone with a balanced life who eats appropriately, exercises regularly, has social relationships and does not have a physical injury or disease. This perception of health, however, was not reflected in most their responses about their personal health experiences. The majority of respondents reported poor health post deployment. The respondents did not differentiate physical and mental health symptoms when responding about their health even though the researcher attempted to do so. Insomnia, fatigue, pain, anxiety and hyper-alertness were reported frequently. Memory lapses and slowed cognitive processing were also reported. A few of the participants reported “good” physical health but the majority of the respondents reported physical pain and suffering. The suffering caused by musculoskeletal pain limited their daily activities post deployment such as the inability to run, walk, bend over or work.

Unexpectedly, respiratory complaints such as asthma attacks, chronic coughing, and chest pain after running were frequently reported. Some of the respondents held cigarette smoking as responsible for these symptoms but others reported exposure to burn pits in Afghanistan and Iraq. These burn pits incinerate all of the organic and inorganic waste near the military bases that include plastics and other hazardous materials. Direct exposure to the fume from the burn pits on a daily basis is common. This might be an

emerging health problem for OEF/OIF veterans similar to Agent Orange and Gulf War Syndrome by those who are exposed to hazardous fumes while serving in Afghanistan and Iraq. This latent health risk has not reached public awareness to the extent that PTSD or even BINT has but may result in costly, long term health problems for OEF/OIF veterans.

Many of the health changes reported by this study's participants related to their continued automatic reactions to certain situations in the form of hyper vigilance and anger after deployment. These symptoms were normalized by recent research. A recent study of soldiers who were deployed to Afghanistan from 2008-2010 found that their brains adapted when they were continuously exposed to stress of long duration. The perceived threat appeared to be the major predictor of brain adaptation, rather than the actual events. The researchers of that study concluded that the effects on the brain are due to experiences in combat that affected the neural circuits in the brain that regulate vigilance and is involved in controlling emotion. This study found that the effect persisted for at least two months after the soldiers returned home. This study confirmed that the fear and vigilance centers in the brain increased for all soldiers on this mission. The study suggested that the emotional control center in the frontal lobe depended strongly on how they perceived threatening events during the mission. That study's implications included further research to determine if those that perceived high levels of stress are also at higher risk of developing symptoms of PTS (Van Wingen, Geuze, Vermetten, & Fernandez, 2011).

Garner's (2010) study of OEF/OIF soldiers normalized sleep disruptions and indicated that insomnia is the most common health issue for service members post deployment. The results of this sleep study of OEF/OIF service members reported that 86 percent of the participants had sleep disturbances upon return from deployment for up to 45 days even though the majority of them had no signs of PTSD or depression. These soldiers were at risk for sleep disturbances if they had a personal history of sleep problems, symptoms of physical illness or mild traumatic brain injury. The implication of this study was that disturbed sleep can be a symptom of existing medical conditions or a risk factor for the development of mental and physical health disorders. The researcher suggested that prompt treatment of sleep disturbances in soldiers returning from deployment might mitigate future physical and mental health problems.

The frequency with which sleep, anger and hyper vigilance were reported by participants of this study suggests that these symptoms should be expected as a normal consequence of the distress encountered to survive in combat conditions. Participants understood the standards for good health and therefore, could capability determine the status of their own health that was reported as predominantly negative. Their reported symptoms post deployment was consistent with current studies on OEF/OIF service members and veterans. The most common complaints involved sleep, pain, anxiety, hyper-alertness, detachment, anger, memory lapses, slowed cognitive processing and respiratory problems which are consistent with symptoms of mild BINT and PTS. These symptoms interfered with relationships, work, and the community. The participants' reported PTS symptoms even though the interview questions were focused on physical

disorders. Most of the symptoms were reported as time limited to about two months although a few respondents had persistent symptoms for years. These findings are consistent with current literature on blast concussion. Recent studies that imply that physical and behavioral symptoms may be physiological responses and that sleep disturbance may be a symptom of existing medical conditions suggests that refining the criteria used to diagnose and treat mild blast concussion and PTSD may help differentiate these two conditions. Studies are beginning to suggest that perhaps psychological symptoms may be over diagnosed in troops who have served in OEF/OIF due to the diagnostic criteria currently used and that these symptoms may be more physiological in nature and may resolve within a few months with only rest, education and non-pharmaceutical treatments for insomnia and pain.

The Hammer & Sauvé's (2011) study supports the notion that when PTSD & mild BINT co-occur an astute awareness of the distinctions between both diagnoses must be made by the clinician. The study goes on to say that when these two conditions are co-morbid; multiple medication interventions should be made to treat this complex symptom presentation. However, the study attests that the single most effective intervention in mild BINT or mild blast concussion is education and reassurance over time and not necessarily polypharmaceutical interventions. The study suggests that a multidisciplinary approach is required and consideration of the neurocognitive impact of prescribed medications and continuous observation for co-morbidities of depression and substance abuse is required. Dangerous adverse reactions of polypharmaceutical interventions may be putting the patient at unnecessary risk when rest and non-pharmaceutical alternative

methods to relieve stress, anxiety and pain can be considered to treat symptoms rather than polypharmacy. Alternative modalities such as acupuncture, yoga, therapeutic massage, neurofeedback and virtual reality may be more beneficial, less expensive and less risky for the patient who may most likely recover naturally from normal responses to prolonged stress if they are removed from the stressful environment and allowed to rest with only over-the-counter pharmaceuticals such as Tylenol and Benadryl as treatment for sleep and pain if needed.

