PHENOMENOLOGICAL STUDY OF HOW STUDENT SERVICE MEMBERS AND VETERANS WITH MENTAL HEALTH DISORDERS DESCRIBE THEIR ACADEMIC EXPERIENCE IN HIGHER EDUCATION

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Abstract

The purpose of this transcendental phenomenological study was to describe the essence of the experiences of 13 student service members and veterans (SSM/V) with a mental health disorder (MHD) living in California. For this study, SSM/V is defined as active service members currently enrolled in higher education, both online and traditional, with a *DSM 5* Veteran Affairs (VA) disability rating. The person-centered and existential (PC/E) theories were the two theories that guided this study. Data collection occurred through in-depth interviews, focus groups, and writing prompts. The study sought to answer the central research question (CQ): How do SSM/V with a MHD living in California describe their higher educational experience? A transcendental phenomenological analysis was drawn upon to reveal four significant themes. The four themes in the study included: Strong Support Networks Were Important for Overcoming the Challenges of Higher Education, Anxiety and Depressive Disorders are Perceived as Having the Highest Prevalence, MHD Symptoms Can Hurt Academic Performance, and Academic Challenges Can Increase MHD Symptoms, and Support Services Tailored for a Military Population Are Needed But Lacking. In addition to the study findings, limitations, implications for stakeholders, and recommendations for future research are presented.

Keywords: student service members and veterans, mental health disorder, support services, VA mental health disability rating, higher education, academic success, relationships

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Dedication

First, I dedicate this dissertation to my wife, Stephanie, who has been a constant source of support and encouragement during graduate school and life's challenges. I am fortunate to have you in my life. This work is also dedicated to my children, Abigail and Cayden. I could not love you both more. I dedicate to Eric, Mandy, Kai, and Lilly, thank you for the honor of allowing me to be your brother and uncle. To my friend Daniel, we started and went through this journey together. I could not ask for a dearer friend and battle buddy. Finally, I dedicate this to my parents and grandparents, Tom, Shelley, Ivan, and Shirley, who have always loved me unconditionally and whose examples I aspire to become.

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List of Abbreviations

Attention Deficit Hyperactivity Disorder (ADHD)

Behavioral Health Officer (BHO)

Department of Defense (DoD)

Department of Veterans Affairs (VA)

Defense and Veterans Brain Injury Center (DVBIC)

Diagnostic and Statistical Manual of Mental Disorders (DSM 5)

Institutional Review Board (IRB)

Licensed Clinical Social Worker (LCSW)

Mental Health Disorder (MHD)

National Cemetery Administration (NCA)

Obsessive-Compulsive Disorder (OCD)

Person-Centered (PC)

Person-Centered and Existential Theory (PC/E)

Posttraumatic Stress Disorder (PTSD)

Student Service Members and Veterans (SSM/V)

Traumatic Brain Injury (TBI)

Veterans Benefits Administration (VBA)

Veterans' Health Administration (VHA)

CHAPTER ONE: INTRODUCTION

Overview

This chapter outlines a qualitative research study describing the experience of current student service members and veterans (SSM/V) in higher education with a Veteran Affairs' (VA) mental health disorder (MHD) rating. At present, SSM/V is one of the largest growing populations enrolling in higher education (Barr, 2019). Given the growing numbers of SSM/V in higher education, it is vital to better under their experience. First, a brief background of the SSM/V challenges in higher education will be presented, followed by the study's problem, purpose, and significance. Lastly, research questions, definitions, and terms related to the study will be introduced.

Background

The background of SSM/V in higher education is extensive and convoluted in many cases (Billman, 2016). SSM/V have most often been identified as outsiders in the higher education ecosystem (Iverson, 2015). According to Arminio et al. (2014), "The military experience influences the college experience on many levels" (p. 106). The historical, social, and theoretical significance of studying the SSM/V population in higher education will be discussed.

Historical Context

Presently, college administrations are facing many issues and concerns. Multifaceted, primary matters are developing and implementing tailored services to the vast array and diversity of students enrolling in higher education (Boelens et al., 2018). One of the most unique and growing populations in higher education is the SSM/V population (Barry, 2021). Since the Post-911 GI Bill passage, there has been an unprecedented increase in the number of SSM/V going to college (Ma et al., 2016). In the first year of the Post-911 GI Bill implementation, over 300,000

veterans pursued higher education, utilizing the benefit (The White House, 2010). Within a month of the new GI Bill, the VA was overwhelmed (Albright et al., 2017; Dao, 2009). While the VA has improved the processing of the GI Bill benefits, lingering concerns persist, with a more streamlined process required (Barr, 2019).

The SSM/V literature in higher education has been significantly lacking in the 21st Century, with only a recent increase in the past eight to 10 years (Arminio et al., 2014; Barry, 2015). There has been a recent increase in studying SSM/V, focusing primarily on combat-related injuries (Barry et al., 2012; Rudd et al., 2011), transition challenges (Bell, 2017; Gregg et al., 2016; Griffin & Gilbert, 2015), and health risks (Cesur et al., 2016; Schiavone & Gentry, 2014). To date, a minute amount of research has been invested in exploring and understanding the experiences of SSM/V in higher education with a MHD (Barry, 2015; Borsari et al., 2017). The experience of SSM/V with a MHD in higher education will be the primary aim of this study.

Social Context

Universally, individuals who graduate from higher education earn more money, have more dependable employment, and live healthier lifestyles than individuals who do not graduate from college (Ma et al., 2016; Robertson et al., 2020). Research in higher education has found that college retention and graduation momentously assist SSM/V's successful transition to non-military life (Borsari et al., 2017). Additionally, while SSM/V earn college degrees on par with traditional students, it takes them significantly longer to do so (Hammond, 2017). This additional time is troubling on many levels, including a slower transition to civilian life, expiration of GI Bill benefits, and overall financial difficulties (Hammond, 2017).

Considering the delays in obtaining their degrees in higher education, MHD in the SSM/V population is far-reaching in higher education. Veterans experience more mental health

concerns than non-veteran students (Barry et al., 2021). These higher degrees of mental health anxieties subsequently impact SSM/V academic achievement and their health and overall functioning (Dobson et al., 2021; Schonfeld et al., 2015).

Lastly, SSM/V bring a unique and uncharted history of trauma, substance abuse, difficulties, and mental health problems (Borsari et al., 2017). As a result of these increases and unique challenges, college administrations throughout the United States must make every effort to better assist and assimilate SSM/V within their academic communities (Albright et al., 2017). Higher education efforts have been made, but more financial and political action is needed (Clark et al., 2020; Eakman et al., 2016).