“I just did it the hard way, pushed it through”.

Coping or tolerating as a health practice emerged as a predominant essential theme and it was closely linked to stigma, quality of care and access to care. As study participants told their stories, coping with or tolerating symptoms was immediately identified as a common health practice and a barrier to care for their personal pain and suffering. The stories also mirrored their health belief of not accessing health care for their ailments even when it adversely affected their lifestyle, daily activities or health. Coping has a proactive connotation but this health practice was interpreted by the researcher more as tolerating symptoms which has a more negative connotation. Both terms coping/tolerating were used as a sub-theme because participants actually used the term coping rather than the term tolerating. This use of these terms together follows hermeneutic phenomenological methodology more closely.

Coping/tolerating is also closely related to the warrior ethos and military stigma. For example, The *U.S. Soldier's Creed* is a standard that all United States Army personnel are encouraged to live by. All U.S. Army enlisted personnel are taught the

Soldier's Creed during basic training, and they recite the creed in public ceremonies at the conclusion of training. It contains 13 statements but those pertinent to this study are: (1) I am a Warrior and a member of a team; and (2) I am disciplined, physically and mentally tough, trained and proficient in my warrior tasks and drills. These values are similar throughout all of the military branches (U.S. Soldier's Creed, 2011). Based on U.S. military troops' training and core values, it is not difficult to understand a service member's reluctance to come forward to seek care for mental or physical disorders because they are viewed as a weakness. Coping or tolerating pain and suffering is actually an expectation in the military and this behavior is admired even when it is detrimental to an individual's health and well-being. These feelings and values persistent even in veterans several years post-deployment. Many service members just don't want the help and believe the ailment will heal on its own. The participants in this study rationalized that since the team is suffering with the same pain and suffering, it is not perceived as a priority. Alcohol abuse was alluded to as an accepted means of self-medication to help them cope. Confirmation of these findings are found in a recent study's key finding of 4,463 OEF/OIF veterans that implied that this population was experiencing more medical diseases but were neglecting their needed medical care by not utilizing it (Possemanto, Wade, Andersen, & Outmette, 2010).

Unfortunately, family members must also endure and cope with the suffering, pain and resulting behavior of their loved ones after deployment. Study participants expressed that family, friends, and medical professionals who have not deployed to OEF/OIF or served in the military do not understand what they have gone through and

are therefore unable to help them. This implies that individuals who have not served as part of the military and understand its culture, values and beliefs cannot relate to them or their experiences. Service members rely on information from their trusted battle buddies and frequently do not seek professional information on their medical conditions until a crisis level is reached either through the law enforcement system, an inability to perform their job or routine activities of daily living.

“I don’t want to be labeled”.

Military stigma was a key essential theme that permeated through all of the other essential themes. Stigma was found to drive health beliefs, health practices and created significant barriers to care. Stigma drove service members to avoid care for ailments, not comply with treatment, or to seek civilian health care for confidentiality.

Recruiting for this study was the first indication that stigma was a significant barrier. Recruiting was extremely difficult. It took nearly three months to recruit and retain the eleven study participants. Despite the difficulty in recruiting due to stigma, in the researcher’s clinical experience with this population, the study’s sample was a typical representation of the military population seen with mild BINT. About five participants expressed interest but two never showed for their interview and did not respond to a follow-up call. The other three initial participants were close associates of colleagues who served as a trusted liaison who knew the researcher well. This colleague explained the concerns of these potential participants. Their concerns included assurance of confidentiality and anonymity of their taped responses due to past negative experiences that resulted in harm to their military careers through reprisal and disciplinary action. To

assure the complete anonymity and confidentiality of each participant's response, the researcher emphasized that this study was not associated with the military in any way but a private university that included an incentive for their time and travel costs. The researcher emphasized that they could choose a pseudonym for the taped interview and that nothing in regard to their true identity would be audio taped. Initially, two active duty service members and a veteran agreed to participate in the study. Prior to the interview, aware of their apprehension about participation in the study, the researcher reiterated that this study was not sponsored or funded by the military or the government but by a private university. The researcher reviewed the consent form very carefully with each participant and emphasized that the consent was required to protect their rights. The researcher encouraged them to call her university advisor whose contact information was listed on the consent form, if they had any concerns about the researcher or the study. The researcher also emphasized that at any time they could stop the interview or not answer a question without any repercussions and would still receive the incentive. Pseudonyms of their own choosing were used during the audio taped interview. I explained that I was a registered nurse and was experienced with maintaining confidentiality. I also emphasized that the intent of the study was to gather personal stories about their health after deployment to help and to prevent injury to service members in the future.

These explanations and assurances appeared to allay their fears but the participants were still guarded in their responses during the interview and may account for shorter interviews than anticipated. After hearing their stories I understood their

justified concerns since the active duty service members were senior enlisted leaders of 17 and 20 years as well as a veteran who was a senior enlisted leader with over 24 years of military service who had either personally observed or experienced military stigma. The fourth participant, Brian, who was a junior enlisted service member with slightly over three years of active military service and had returned only a few months earlier from OEF actually responded to a mailed flyer via email. After much assurance, Brian agreed to meet the researcher in a community park. Brian and the researcher had an interview revealing many experiences that were difficult for him to describe that pertained to stigma. After Brian interviewed and felt assured that the interviews were confidential, he agreed to recruit others for the study when asked by the researcher.

The senior enlisted leaders shared openly that stigma was an issue in access to care for themselves and other service members. They acknowledged that many service members do not get help even though they know that they need it because the service member does not want to get diagnosed with PTS because, “They kick Marines out for it medically” or because they are “...not going to talk about it.” Other participants shared their personal experiences of verbal and emotional abuse by their leaders due to stigma or abuse of their battle buddies that they had observed.

Later participants who had recently returned from OEF/OIF shared their outrage at their leadership for this type of abuse but felt powerless to do anything about it. Participants explained that leadership would make going to medical appointments difficult. Many shared that they decided not to get mental health treatment because they did not want people to know and feared they would have to stay on active duty longer to

get that treatment and they just wanted to be discharged as soon as possible. Participants shared that they were ridiculed and punished for seeking health care. Chief, a senior enlisted veteran, admitted that he did not seek health care until he retired due to stigma and this interview was held five years after he last deployed.

A recent study of OEF/OIF veterans cited a possible reason for service members waiting until leaving the military to access health care. The study (Copeland, et al., in press) reported that a significant percentage of physical injury patients who went to the Veterans Health Administration (VA) for care also sought mental health care. The study indicated that perhaps there may be less stigma surrounding mental health care at the VA compared to DoD facilities.

Brian admitted that he took himself off his anti-depressants because, “the military really frowned upon it, and they gave me a lot of crap...I got a lot of...negative input from that. There’s problems of leadership...”

An often-shared, prevalent subtheme from the study’s participants was the sense of not belonging and a subsequent feeling that one was a burden to the team if they received medical care because they could not do their job. A study participant shared, “...they put me in the office pushing papers.” This participant shared that he would have preferred civilian care but the process was too arduous. Respondents implied that leaders lowered standards or expectations of those with medical conditions, decreasing team cohesion and alienated those with medical conditions by emphasizing their deficiencies to the team. An inclusive, shared team experience in overcoming adversity such as a physical or mental condition is more likely to return troops to duty than ridicule

or isolation and to build esprit de corps that improves unit cohesion and readiness. This sense of isolation and alienation resulting from stigma associated with seeking health care for symptoms and the predominant use of coping/tolerating as a health practice may be one root cause for the suicide epidemic currently among OEF/OIF troops. A recent report stated that suicides in the U.S. Army rose from 85 in 2005 to 140 in 2009. The report found that substance abuse and prescription-drug abuse was increasingly a contributing factor (Youssef, 2009).

“They share a lot of the information you shared with them”.

Lack of confidentiality of personal health information (PHI) in the military was related to stigma and fears of either being alienated by peers or threats to their military careers. It was identified as a barrier to care in the military and drove service members to more confidential community sources of health care for their ailments. The military allows their executive non-medical leadership access to PHI. Greg, a senior enlisted leader with twenty years of active service used and advocated the use of *Military OneSource*, a web-based 24/7 referral and counseling site for each specific branch of service that provides 100% confidentiality of their clients without notifying their military chain of command. This organization is concerning to military leaders and military clinicians because of their need for access to PHI for military readiness, medication reconciliation and treatment plans. Participants’ described their experiences when “counseling on base make things worse...where they share a lot of the information you shared with them to your superiors.” Participants perceived leadership as a barrier to care by not allowing service members to go to their medical appointments without revealing

their PHI in detail.

The U.S. Army pilot program for self-referral for confidential alcohol treatment has been underway since 2009. The program allows soldiers to self-refer into and seek treatment without notifying their chain of command to prevent harm to their military career. Special hours, off- duty and weekend access, have been set up to head off this confidentiality problem. The caveat of this program is that certain military occupational specialties will continue be reported to their superiors due to Army regulations but will service members will benefit from career protections offered by the program (Lopez, 2009). This program implies that the Army is aware that military stigma and confidentiality of service members' PHI is a key element to discouraging service members with medical conditions to access military healthcare for their conditions. However, this program may not go far enough since their superiors will still be notified in certain instances, understandably so for safety and security reasons. This study's participants wanted complete confidentiality and were willing to use resources such as *Military OneSource* to ensure complete confidentiality of their PHI or they avoided care until a crisis level was reached. Given the unabated rise in suicides in the Army even with a massive push toward prevention and identification of at-risk individuals (Youssef, 2009) programs with complete confidentiality and without DoD affiliation may need to be explored by the different service branches. A confidential, self-referral program may prevent suicide, homicide, domestic violence or military accidents arising from a service member's inability to safely perform their job due to an untreated medical or mental health condition caused by not seeking treatment due to lack of confidentiality of their

PHI.

“They weren’t listening to me”.

This study’s participants’ perceived poor quality of care from experiences with prescription drug abuse, delayed care, inability to get timely appointments or diagnostic tests, the non-caring attitudes of their clinicians and other medical personnel and their perceived lack of understanding about or knowledge of military culture. These perceptions led to non-adherence to treatment, coping/tolerating as their primary health practice or drove them to civilian health care providers. A belief that civilian health care provided better quality of care was implied by many participants’ stories as they described their experiences in both the military and veterans healthcare systems.

Veteran Health Administration (VA) officials admitted in a recent report that they lacked the resources and ability to treat the new wave of disabled OEF/OIF veterans in addition to those from Vietnam, Korea, and World War II that are now overwhelming the VA healthcare system. Veterans’ care is not standardized throughout the country and resources differ based on geographic location and the concentration of disabled veterans in specific regions of the country especially mental health professionals in the western and rural states with a disproportionate share of the troops from the wars in Iraq and Afghanistan. This leads to long waits for appointments in the VA network only 39 percent of veterans are able to get an appointment within thirty days. Once in the door the veterans’ clinician visits are from 20-80 minutes and that varies by geographic location and resources. Nationwide, 21 percent of veterans get their mental health care outside the VA’s mental health system (Adams, 2007).