Theoretical Context

Based on the seminal and contemporary research into SSM/V, two key theoretical concepts have been identified. First, SSM/V need to perceive and receive social support to be fully successful in their academic pursuits (Buzzetta et al., 2020). Of note, this support is especially important when it is offered by other military-affiliated peers (Barry et al., 2021). Secondly, SSM/V experience significant mental health symptoms, which impact their health, overall functioning, and academic achievement (Borsari et al., 2017). This study sought to add to the body of existing literature on SSM/V by exploring the essence of the experiences of current SSM/V that are actively engaged in higher education and have a VA MHD rating. By seeking to discover this essence of SSM/V, new theoretical information was discovered on how the population views the importance of social support and experiences their MHDs in higher education.

Problem Statement

The problem is a lack of qualitative understanding and documentation of how SSM/V with a MHD describe their higher educational experience. Prior research has primarily focused on the quantitative analysis of the difficulties SSM/V encounter in higher education (Barry et al., 2021; Borsari et al., 2017). The unique challenges and necessity to support SSM/V have been well reported, showing that SSM/V experience inordinate academic difficulties in higher education and require unique support to overcome noted complications (Blosnich et al., 2016; Dobson et al., 2021). Furthermore, the contemporary literature illustrates that SSM/V do not access support services to the necessary degree (Albright et al., 2017) and have divergent perspectives on the role and use of such services compared to non-SSM/V (Darcy et at., 2018). While quantitative research is present on the SSM/V population in higher education, very little attention has been given to the qualitative reports of the academic experiences and challenges specific to SSM/V with a MHD (Brown & Bruce, 2016; Eakman, 2019). The number of SSM/V with a MHD is rising (Albright et al., 2017; Barry et al., 2021). With the growing population of SSM/V with a MHD in higher education, further research is needed regarding how this population experiences their higher educational experience. Primarily, there is a need for educational research that gives a voice to SSM/V with a MHD in higher education.

Purpose Statement

The purpose of this study is to document how SSM/V with a MHD living in California describe their higher educational experience. For this study, a MHD will be defined as those outlined in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM 5*) (American Psychiatric Association [APA], 2013). PC/E worldviews and theories helped shape this study. The primary theorist of the person-centered theoretical framework was Carl Rogers (1902-1987).

The chief theorist of existential theory in this study is Victor Frankl (1905-1997). The PC/E theoretical frameworks inform research on the struggles of SSM/V through an assortment of facades. The PC/E theories are grounded in constructivism, lending themselves to a more qualitative research approach. The procedures strongly support and encourage individuals' phenomenal worlds (Frankl, 1985; Rogers, 1961; Rogers, 1995). Based on the current literature, SSM/V have a more remarkable history of trauma, psychiatric difficulties, and significant worries about integrating into the college environment than other student populations (Smith et al., 2017; Arminio et al., 2018). Research has identified the academic complications SSM/V experience and the importance of supportive relationships in assisting persistence (Barry, 2015). However, minimal research has investigated the lived experiences of SSM/V in undergoing these complications.

Significance of the Study

The population of SSM/V enrolling in higher education, both online and traditional, continues to rise as the conflicts in the Middle East cease (Ulrich et al., 2020; Zhang et al., 2020). To complicate matters, qualitative inquiries into the experience of SSM/V, especially those with an MHD, are lacking in higher education (Hornor, 2021; Mahoney, 2021). This lack of present research into SSM/V and their higher education academic difficulties makes it difficult for higher education institutions to advance support practices for the population and increases the likelihood of SSM/V dropping out of college. The present study has empirical, partial, and theoretical significance. By seeking to describe *what* is experienced by SSM/V with a MHD in attending higher education and *how* it is experienced, the data gained may be helpful to institutions of higher education that serve SSM/V with a MHD. Furthermore, this study added to the documentation by producing significant insights related to the perceived prevalence of

MHDs in the SSM/V population, the impact of MHDs on the academics of SSM/V, and finally, needed support services for SSM/V with a MHD in higher education. All three of these identified topics are even more significant to study when the current literature indicates that the SSM/V population is one of the largest growing populations enrolling in higher education today (Bell, 2017; Bond Hill, 2019).

Empirical Significance

There is empirical significance to exploring the experience of SSM/V with MHDs. The literature has suggested that by examining disadvantaged students' achievements, a better comprehension can be gained of how they address their trials and achieve more academic success (Novotny, 2011). Guided by these findings, the present study explored the experiences of SSM/V with a MHD successfully enrolled in and attending an institution of higher education. Examining SSM/V who are successfully enrolled in higher education is divergent from much of the present literature, which primarily focuses on the opposing challenges of veterans that have disenrolled from college (Falkey, 2016; Hammond, 2016; Hammond, 2017). The desire for this study was to contribute to the documentation by providing the required insight into the experience of SSM/V with a MHD. In turn, it is hoped that this obtained knowledge will be drawn upon to progress and implement support services to help the SSM/V population in their educational pursuits.

Practical Significance

There is practical significance in studying the experience of SSM/V with an MHD beyond empirical significance. Based on the literature review, it is evident that SSM/V have unique challenges, including a history of trauma, substance abuse, and MHDs (Thomas et al., 2018). Grounded in this identified history, these past and present difficulties cause barriers and

hurdles to academic achievement (Barry, 2015). Presently, PTSD, anxiety, and depression are the most significant challenges to SSM/V's adjustment and achievement in higher education (Schonfeld et al., 2015). This study will give higher education leaders new insights from the research participants' perspectives of identified issues.

Theoretical Significance

By exploring the unique experiences of SSM/V with MHDs in higher education through the lenses of the PC/E framework, invaluable insights were identified. Key understandings were recognized in assisting the population in their academics. Through the importance of relationships emphasized in the PC/E framework (Frankl, 1985; Rogers, 1961; Rogers, 1985), this study sought to add more literature knowledge to the topic. This additional knowledge acquired the unique experiences of SSM/V with MHD in higher education, highlighting beneficial support services.

Research Questions

The research question (RQ) and sub-questions (SQ) for this study were derived from the study's problem and purpose and are feasible, significant, and ethical. Following a quantitative slant (Creswell & Poth, 2018), the research questions are philosophical and pragmatic. There was one central RQ for this study, followed by three SQs.

Central Research Question

How do student service members and veterans with a mental health disorder living in California describe their higher educational experience?

Sub-Question One

Out of the 19 *DSM 5* core disorders in the overall veteran population, what five mental health disorders do student service members and veterans with a Veteran Affairs mental health

rating perceive as most prevalent among the student service member veteran collegiate population?

Sub-Question Two

What are the academic impacts of mental illness for student service members and veterans with a Veterans Affairs mental health disorder rating in higher education?

Sub-Question Three

What support services do student service members and veterans with a mental health disorder rating identify as helpful and/or lacking in their higher educational pursuits?

Definitions

1. *Academic Success* – Meeting an institution's expectations (Alyahyan & Duştegor, 2020).
2. *Active-Duty Service Member* – Service members that work full-time in the branches of the U.S Army, U.S. Navy, U.S. Marine Corps, U.S. Air Force, and U.S Coast Guard. Active-duty service members are always under Title 10 (Naifeh et al., 2019).
3. *Department of Defense (DoD)* – The federal department responsible for safeguarding the national security of the U.S. (Tschanz et al., 2020)
4. *Epochè* – "A Greek word meaning to refrain from judgment, to abstain from or stay away from the everyday, ordinary way of perceiving things" (Moustakas, 1994, p. 33). The researcher, not the participants, set aside prejudgments by opening the research endeavor with an unbiased, receptive presence (Roberts, 2019).
5. *Higher Education* – Any education beyond the secondary level (Mwandosya & Montero, 2017).
6. *Mental Health Disorder (MHD)* – As defined in the *DSM 5*, it is a syndrome characterized by a clinically-significant disturbance in an individual's cognition, emotion

regulation, or behavior that reflects psychological, biological, or developmental dysfunction processes underlying mental functioning (APA, 2013).

7. *National Guard* – Service members that serve one weekend a month and two weeks out of the year in the U.S. Army and U.S Air Force branches. National Guard service members are under Title 32 orders, though they can be activated for Title 10 missions when required (Naifeh et al., 2019).
8. *Post-9/11 GI Bill* – U.S. law that provides education benefits to military veterans who have taken part in active-duty service after September 10, 2001. To be eligible for the Post-9/11 GI Bill, a veteran must have served at least one year in an active-duty status or served at least 30 continuous days and been honorably discharged for a service-related disability (Defense, 2017).
9. *Reserve Service Member* – Service members that serve one weekend a month and two weeks out of the year in the branches of the U.S Army, U.S. Navy, U.S. Marine Corps, U.S. Air Force, and U.S Coast Guard. Reserve service members are always under Title 10 (Naifeh et al., 2019).
10. *Student Service Members and Veterans (SSM/V)* – Active service members, including those in the components of Active Duty, Reserves, and National Guard, currently enrolled in higher education, online or traditional (Barry, 2015).
11. *Support Services* – Any services provided by higher education institutions that assist students in their academic pursuits (Pickerell, 2018).
12. *Title 10* – U.S. code that outlines the role of the armed forces. Provides the legal basis for each of the services' roles, missions, and organization. Under Title 10, service members

are under the command and control of the Department of Defense (DoD) (Defense, 2017).

13. *Title 32* – U.S code that outlines the role of the U.S. National Guard. Under Title 32, the National Guard remains under the command and control of each U.S. state (Defense, 2017).
14. *Transcendental Phenomenology* – The awareness or consciousness a person has of something (Moustakas, 1994).
15. *VA Disability Rating* – A rating for veterans with military service-connected conditions. A disability rating is based on (a) how severe the veteran's condition is and (b) how the disability impairs their earning capacity. VA disability ratings range from 0 to 100% (Tsai & Rosenheck, 2016).
16. *Veterans* – Individuals who have served or are currently serving in the military within the U.S Army, U.S. Navy, U.S. Marine Corps, U.S. Air Force, and U.S Coast Guard (Tschanz et al., 2020).
17. *Veterans Affairs* – The U.S. government-run organization that provides medical care, benefits, and various essential services to veterans of the U.S. Armed Forces and their families. The VA is broken into three administrations: the Veterans' Health Administration (VHA), the Veterans' Benefits Administration (VBA), and the National Cemetery Administration (NCA) (Tschanz et al., 2020).

Summary

At present, SSM/V are one of the largest growing populations enrolling in higher education. Regarding other higher-education populations, SSM/V have a greater prevalence of MHDs than their civilian classmates. These higher rates of mental health complications have a

direct adverse impact on their academic performance. Subsequently, specially tailored SSM/V support services are needed in higher education to help them succeed in their academic pursuits. The purpose of this study is to describe and understand the prevalence, corresponding academic impact, and need for specialized support services afforded to SSM/V with an MHD. This phenomenological study reported the collegiate experiences of 13 SSM/V participants with a VA MHD rating. Drawing upon the frameworks of PC/E theories, institutions of higher learning may acquire how to better support the SSM/V population with the goal of academic success.

CHAPTER TWO: LITERATURE REVIEW

Overview

This literature review examines the scholarly documentation of the prevalence of MHDs in veterans and the academic impact these high prevalence rates have on SSM/V in higher education. PC/E frameworks were utilized to explain and inform the research. Both theories focus on the importance of relationships and understanding the inner world of individuals to help people overcome their difficulties (Frankl, 1985; Rogers, 1995). Three primary themes and subsequent subthemes were identified in the research: (a) a high MHD prevalence in the SSM/V population, (b) the impact of MHDs on SSM/Vs' educational pursuits, and (c) the need for more specialized support services for SSM/V with an MHD. Research has been conducted on the SSM/V population with a MHD in higher education. However, there is still a significant gap in the qualitative understanding of SSM/V with a MHD experience. This gap has subsequently contributed to a shortcoming in examining needed support services for the population.

Theoretical Framework

This literature review used two theoretical frameworks: person-centered and existential. The primary theorist of the person-centered theory was Carl Rogers (1902-1987). According to Rogers (1961), the prime proposition of the person-centered theory is to "provide a certain type of relationship [so that] the other person will discover within himself or herself the capacity to use that relationship for growth and change, and personal development will occur" (p. 33).

Person-centered theory has its roots in humanistic and existential philosophy, which affirms people to be trustworthy and having a latent understanding of themselves and their specific struggles (Rogers, 1961). Additionally, the theory holds that individuals have full competency for self-directed growth. Person-centered theory postulates that self-directed

development occurs only when an individual is in a relationship based on genuineness, acceptance, and empathy (Rogers, 1961). Rogers (1995) believed empathy to be the most important of all three relationship characteristics. Rogers (1995) stated that "the state of empathy, or being empathetic, is to perceive the internal frame of reference…as if one were the person, but without ever losing themselves" (p. 210).