If the VA, indeed, lacks the stigma associated with seeking mental health care that the DoD health system possesses, it is understandable that service members wait until they are discharged or retired to access mental health care resulting in pressure from the increased patient load and the accompanying process issues. Obviously, veterans' healthcare systems require a comprehensive review and innovation evidence-based solutions to these process issues need to be developed or implemented. Participants in this study confirmed the findings of this report by sharing that they waited until their retirement to seek mental health and medical care for their post deployment symptoms due to stigma.

Patients, nurses, and qualitative researchers have long understood the power of telling and listening to personal narratives from their patients. Whether among patients in peer support groups or between health care professionals and their patients in any setting or even between health care professionals during consultations, stories are an essential part of how we communicate, interpret experiences and incorporate new information into our lives. Despite the ubiquitousness of storytelling among all disciplines within the health care field, research on its effects in the clinical setting has remained relatively thin. While important, a vast majority of studies have been anecdotal, offering up neither data nor statistics but rather stories to back up the authors' claims of its effectiveness in treatment.

A randomized trial examining the effects of storytelling on patients with high blood pressure reported that at least for one group of patients, listening to personal narratives helped control high blood pressure as effectively as the addition of more

medications (Houston, et al., 2011). While more research still needs to be done, the possibilities for integrating storytelling and listening into clinical practice are numerous. Currently on military websites, videos are accessible for health professionals and patients of service members recounting their own experiences with the same disease or injury

Storytelling can counteract the initial denial that can arise when a patient learns of a new diagnosis or is asked to change deeply ingrained behaviors. Patients may react to this news by thinking, “This is not directly related to me,” or “My experience is different.” Stories help break down that denial by engaging the listener, often through some degree of identification with the storyteller or one of the characters. Encouraging health professionals’ to listen to their patients’ stories about their health and symptoms may provide information that will help health professionals determine the appropriate treatment for their patients and promote adherence to that treatment.

In health care, storytelling may have its greatest impact on patients who distrust the medical system or who have difficulty understanding or acting on health information because they may find personal narratives easier to digest. Stories may also help those patients who struggle with more “silent” diseases. In these cases, stories can help patients realize the importance of addressing a disease that has few obvious or immediate symptoms such as BINT. Telling and listening to stories is the way we make sense of our lives. That natural tendency may have the potential to alter behavior and improve health. The magic of stories lies in the relatedness they foster. Storytelling is human. We learn through stories, and we use them to make sense of our lives. It’s a natural extension to

think that we could use stories to improve our patients' health by listening to them as part of their treatment.

Listening is the key skill that health care providers and especially nurses must foster in practice and research to find innovative solutions to current health issues. Results of this study suggest the efficacy of taking the time to ask a patient to tell you whatever he thinks you should know about his health situation and listening empathically for both the content and temporal course of his story. Listening so that the patient can tell their story will reveal many aspects of their lived experience that impacts their health and demonstrates caring and understanding on the part of the health professional which in itself can be healing.

“It was truly impossible to get in there and get an appointment”.

This study's participants' verbalized stories of lack of access to health care in both the military and veterans healthcare systems. These process and systematic inefficiencies became barriers to care that adversely affected their health and health practices. The perceived lack of access to care negatively influenced their perception of the quality care that they received in these organizations.

Service members with small health units attached to their commands have limited resources and limited access to medical personnel. Corpsmen or medics serve as gatekeepers to the hospital or larger clinics with more resources and higher level providers but the process for visits to medical providers is frustrating and difficult and at times delayed. Service members described their frustration with that system during the interviews. A recent study of military personnel recommended that medical gatekeeper

training should be evaluated since the uniformed services rely heavily on gatekeepers (Ramchand, Acosta, Burns, Jaycox, & Pernin, 2011). As far as blast concussion and its most common co-morbidity PTSD is concerned, special standardized training for the gatekeepers on presenting symptoms, management and triage is critical to prevent delay in their identification, diagnosis and treatment.

Veterans in this study voiced their experiences about delays, lack of follow-up and lack of communication with the healthcare system. This extreme frustration combined with their PTSD and persistent blast-induced concussion symptoms were at times overwhelming for them. Their stories revealed that several processes such as intake and coordination of outpatient care were frequently ineffective. Key findings from a recent study of military veterans were that PTSD, depression, and substance use disorders were associated with increase medical disease burden and mental health care utilization, but not increased general medical health care utilization. This study of 4,463 OEF/OIF veterans implied that this population is experiencing more medical diseases but are under utilizing medical care that they needed (Possemanto, Wade, Andersen, & Outmette, 2010). This study reinforces the importance of a more efficient intake process and coordination of care for these at-risk veterans.

Service members expressed dismay over processes such as referrals, getting past the gatekeepers despite their pain and suffering and long waits for care in the DoD system. Respondents shared that this lack of access became a barrier to care and resulted in them coping with or tolerating their pain and suffering even when it negatively affected their work performance and quality of life. Participants shared their view that

civilian networks would better satisfy their needs because military and VA systems are overwhelmed. Perhaps the systems are not only overwhelmed by large patient volume but also have process inefficiencies in place. Two of the study's participants' did not perceive any barriers to care and basically explained that once you get into the system, the quality of care provided by the military and VA health system is high. A study to review intake processes, care coordination and the training and effectiveness of gatekeepers and providers would be helpful for both the military and veteran healthcare systems. Delayed treatment of invisible injuries such as BINT can lead to more costly, long term consequences.