Frankl (1905-1997) is one of the founding fathers of existential thought applied to psychotherapy. Existentialism is grounded on the assumption that individuals are free, which results in their being responsible for their choices and actions. Frankl stated that the constructs that reappear in existential theory include an individual's capacity for self-awareness, the importance of freedom and responsibility, the awareness of forthcoming death, and the significance of discovering meaning in life. Existential theory emphasizes that individuals must find a strong enough purpose to serve as a foundation to contest the everyday difficulties of life. The existential approach rejects the deterministic view of human nature exposed by orthodox psychoanalysis and radical behaviorism corresponding to person-centered theory (Frankl, 1985).

The PC/E theories inform research on the prevalence of MHD in veterans and the academic experience of SSM/V with a MHD on multiple levels. PC/E theories are grounded in constructivism, lending themselves to a more qualitative approach to research (Frankl, 1985; Rogers, 1961). The methods support and encourage the phenomenal world of individuals. SSM/V have a more significant history of trauma, experience more psychiatric difficulties, and have more significant worries about integrating into the college environment than other students (Barry, 2015; Borsari et al., 2017). Research has identified the academic complications SSM/V have experienced and the importance of supportive relationships in assisting their persistence in higher education (Barry, 2015; Canfield & Weiss, 2015). However, minimal research has

focused on operationalizing and incorporating noted supportive relationships in improving SSM/Vs' higher educational pursuits (Borsari et al., 2017; Greer et al., 2020). Applying the PC/E theories as a framework, focusing on the importance of positive relationships and support provides a better understanding of the problems identified in the SSM/V population. The PC/E frameworks provide a solid foundation for finding practical solutions to help SSM/V overcome acknowledged difficulties by focusing on relationships.

Related Literature

The purpose of this literature review is to examine studies that have explored the prevalence of the 19 main *DSM 5* categories of MHDs in veterans and to identify the academic impact and support services offered to SSM/V diagnosed with one of these *DSM 5* conditions. After reviewing the prevalence of the 19 main *DSM 5* MHD categories in veterans, a review of the correlation to the academic impact of MHDs in SSM/Vs' academic achievement will be noted. Throughout this manuscript, PC/E theoretical connections will be made for each area of exploration to investigate support services to assuage identified MHD difficulties.

Prevalence of Poor Mental Health

Poor mental health is a significant problem for veterans with the difficulties being mutually diagnosed or undiagnosed (Fulton et al., 2015; Schonfeld et al., 2015). In reviewing the prevalence of MHDs in veterans, PC/E theories highly enlightened the review. Considering prevalence, veterans with weaker relationships and social support networks reported a higher degree of MHDs than their counterparts (Ness et al., 2015; Xue et al., 2015). These findings directly relate to Rogers' (1961) assertion of the importance of relationships in combating MHDs within clients and individuals. For example, veterans that felt they lacked purpose were identified as more likely to attempt suicide than those who believed they had a purpose (Bryan et

al., 2015; Ray-Sannerud et al., 2015). As it relates to Frankl's (Frankl, 1985) theory of having a definite purpose for overcoming everyday difficulties, veterans need help establishing internal purposes to succeed in their higher educational endeavors. Lastly, emotional numbing was shown to impair relationship functioning (Schuman et al., 2019), highlighting the importance of the relationship in both PC/E frameworks.

Mental health is a significant factor for veterans (Barry et al., 2014; Pickett et al., 2015). For example, out of 1.9 million veterans of Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND), 57.2% (662,722) received at least a provisional MHD, with the most common conditions being traumatic, depressive disorders, anxiety disorders, and substance abuse disorders (Greer et al., 2020). In addition, studies have found that approximately 23% of OEF, OIF, and OND veterans have an MHD considering non-provisional official mental health diagnoses (Fulton et al., 2015; Morris et al., 2020).

Trauma, depressive disorders, anxiety disorders, and substance abuse disorders are the most common MHDs in veterans (Borsari et al., 2017; Pickett et al., 2015). According to the Veterans' Affairs Disability Rating Scale, any diagnosis in the *DSM 5* can be considered a disability rating (Sripada et al., 2018; Tsai & Rosenheck, 2016). There are approximately 265 unique diagnoses in the *DSM 5* (APA, 2013). In examining the prevalence of *DSM 5* disorders in veterans, this literature review will provide an overview of the 19 main *DSM 5* categories of diagnoses, including anxiety disorders; bipolar disorders; depressive disorders; dissociative disorders; disruptive, impulse control, and conduct disorders; elimination disorders; feeding and eating disorders; gender dysphoria disorders; neurocognitive disorders; neurodevelopment disorders; obsessive-compulsive and related disorders; paraphilic disorders; personality disorders; schizophrenia spectrum and other psychotic disorders; sexual dysfunction disorders;

sleep-wake disorders; somatic symptom disorders; substance-related and addictive disorders; and finally trauma and stressor-related disorders (Appendix J). In describing the prevalence of each diagnosis in the veteran population, a brief description of the diagnostic criteria and symptoms will be explored.

Given the current lack of qualitative and quantitative documentation on the prevalence of MHDs specific to SSM/V (Barry, 2015; Borsari et al., 2017; Blosnich et al., 2015), examining the prevalence rates of the primary 19 *DSM 5* diagnostic categories (Appendix J) is required for all veterans. However, in the slight amount of research that has been conducted on MHDs in the SSM/V population, there is a direct correlation to the more extensive military and veteran diagnosis prevalence rates (Currier et al., 2018; Greer et al., 2020). Studies have revealed that up to 44.9% of SSM/V reported a current psychiatric diagnosis (Thomas et al., 2018; Currier et al., 2018). Also, 14.8% of additional SSM/V, while not noting a psychiatric diagnosis, reported symptoms indicating a diagnosis (Aikins et al., 2020; Thomas et al., 2018). Lastly, studies that have examined SSM/V compared to civilian counterparts found that SSM/V scored significantly higher on poor mental health rates than their non-veteran classmates (Barry, 2015; Fortney et al., 2016).

Anxiety Disorders

Individuals suffering from anxiety disorders often exhibit excessive fear, anxiety, and other related behavioral health disturbances (APA, 2013). Anxiety is the anticipation of a future threat, whether real or perceived (Knepley et al., 2019; Raines et al., 2017). Fear is the emotional response to a real or perceived imminent threat (Heimberg et al., 2014). Anxiety disorders in the *DSM 5* include separation anxiety, selective mutism, specific phobia, social anxiety, panic,

agoraphobia, generalized anxiety, and substance-induced anxiety disorders due to another medical condition (APA, 2013).

Behind only PTSD and depressive disorders, anxiety disorders are among the top conditions with which veterans are diagnosed, the most common being social anxiety disorder (Byrne, 2021). Through the Veterans' Health Administration's (VHA's) Primary Care Mental Health Integration program, 4.8% of the 4,461,208 veterans studied had an anxiety disorder (Trivedi et al., 2015). Anxiety in veterans is associated with ethnicity, education, other medical conditions, and age (Gould et al., 2015). Significantly, younger generations of deployed veterans have shown a higher level of anxiety disorders than older veterans (Gould et al., 2015).

Bipolar Disorders

Bipolar disorder is manifested in alternating periods of elation and depression (APA, 2013). In the elation or manic stage, individuals become euphoric, full of energy, and unusually irritable (Angst, 2015). In the depressive phase, individuals become sad and hopeless and lose pleasure in most activities (Liu et al., 2021). Symptoms negatively affect sleep, judgment, activity, energy, behavior, and thought processes (Pompili et al., 2021). Bipolar disorders in the *DSM 5* include bipolar I, bipolar II, cyclothymic, substance-induced bipolar, and bipolar disorders due to another medical condition (APA, 2013).

Bipolar disorder has increased significantly in veterans in recent years, rising 23% over the past decade (Hunt et al., 2019). Current estimates have shown that over 100,000 veterans seeking care through the VA have an official diagnosis of bipolar disorder (Defense Manpower Data Center, 2021). Veterans with bipolar disorder are at a substantially higher risk of suicide than other mental health conditions such as PTSD (McCarthy et al., 2015). Bipolar I disorder is

the most common bipolar disorder experienced by SSM/V, accounting for over 50% of all diagnosed bipolar conditions in the population (Harvey et al., 2018).

Depressive Disorders

Depressive disorders are characterized by persistent feelings of sadness and worthlessness, including a lack of desire to engage in pleasurable activities (APA, 2013). Depressive disorders are not passing negative moods or usual day-to-day regret but complex mind and body disorders that interfere with everyday functioning (Mundy et al., 2021; Zuckerman et al., 2018). Depressive disorders in the *DSM 5* include disruptive mood, dysregulation disorder, major depressive disorder, and persistent depressive disorder. It also includes premenstrual dysphoric disorder, substance-induced depressive disorder, and depressive disorder due to another medical condition (APA, 2013).

Besides trauma-related disorders such as PTSD, depressive disorders are the leading conditions with which veterans are diagnosed. Of the 1.9 million veterans registered for VA health care service since 2002, 45% have been identified as having a provisional diagnosis of a depressive disorder (Ramsey et al., 2017). Upon examining official diagnoses, 12.3% of veterans have been diagnosed with a depressive disorder (Liu et al., 2019). Depressive disorders are twice as likely in veterans deployed to a combat zone (Blore et al., 2015). The most common depressive disorder in veterans is major depressive disorder (Goetter et al., 2020; Ramsey et al., 2017).

Dissociative Disorders

The primary features of dissociative disorders are disruption and discontinuity in memory, consciousness, emotion, identity, motor control, body representation, and behavior (APA, 2013). The symptoms of dissociative disorders have a strong likelihood of disrupting and

causing distress in each area of psychological functioning (Ganslev et al., 2020; Swart et al., 2020). Dissociative disorders in the *DSM 5* include dissociative identity, dissociative amnesia, and depersonalization/derealization disorders (APA, 2013).

The overall prevalence of dissociative disorders in veterans is unknown (Herzog et al., 2020; Tsai et al., 2015), with present studies only focusing on the symptoms of dissociative disorders in the population (Armour et al., 2014; Boyd et al., 2018). It has been found that 20.8% of veterans endorse symptoms of dissociative disorders, with the most common being depersonalization/derealization disorder (Herzog et al., 2020). Dissociative symptoms have increased suicidality and psychiatric comorbidities (Boyd et al., 2018; Herzog et al., 2020). In exploring veterans with PTSD, a 12-32% comorbid rate was found with dissociative symptoms (Blevins et al., 2014; Hansen et al., 2017; Tsai et al., 2015).

Disruptive, Impulse-Control, and Conduct Disorders

Disruptive, impulse-control, and conduct disorders are characterized by problems in the self-control of emotions and behaviors (APA, 2013). Disorders that have the traits of self-control difficulties, disruptiveness, impulse-control, and conduct disorders are unique in that they directly violate the rights of others (Frick & Matlasz, 2018; Zhu et al., 2021). Disruptive, impulse-control, and conduct disorders in the *DSM 5* include oppositional defiant disorder, intermittent explosive disorder, conduct disorder, pyromania, and kleptomania (APA, 2013).

The prevalence of disruptive, impulse-control, and conduct disorders in the veteran population is challenging to measure (Hunt et al., 2019; Trivedi et al., 2015). The research conducted on the prevalence shows that veterans with disruptive, impulse-control, and conduct disorders often also are evaluated as having PTSD symptoms (Dillard et al., 2007). In examining the homelessness in the veteran population, it has been found that more homeless veterans have a

diagnosis of disruptive, impulse-control, and conduct disorders when compared to non-homeless veterans (Tsai & Rosenheck, 2016). Lastly, up to two-thirds of impulsive and conduct-related behavior has been contributed to combat exposure in the veteran population (Cesur et al., 2016).

Elimination Disorders

Elimination disorders involve the inappropriate elimination of urine or feces (APA, 2013). Elimination disorders are most often first diagnosed in childhood or adolescence (Equit et al., 2014; Von Gontard, 2013). The two elimination disorders in the *DSM 5* include enuresis, the repeated voiding of urine into inappropriate places, and encopresis, the repeated passage of feces in wrong places (APA, 2013).

Little literature has been conducted on the prevalence of elimination disorders in veterans (Trivedi et al., 2015). In the minute amount of research conducted, the symptom of enuresis has been shown to have an above-average comorbidity rate in SSM/V compared with other MHDs, with the most predominant being trauma-related disorders (Ninivaggio et al., 2018; Trivedi et al., 2015). Lastly, current research suggests that women veterans are more likely than male veterans to be diagnosed with an elimination disorder (Ninivaggio et al., 2018).

Feeding and Eating Disorders

Feeding and eating disorders are characterized by obstinate eating-related behaviors (APA, 2013). These altered eating behaviors result in altered food consumption, which significantly impairs psychosocial functioning and overall physical health (Iron-Segev et al., 2020; Kennedy et al., 2018). Feeding and eating disorders in the *DSM 5* include pica, rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa, bulimia nervosa, and binge eating disorder (APA, 2013).