The plight of the OEF/OIF service member is not just a military problem but part of a public health problem that Americans still have not woken up to. The costs to the country when police are called in for domestic violence, suicide, homicide, child abuse as well as the high suicide is beginning to become apparent. Americans are slow to acknowledge this is as an emerging public health issue and the country will pay dearly in the long run. The veterans of OIF/OEF are beginning to experience the war at home when they leave the military and the public health implications are already emerging in the form of homelessness, substance abuse, high unemployment rates, suicide and criminality of veterans and the high public costs associated with these societal public health problems.

Reminiscent of Vietnam veterans, homelessness is emerging as a consequence of military service in OEF/OIF among veterans. Homeless shelters are now seeing OEF/OIF era veterans both men and women. A homeless veteran report to Congress by

the Department of Housing and Urban Development and the Department of Veterans Affairs (2009) stated that more than 3,000 cities and counties reported 75,609 homeless veterans on a single night in January of 2009. The report went on to say that 57 percent were staying in an emergency shelter or transitional housing program while the remaining 43 percent were unsheltered. The VA reported that OEF/OIF veterans represented approximately 12 percent of all homeless persons counted nationwide during 2009 and also suffered from drug, alcohol and mental health problems.

The Bureau of Labor Statistics reported that the 2010 unemployment rate for veterans of our wars in Iraq and Afghanistan was 11.7 percent, nearly four points higher than it had been for those veterans in 2009 and higher than that of the civilian sector at 9% (U.S Department of Labor Bureau of Labor Statistics, 2010).

The Ramchand et al. (2011) study reported that suicides are increasing across the U.S. Department of Defense and in 2008 the U.S. Marine Corps and the U. S. army had the highest rates (19.5 and 18.5 respectively). The suicide rate across DoD has climbed from 10.3 in 2001 to 15.8 in 2008 representing a 50 percent increase. This same study indicated that public cost has been estimated as high as \$6.2 billion in the two years following deployment, in medical care, lost productivity and suicide.

Additionally, this same study reported that there were 146 active duty deaths related to high risk behavior including 74 drug overdoses. The report stated that 1,713 known attempted suicides had occurred in the same period. The report indicated that high risk behavior such as suicide attempts, illicit drug use, binge drinking, and criminal activity was a factor in most of these deaths. The report asserted that a direct link was

found between suicides and increased life stressors and increased high risk behavior that resulted in a sense of isolation, hopelessness and life fatigue.

Neither the military nor the VA contacts service members after discharge to ask how they are doing. Only a crisis situation with law enforcement may make a veteran realize that they have a problem after they leave military service. An inability to sustain meaningful relationships and controlling rage increase chances that service members and veterans will find themselves in the criminal justice system. Veteran's courts are now being created for the large number of OIF/OEF veterans nationwide being caught up in the criminal justice system. Due to the high likelihood that these veterans' crimes may be related to untreated PTSD and TBI, veteran's courts are intended to provide treatment instead of jail for veterans who suffer these invisible wounds. Veterans in pain, reliving their trauma, may fall back on the reactions that kept them alive in a combat situation cause them to run into trouble with the law (Gulley, 2011).

These societal public health issues are only beginning to emerge and as more service members are discharged with untreated BINT or PTSD, the costs in human and financial terms will only grow. Is the American public ready for the long term consequences and costs of these wars as they begin to touch each American's life? Is the American public and community health care professionals too disengaged from these military health problems, as this study's participants believe, because it has not touched their lives yet?

Critique of the Study

The essence of this study was to reveal the meaning of the lived experience of male U. S. troops while deployed in support of OEF/OIF after blast exposure to determine the health perceptions of this population and their health status and practices after they returned home. This study uncovered many significant challenges involved in preserving the psychological and physical health of service members in a war-fighting environment. The service members and veterans revealed their struggles in performing their war-fighting duties and reintegrating back from an aberrant war environment to routine life back in the U. S. Most of these participants were not diagnosed with blast concussion but described symptoms that indicated that they should have been medically evaluated for this injury. Their war-fighting experience was overwhelmingly depicted as not merely a single event in their lives but, rather a catalyst for major and ongoing life changes. This study described their horrific and terrifying lived experiences, their feelings and responses while in support of the wars in Afghanistan and Iraq. The participants' lives were threaded with pain and suffering, uncertainty and the constant fear of death and injury. These men revealed their moments of suffering as they lived daily in an uncertain present under grueling conditions without even the most basic necessities and looked toward the future with uncertainty.

The dichotomy of blast-induced concussion and post traumatic stress symptoms are not a new phenomena but merely a new emergence of these old disorders that date back to WWI. Little more is known about diagnosing and treating blast concussion or distinguishing between blast concussion and PTSD, its most common co-morbidity when overlapping symptoms occur than was known nearly 100 years ago. Even in WWI, they

knew that inflammation of the brain and surrounding tissue was involved and deduced may be responsible for many of the overlapping symptoms of both PTSD and blast concussion. New research is now suggesting and confirming what was known in WWI and provides insight into the need for more definitive diagnostic criteria for both conditions.

Military stigma is frequently cited as a source of stress experienced by injured service members and a barrier to accessing healthcare until symptoms are severe enough to affect quality of life and the ability to function at work, home and in the community. This study confirmed that military stigma was indeed a significant barrier to care and profoundly adversely affected service members' health. This hermeneutic phenomenological study provided narrative that provided an understanding of military service members' perceptions of illness and health and their health practices within the military context after combat-related blast exposure. Unexpected knowledge emerged from individuals as they described their perceptions and lived experience and uncovered that respiratory health problems due to exposure to burn pits may also be a growing health concern. The results of this study contributed to the understanding of the dynamics and coping that result when loved ones return home from deployment. The study brought to the foreground how these men shared this experience with loved ones and how friends and family members lived with silencing, suffering and coping. The moments of pain and suffering experienced by these war fighters were also revealed. This study was unique in that it used a hermeneutic methodology to uncover meaning in the lives of the men, their families and loved ones who live with the consequences of

exposure to blasts in a war zone. Because of the method used, a deeper understanding of the experience emerged that otherwise might have remained hidden. This study supported previous and new studies that likewise indicated that service members experience long term distress, but provided a context and depth to the understanding of the causes for the enduring nature of these men's distress. Through the phenomenological methodology, the men's personal meanings were uncovered rather than numerically reporting an attempt to measure coping/tolerating, pain and suffering and quality of life.

The study is limited by the recruitment location from the geographical area of Southern California and by only two branches of the uniformed services being represented. Following the tradition of phenomenology, only a small segment of service members and veterans were interviewed, therefore only certain voices were heard. Including more diverse participants from all branches of the uniformed services would have enhanced the study and would be recommended for future work.

Also consistent with phenomenology, the analysis of the text and emerging themes reflected only one interpretation of the text rather than representing all possible interpretations. Thus, caution is advisable when transferring findings to other populations. The reader must assume responsibility for coming to his or her own understanding of the phenomenon studied and then decide upon its applicability.

Implications

Research.

The current study examined the experiences of a small group of U.S. military service members and veterans who had been exposed to blasts while deployed in support of the wars in Afghanistan and Iraq. While the investigation led to insights about what the experience was like for them, it also raised a number of questions. These questions form a basis for potential future research investigations.

This study explored this experience from one perspective, the male service member or veteran serving in the U.S. military. Further research on the meaning of the experience for other individuals would add depth to the knowledge and understanding of the phenomenon. A similar phenomenological study of female U. S. troops would provide useful information in determining whether the findings would be similar to those of this study. It would be important to learn whether men and women exposed to blasts in combat settings represented a specific type of response or rather, was gender specific.

Further investigation of various ethnic cultural backgrounds and military service branches, in order to determine whether the themes in this study reflected only certain ethnic groups and military branches would help clarify the meaning of behaviors and emotions, both of the people experiencing them and those who support them, both professionally and personally. Furthermore, a grounded theory model could assist in the development of a health - illness continuum model that could address the issues of an individual who recovers spontaneously and those who have persistent symptoms.

Research using quantitative methods is necessary. Current instruments that measure suffering and quality of life may need to be developed or adapted to this military

population. Instrument development and testing that captures the military experience would be a future step in moving research on this topic forward.

Further inquiry and refinement is necessary on the diagnostic criteria and testing for both mild BINT and PTSD especially when they are co-morbid. Determining what interventions are supportive and effective and understanding these factors could lead to more focused interventions for those who work with this population. After development of these interventions founded on reported experiences, longitudinal studies could be conducted in which the well-being of participants is compared to well being of a control group who did not receive these interventions. An additional investigation into whether men or women have more positive outcomes would be useful for treatment.

Further exploring disturbed sleep as a symptom of existing medical conditions or a risk factor for the development of mental and physical health disorders might result in more definitive diagnostic criteria for blast-induced concussion so that prompt treatment of sleep disturbances in troops returning from deployment might mitigate future physical and mental health problems.

The current military health care model for BINT is focused on illness and symptoms treated with pharmaceuticals in a military context. Neither family concerns nor wellness issues are emphasized in this model. In order to more effectively treat this injury, as well as address the many related issues for these individual and for the community, an important element in any healthcare policy needs to an openness for changes in clinical treatment modalities.

Perhaps, advance practice nurse managed centers for alternative modalities could become a model for care for this population as a first alternative to treat stress, anxiety, insomnia and pain. Studies on control and intervention groups for these treatment modalities would be insightful. The notion expressed by the study's participants that intervention by a peer or care provided by a clinician knowledgeable of the military culture as necessary to help them heal could be explored.

Significantly improving the sensitization and knowledge of professionals to the differences of the needs of persons who have a military background is a priority for future research. Continued work in this area can increase the body of nursing knowledge and enhance the quality, scope, and depth of nursing care provided to these individuals regardless of the setting: the military or the community at large.

Praxis

The meaning of what it is like for men to live with blast-induced concussion was revealed in this study and has ramifications for praxis. Praxis is the practical application of knowledge or a professional skill; it is the coming together of theory and practice (Rolfe, 1993). With the understanding of an experience comes the potential for greater empathy. The dissemination of the findings of this study can enable nurses to understand the experience of these participants so that hopefully they become more able to appropriately assist other individuals with similar issues across all healthcare settings. Enhanced insight can lead to improved practice through more sensitive interactions with service members, veterans and their families to allow a more focused assessment of their needs. Individuals coping with the aftermath of the war experience and blast exposure

need to make sense of their life-threatening experiences within a framework that is relevant to, and influenced by, their own experiences.