Overall, female veterans report more eating disorders than male veterans, with studies showing as high as one-third of female veterans and one-fifth of male veterans reporting symptoms consistent with a *DSM 5* eating disorder (Bartlett & Mitchell, 2015; Masheb et al., 2021). The most prevalent feeding and eating disorders in veterans are bulimia, nervous eating disorder, binge eating disorder, and atypical anorexia nervosa (Antczak & Brininger, 2008; Arditte Hall et al., 2017). Lastly, eating disorders have been shown to have a high comorbidity rate with other mental health diagnoses in the veteran population (Bodell et al., 2014; Masheb et al., 2021).

Gender Dysphoria Disorders

Gender dysphoria disorder is characterized by a marked incongruence between an individual's experienced or expressed gender and assigned gender (APA, 2013). The distress and incongruence of gender must last for six months for an official diagnosis to be given (Byne et al., 2020; Dhejne et al., 2016). Dysphoria is the critical focus of the diagnosis and change from previous versions of the *DSM*, which primarily focus on identity (APA, 2013).

Gender dysphoria disproportionally impacts veterans compared to the general population (Kameg, 2020). Per the VHA, current rates of gender dysphoria in veterans are as high as 22.9% per 100,000 individuals, compared to estimates of 4.3% per 100,000 individuals in the U.S. general population (Blosnich et al., 2013). It is estimated that over 150,000 active duty SSM/V and reservists are either transgender or have gender dysphoria (Ahuja et al., 2019). In the SSM/V population, gender dysphoria has many comorbid diagnoses, with 50% also having a mood disorder and 25% having a PTSD diagnosis (Blosnich et al., 2013). It is estimated that over 65% of those with gender dysphoria experience suicidal ideation (Blosnich et al., 2013).

Neurocognitive Disorders

Neurocognitive disorder's primary feature is a decline in thinking skills (APA, 2013). Neurocognitive disorders are unique among other disorders in the *DSM 5* in that both underlying pathology and etiology can frequently be determined (Sachdev et al., 2014; Sachs-Ericsson & Blazer, 2015). Neurocognitive disorders in the *DSM 5* include delirium, vascular neurocognitive, frontotemporal neurocognitive, neurocognitive with Lewy bodies, major and mild neurocognitive due to Alzheimer's disease, TBI, prion, Parkinson's, Huntington's disease, substance-induced neurocognitive disorder, and neurocognitive disorder due to another medical condition (APA, 2013).

The most prevalent and studied neurocognitive disorder in veterans is TBI (Barnes et al., 2018; Jak et al., 2019). TBI is defined as a traumatically-induced structural injury or physiological disruption of brain function due to an external force (Greer et al., 2020). According to the VA, from 2007 to 2013, 185,437 veterans reported a history of TBI (Silva et al., 2021). The Defense and Veterans Brain Injury Center said that there had been approximately 330,000 TBI cases among all service members since 2000 (Nakase-Richardson et al., 2017). Veterans with a history of TBI present extreme challenges, significantly when the post-brain injury/concussion symptoms co-occur with mental health diagnoses (Pickett et al., 2015). Most substantially, PTSD, depressive disorders, substance abuse disorders, and anxiety disorder prevalence were significantly higher in those with TBI than those without (Greer et al., 2020).

Neurodevelopment Disorders

Neurodevelopmental disorders are a group of diagnoses with onset in the developmental period (APA, 2013). The disorders typically emerge before elementary school and are characterized by developmental deficits that lead to impairments in personal, social, academic,

and occupational functioning (Bishop, 2010; Thapar et al., 2017). Neurodevelopmental disorders in the *DSM 5* include intellectual disabilities, communication, autism spectrum, attention-deficit/ hyperactivity, specific learning, and motor disorders (APA, 2013).

ADHD is veterans' most common neurodevelopment disorder (Shura et al., 2017a). The prevalence of ADHD in veterans is 7%, which is below the prevalence rates of the most common diagnoses in veterans—PTSD, TBI, depression, anxiety, and substance-related disorders (Shura et al., 2017b). With a 7% prevalence, ADHD is diagnosed almost three times more in veterans than in the general population (APA, 2013).

Obsessive-Compulsive and Related Disorders (OCD)

The two primary features of OCD and related disorders are obsession and compulsions (APA, 2013). Obsessions are recurrent, persistent, and unwanted thoughts, images, or urges (Stein et al., 2016). Compulsions are repetitive mental acts or behaviors an individual feels driven to perform to alleviate obsessions (Abramowitz & Jacoby, 2015). In the *DSM 5*, OCD and related disorders include body dysmorphic disorder, hoarding disorder, trichotillomania, excoriation disorder, substance-induced OCD, and OCD due to other medical conditions (APA, 2013).

The overall prevalence of OCD in veterans to date remains limited and highly unclear (McIngvale et al., 2019; Stanley et al., 2017). However, OCD and related disorders have been shown to have a high prevalence in veterans, with OCD having the highest diagnosis rate (Stanley et al., 2017). The estimated prevalence of OCD in veterans varies widely, from 0.4% to 28% (McIngvale et al., 2019). The high variation in OCD currently arises from the nature of the target population of veterans and the methods of case identification (McIngvale et al., 2019; Stanley et al., 2017). OCD is higher in combat veterans (Miller et al., 2008). Obsessive-

compulsive disorders in veterans have been found to have a higher diagnosis rate in veterans with substance use difficulties (McIngvale et al., 2019), depression (Scherrer et al., 2010), and PTSD (Orsillo et al., 1996). Among veterans with PTSD primarily, a related OCD is as high as 41% (Nacasch et al., 2011).

Paraphilic Disorders

The prime feature of paraphilic disorders is sexual arousal and gratification that is atypical and extreme (APA, 2013). A paraphilia becomes a disorder when it causes individual distress or threatens to harm someone else (First, 2014; Holoyda & Kellaher, 2016). Paraphilic disorders in the *DSM 5* include voyeuristic, exhibitionistic, frotteurism, sexual sadism, pedophilic, fetishistic, and transvestic disorders (APA, 2013).

The most common paraphilic disorder in veterans is transvestic disorder (Sheffler et al., 2016). It is approximated that there are 150,000 veterans diagnosed with transvestic disorder (Kauth et al., 2014), with over 15,000 in an active status (Kauth et al., 2017). More than 5,000 veterans diagnosed with transvestic disorder seek services through the VA (Kauth et al., 2014). In addition, veterans diagnosed with transvestic disorder are more likely to be diagnosed with other psychiatric conditions (Blosnich et al., 2016; Brown & Bruce, 2016) and significantly increased suicide risk (Blosnich et al., 2016).