An increased understanding and awareness of military stigma and military culture as well as more effective service member and family education could influence development of more effective systems and structures for their support and health care. The results of the study suggests a need to reconsider the military model of care so that a service member is permitted to anonymously self-referral himself to community based-care that is not part of military installations so that the confidentiality of PHI is maintained. The military could also review the need for non-medical military personnel to have access to a service member's PHI. The participants in this study who did seek anonymous, community-based care acknowledged that it exists and related how they advised their fellow service members to self-refer to these resources to escape the stigma attached to illness and injury in the military. Research-based programs that will change the paradigm of military stigma and the perception that injury or illness is a weakness should be developed for leadership at all levels. Peer-led interventions and care provided by health professionals who share the language and experiences of those in the military step is recommended.

Restructuring post-deployment health service processes may help circumvent the stigma attached to illness and injury. A mandatory comprehensive physical examination in addition to post deployment health risk screening for all service members completed either prior to their return or immediately upon their return from deployment may help identify service members with blast-induced concussion and psychological symptoms

that require further evaluation. These physical are warranted not only as a screening mechanism but due to the hazardous working conditions service members work under while deployed.

Education about re-integration and prior to a service member's return that currently exists should be expanded to add families and other loved ones. This group lacks representation so only a few of these service members and veterans are truly ever heard or listened to. The researcher learned that their stories were soulful and deep, and they were worthy of truly being heard. The rich, contextual descriptions presented by the participants' bridge research and practice. A nurse-led or interdisciplinary support and skills building program as part of their treatment plan would offer participants the opportunity to share their own experiences to better understand the experience and possibly learn new skills that would enable them to more successfully navigate their way through their illness, reintegration and recovery.

Initiatives for sensitizing health care providers are necessary to challenge the historical perception of military stigma and its association with the warrior ethos. It is imperative to uncover and to challenge the existing negative consequences that these labels cause. Further, it is essential to challenge the long held judgmental view in military healthcare that a service member is malingering when seeking health care.

A final implication for practice is a simple reminder about the power of listening. A number of participants brought this issue clearly to light when they expressed very directly, "They weren't listening to me". It is at the foundation of authentic communication. If we are sincerely interested in our patients, and others with whom we

talk, we will offer them the opportunity to say what they want to say. People have stories to tell. If we, as nurses, are genuinely present with people, we cannot afford to miss drawing out these stories. Telling one's story and having it genuinely heard is a powerful, as well as an empowering experience, as was repeatedly demonstrated in the study. At present, the lived experiences of service members who have served supporting OEF/OIF is generally under-acknowledged and in many ways, invisible since these experiences occur to only about 1-2% of the U.S. population. If these men's stories are encouraged in practice then clinical interventions and support are more likely to be accepted. It is imperative for nurses to recognize that the men in these situations frequently experience moments of great suffering when they live with their memories and persistent symptoms that they feel they must endure rather than treat.

Epilogue

The findings of this study uncovered common meanings embedded in the lived experience of men who revealed the nature of their everyday lives. This story that was shared with the researcher by a colleague who observed this incident in a military hospital and may offer deeper meaning of the findings of this study for the reader:

A young military service member brought his 9 year old son into the emergency room of a military hospital for care. He was not in uniform and had his dog with him. The young military service member had visible scars on his head and face. The nurse at the reception area told the young military service member immediately to take the dog outside because, 'This is a hospital and dogs are not permitted here.' The young service member explained, 'I need my dog.' The nurse insisted, 'Take the dog to your car or I will call security and have the dog removed from here.' The nurse had not even asked why the young service member had come to the emergency room. He became angry and told her again that he would not take his dog to his car because he needed his dog. The nurse called security and the service member became combative with them, when his 9 year old son intervened and said, 'Don't hurt my dad. He is really nice and he

loves us. He needs his dog. He came back from the war really messed up. He needs his dog. He is a special dog. He makes my dad feel not afraid.' At that point, one of the military security guards asked, 'Is your dog a service dog?' The service member said, 'Yes, but I couldn't remember what kind of dog he was called and I forgot his jacket.' At that point, the security guard let go of him and said to the nurse, 'Service dogs are allowed in the hospital. Go ahead and take care of them.' They were quickly registered, treated and discharged.

Many service members and veterans use service dogs to help with PTSD to overcome their fear of entering certain places and to feel safe. Why did this service member and his child have this experience from a nurse in a military hospital while seeking care? Unfortunately, this event could have happened at in any hospital or any health care setting.

This author's hope is that the findings of this study may provide nurses who know nothing about the military or the war experience, an understanding and awareness that supporting the troops means more than waving the flag when they come home. Supporting the troops means providing help when they need it most and to be their advocate using nursing practice, education and research, because the nursing profession will touch their lives in every setting over the next century.

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Appendix A
Recruitment Flyer

Are you a service member or veteran who deployed to OEF/OIF in the last 5 years & felt a blast wave ?

- A nurse-researcher student from the University of San Diego wants to hear about your post-deployment experiences and opinions.
- A short **CONFIDENTIAL** interview & completing a short questionnaire is all that is needed to participate.

\$75 for participation and travel expenses

INTERESTED?

Want to hear more about the study?

Call or Text: 619-857-0112

OR

Email: usdresearch@cox.net

Appendix B
Demographic Data Sheet

Demographic Data

Please circle the correct answer.

Research ID Code: (To be completed by researcher):

Age	17-19 years	20-22 years	23-25 years	26-29 years	30+ years
Service	USMC	USN	USA	USAF	USCG
Rank	E1-E3	E4-E6	E7-E9	O1-O4	O5-O6
Years of service	1-2 years	3-4 years	5-8 years	9-12 years	13+ years
Military Status	Active Duty	Reservist	Discharged	Retired	
Education	GED	HS Diploma	Some college	Undergraduate College Degree	Graduate College Degree
Ethnicity	White (Non- Hispanic)	Black (Non- Hispanic)	Hispanic	Asian	Pacific Islander
Marital Status	Single- never married	Married	Legally separated	Divorced	Widowed
Ever felt a blast wave while deployed to OIF/OEF?	Yes	No			
Time since first blast exposure	1 year	2 years	3 years	4 years	5 years

Appendix C

General Statements/ Interview Question Guide

GENERAL STATEMENTS/INTERVIEW QUESTION GUIDE

1. Talk to me about what it was like for you when you returned from your deployment to Afghanistan or Iraq?
 - a. Who did you come home to?
 - b. What went well?
 - c. What didn't go well?
 - d. Was there anything you didn't expect about coming home?
2. What was your health like when you returned from your deployment to Afghanistan or Iraq?
 - a. How did you feel physically?
 - b. How did you feel emotionally?
 - c. Are there any problems with your health?
 - d. How is your health different than before you were deployed?
3. Tell me a story that demonstrates what it was like for you to get medical care for any health problems or concerns that you had after your deployment to Afghanistan or Iraq?
4. Is there anything else you want to add?
 - a. What stands out for you about what you've gone through since you returned?
 - b. What would you recommend to anyone deploying to Afghanistan or Iraq?
 - c. What would you recommend to anyone returning from deployment to Afghanistan or Iraq?

Appendix D

Research Participant Consent Form

Appendix D
University of San Diego

Institutional Review Board
Research Participant Consent Form

For the research study entitled:

The Lived Experience of U. S. Military Troops after Combat-Related Blast Exposure

I. Purpose of the research study

Shirley Jett is a doctoral student in the School of Nursing at the University of San Diego. You are invited to participate in a research study she is conducting. The purpose of this research study is to explore the experiences and perceptions of U. S. military service members and veterans who deployed to Operations Enduring Freedom (OEF) and/or Iraqi Freedom (OIF) within the last 5 years and who were exposed to one or more blasts.

II. What you will be asked to do

If you decide to be in this study, you will be asked to complete a survey with 10 questions and one interview that asks questions about what it was like for you after returning home after your blast exposure during your OEF and/or OIF deployment. The survey will include some questions about you, such as your age, military branch of service, rank, years of service, military status, ethnicity, education, marital status, and how long it has been since you were exposed to a blast. You will be audio taped during the interview.

Your participation in this study will take a total of about 90 minutes.

III. Foreseeable risks or discomforts

Sometimes when people are asked to talk about their deployments, they feel sad or anxious. If you would like to talk to someone about your feelings, you can contact the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury 24/7 Outreach Center at www.dcoe.health.mil or 1-866-966-1020 and/or the San Diego Mental Health Hotline at 1-800-479-3339.

Remember, you can stop the interview at any time you feel tired or for any other reason and reschedule at another time or not at all.

IV. Benefits

While there may be no direct benefit to you from participating in this study, the indirect benefit of participating will be knowing that you helped researchers better understand what it's like to be exposed to a blast during OEF/OIF.

V. Confidentiality

Any information provided and/or identifying records will remain confidential and kept in a locked file and/or password-protected computer file in the researcher's office for a minimum of five years. All data collected from you will be coded with a number or pseudonym (fake name). Your real name will not be used. The results of this research project may be made public and information quoted in professional journals and meetings, but information from this study will only be reported as a group, and not individually.

VI. Compensation

If you participate in the study, the researcher will give you a \$50 Visa card personally. You will receive this compensation even if you decide not to complete the entire interview session. If you would prefer to meet somewhere besides your home for this interview, the researcher will reimburse you up to \$25 for travel expenses. This reimbursement will be in the form of a Visa cash card and will be given to you personally by the researcher at the interview.

VII. Voluntary Nature of this Research

Participation in this study is entirely voluntary. You do not have to do this, and you can refuse to answer any question or quit at any time. Deciding not to participate or not answering any of the questions will have no effect on any benefits you're entitled to, like your health care, your military status, or employment. **You can withdraw from this study at any time without penalty.**

VIII. Contact Information

If you have any questions about this research, you may contact either:

1) Shirley Jett RN

Email: sjett-11@sandiego.edu

Phone: 619-857-0112

2) Dr. Jane Georges, Associate Professor, Univ. of San Diego

Email: jgeorges@sandiego.edu

Phone: (619) 260-4566

I have read and understand this form, and consent to the research it describes to me. I have received a copy of this consent form for my records.

Signature of Participant

Date

Name of Participant (**Printed**)

Signature of Investigator

Date

Appendix F

Transcriber's Pledge of Confidentiality Form

APPENDIX F

Transcriber's Pledge of Confidentiality

I will be participating in the dissertation research project entitled:

The Lived Experience of U. S. Military Troops after Combat-Related Blast

Exposure

I will be transcribing audio-recorded interviews into text. I will not know the names of the informants, but if I should recognize information that enables me to identify any of the participants I agree to maintain their confidentiality. By signing this agreement I pledge to keep all information strictly confidential. I will not discuss the information I transcribe with any person for any reason. I understand that to violate this agreement would constitute a serious and unethical infringement on the informant's right to privacy.

Signature of Transcriptionist

Date

Signature of Principle Investigator

Date