Personality Disorders

A personality disorder is a continuing pattern of inward experience and behavior that deviates drastically from an individual's culture (APA, 2013). The experiences and behaviors are pervasive, inflexible, and lead to distress and impairment (Kramer, 2019). The onset of personality disorders occurs in adolescence or early adulthood and is highly stable over time (Volkert et al., 2018). Personality disorders in the *DSM 5* include paranoid, schizoid, schizotypal,

antisocial, histrionic, narcissistic, avoidant, dependent, obsessive-compulsive personalities, and personality disorders due to another medical condition (APA, 2013).

Given the high potential of personality disorders having an adverse admirative effect on a veteran's career, including discharge from service, little research has been conducted on the spectrum of personality disorders in veterans (Leroux, 2015). In the little research conducted, antisocial, narcissistic, and borderline personality disorders are the most prevalent (Chu et al., 2017). An increased risk of suicide has been found in veterans diagnosed with a personality disorder (Ghahramanlou-Holloway et al., 2018). Additionally, veterans diagnosed with personality disorders are at greater risk of having another MHD, with the most predominant diagnosis being PTSD (Dunn et al., 2004).

Schizophrenia Spectrum and Other Psychotic Disorders

The two essential characteristics of the schizophrenia spectrum and other psychotic disorders are delusions and hallucinations (APA, 2013). Other symptoms include disorganized thinking, disorganized or abnormal motor behavior, and negative symptoms, such as diminished emotional expression (Gaebel et al., 2020; Lieberman & First, 2018). In the *DSM 5*, the schizophrenia spectrum and other psychotic disorders include delusional, brief psychotic, schizophreniform, schizophrenia, schizoaffective, substance-induced psychotic, and psychotic disorders due to another medical condition (APA, 2013).

Given the unfitting nature of psychotic disorders in military service, a small amount of research has been conducted on the prevalence of solely psychotic disorders in veterans (Frueh et al., 2002). Research often focuses on psychotic disorders secondary to other diagnoses, such as PTSD, depression, and anxiety (Lemaire & Graham, 2011; Oconghaile et al., 2018; Sexton et al., 2017). Capturing the research that has been conducted on the prevalence of psychotic disorders

in SSM/V shows that the most prevalent psychotic disorder is schizophrenia (Oconghaile et al., 2018). A strong correlation between veterans with a diagnosis of psychotic disorder also have a comorbid psychiatric disorder, with the strongest correlation being PTSD (Compean & Hamner, 2019). Lastly, it has been shown that out of non-routine military service discharges, psychotic disorders account for 3.98% of such releases, being on average with other psychiatric disorders (Brignone et al., 2017).

Sexual Dysfunction Disorders

Sexual dysfunction disorders are typically characterized by a clinically significant disturbance in an individual's ability to respond sexually or experience sexual pleasure (APA, 2013). In many cases, individuals have several sexual dysfunctions simultaneously (Ma et al., 2021; Rezaei et al., 2021). Sexual dysfunction disorders in the *DSM 5* include delayed ejaculation, erectile, female orgasmic, female sexual interest/arousal, pelvic pain/penetration, and male hypoactive sexual desire disorders, as well as premature ejaculation and substance-induced sexual dysfunctions.

Sexual dysfunction disorders are prevalent in veterans, especially ones with other comorbid mental health conditions (Bentsen et al., 2015). It has been found that given the stressors and traumas highly correlated with military service, veterans have an increased risk of sexual dysfunction (Badour et al., 2015). Systematic reviews have indicated a sexual dysfunction rate of between 8.4% and 88.6% among male veterans with PTSD (Bentsen et al., 2015; Yehuda et al., 2015). Sexual dysfunction in PTSD veterans has arisen from the disorder's symptoms, including primarily avoidance (Bentsen et al., 2015). Psychotropic medications utilized to treat PTSD have directly impacted sexual dysfunction in veterans with PTSD, the most common being erectile dysfunction (Bernardy et al., 2012; Hosain et al., 2013; Labbate, 2008).

Sleep-Wake Disorders

Sleep-wake disorders are manifested by individual complaints of dissatisfaction with the quality, timing, and amount of sleep one receives (APA, 2013). Daytime distress and impairment are core features shared by all sleep-wake disorders (Duffy et al., 2021; Nishimon et al., 2021). Sleep-wake disorders in the *DSM 5* include insomnia, hypersomnolence, narcolepsy, obstructive sleep apnea-hypopnea, central sleep apnea, sleep-related hypoventilation, circadian rhythm sleep-wake, non-rapid movement, sleep arousal, nightmare disorders, rapid eye movement, sleep behavior disorder, restless legs syndrome, and substance-induced sleep disorders (APA, 2013).

Over the last two decades, sleep disorders among veterans have steadily increased (Alexander, 2016; Martin, 2016). The most prevalent sleep disorders in veterans are insomnia and sleep apnea (Folmer et al., 2020). Over the last decade, insomnia diagnoses have increased from 0.2% to 1.5%, a 650% increase, and sleep apnea diagnoses increased from 0.4% to 3%, displaying a similar 650% increase (Caldwell et al., 2017, 2019). Sleep disorders in veterans are often accompanied by other comorbid mental health and physical ailments, including obesity, diabetes, congestive heart failure, depression, PTSD, and TBI (Folmer et al., 2020).

Somatic Symptom Disorders

Somatic symptom disorders are defined by an individual overly focusing on physical symptoms, which subsequently causes significant distress or problems in their functioning (APA, 2013). In somatic symptom disorders, the individual's physical symptoms may or may not be associated with a diagnosed medical condition, but the person believes they are sick (Eger-Aydogmus, 2020; Jang et al., 2021). Somatic symptom disorders in the *DSM 5* include somatic symptoms, illness anxiety, conversion disorders, psychological factors affecting other medical conditions, and factitious disorder (APA, 2013).

Numerous studies have displayed the high prevalence of somatic symptoms and disorders in veterans (Cyr et al., 2014; Ketcheson et al., 2018; McCutchan et al., 2016). In a longitudinal study of currently serving US forces, 8.7%, 9.9%, and 12.5% of participants had at least moderate somatic symptom severity at baseline at three and six years (McCutchan et al., 2016). Military personnel with other mental health conditions, especially PTSD and major depressive disorder, are at exceptionally high risk for somatic symptoms and diseases (Engel et al., 2000; Ketcheson et al., 2018; McCutchan et al., 2016). Ketcheson et al. (2018) reported that military personnel and veterans diagnosed with PTSD and major depressive disorder are most likely to have somatic and related conditions.

Substance-Related and Addictive Disorders

The primary traits of substance-related and addictive disorders are cognitive, behavioral, and physiological symptoms (APA, 2013). However, instead of stopping or curtailing the substance use or addictive behaviors, individuals continue despite the related problems and distress caused in their lives (Carr et al., 2020; Gutwinski, 2021). In the *DSM 5*, substance-related and addictive disorders include alcohol, alcohol intoxication, caffeine, cannabis, hallucinogen, opioid, sedative, stimulation, tobacco, and gambling disorders.

The most prevalent type of substance use problem in veterans, both male, and female, is alcohol consumption (Hoggatt et al., 2017; Teeters et al., 2017). A study that examined data collected from the National Survey of Drug Use and Health found that veterans (56.6%) are more likely to use alcohol than their non-veteran counterparts (50.8%) (Bray et al., 2013). Additionally, it has been found that veterans (9%) have more problematic drinking behaviors than non-veterans (4%) (Bray et al., 2013). Based on this higher level of substance abuse, approximately 11% of veterans presenting to the VA health care system meet the criteria for a

substance-related disorder (Seal et al., 2011). High levels of substance abuse are also found to correlate with combat exposure, with veterans experiencing high levels of combat exposure engaging in heavy (26%) and binge (54%) drinking relative to veterans without combat exposure, 17% and 45%, respectively (Bray et al., 2013; Kelsall et al., 2015). Moreover, combat exposure in veterans has been found to contribute up to two-thirds of risky health behaviors in veterans, including activities such as smoking, illicit drug use, and gambling (Cesur et al., 2016; Larson et al., 2012).

Substance-related and addictive disorders have also been found to have a high comorbidity rate between other mental health diagnoses in the SSM/V population (Niv & Bennett, 2017; Norman et al., 2018). This correlation between substance-related disorders and addictive behaviors has been found in PTSD, depression, and anxiety (Bowe & Rosenheck, 2015; Najavits et al., 2018). In examining the diagnosis of PTSD specifically, a comorbidity rate of 21.9% was found with substance-related disorders in veterans (Bowe & Rosenheck, 2015). The number of veterans presenting for VA care with PTSD and a comorbid substance-related condition increased by approximately 76% over the last decade alone. This comorbidity rate is only likely to grow in the coming years (Allen et al., 2016).

Trauma and Stressor Related Disorders

Trauma-related disorders are characterized by individuals undergoing a traumatic event and having an adverse reaction (APA, 2013). Traumatic events occur in childhood and adulthood (Maercker & Lorenz, 2018; Strain, 2018). In the *DSM 5*, trauma and stressor-related disorders include reactive attachment, disinhibited social engagement, PTSD, acute stress, and adjustment disorders (APA, 2013).

PTSD is the most common trauma and stressor-related disorder in veterans, often called

the ‘signature wound’ of military veterans (Hunt et al., 2019; Tanielian et al., 2008). Estimates of official PTSD diagnoses in veterans range from 4% to 21%, with the significant variance primarily arising from the measurement of clinical interviews versus self-report measures (Hunt et al., 2019; Lehavot et al., 2012). Compared to non-veterans, military veterans have been shown to have a higher diagnosis rate of PTSD (Hoerster et al., 2012; Lehavot et al., 2018). Studies have shown that female veterans are more likely to be diagnosed with PTSD than male veterans (Lehavot et al., 2012, 2018; Yano et al., 2010); however, male veterans are less likely to seek treatment for their PTSD (Fortney et al., 2016; Wisco et al., 2016).

Risk Factors

Risk factors for PTSD and other MHDs in veterans range through the entire spectrum. Multiple significant risk factors in developing combat-related PTSD and other mental health conditions include prior history of trauma, lack of social support networks and relationships, female gender, ethnic minority status, low education, non-officer ranks, army service, combat specialization, high numbers of deployments, longer cumulative length of elements, more adverse life events, prior trauma exposure, and preceding psychological problems (Xue et al., 2015). Hazardous duty and combat-related trauma positively correlate with mental health problems among SSM/V (Blosnich et al., 2015). Both veterans and civilian counterparts that have experienced a traumatic event experienced more academic difficulties than students without a history of trauma (Smith et al., 2017). Psychological problems can occur immediately after a traumatic event and have long-lasting effects (APA, 2013). SSM/V have a higher rate of trauma than civilian students, which is positively associated with more significant psychiatric diagnoses in the population (Barry, 2015; Borsari et al., 2017). Combat exposure is significantly associated with depression and suicidal behavior (Dillon et al., 2018). Corresponding to MHDs, combat-

related trauma increases the risk of other health factors, including asthma, arthritis/rheumatism, lung diseases, headaches, and pain (Sheffler et al., 2016).

Emotional Disturbances

Analogous to psychological difficulties, overall emotional disturbances are high among veterans (Macia et al., 2020; Schuman et al., 2019). Schuman et al. (2019) found emotional numbing in combat veterans significantly high, resembling and corresponding to the high rates of MHD. Considering impairment, emotional numbing has the most adverse effects in service utilization, relationship functioning, quality of life, substance use disorders, and suicidality. Macia et al., 2020; Schuman et al., 2019). Especially regarding suicidality, Brenner et al. (2009) found emotional disturbances to drive suicidal ideations and attempts.

Suicide

Given its great significance and repercussions, suicide ideations and attempts are distinct disquiet for SSM/V. Previous suicide attempts among SSM/V range between 7% and 8% (Bryan et al., 2015). Between 14% and 35% of SSM/V report a history of suicidal thoughts, including a plan to follow through (Ray-Sannerud et al., 2015). Risk factors for suicidal ideation and attempts include a history of same-gender sexual partners, victims of military sexual trauma, lack of purpose, women with pre-military sexual abuse, and men who have experienced military sexual trauma (Rolbiecki et al., 2015).

Theoretical Connection to Prevalence

Understanding the prevalence rates of MHDs in veterans is important (Albright et al., 2017; Borsari et al., 2017). The prevalence rates of MHDs in the veteran population are high, indicating an identified issue (Fulton et al., 2015; Schonfeld et al., 2015). Moreover, reviewing

these prevalence rates from the theoretical lens of the PC/E paradigms is lacking in several key areas.

As detailed above, PC/E theory is founded on the principle of understanding the lived experience of individuals (Frankl, 1985; Rogers, 1961), lending itself to a more qualitative approach to understanding a problem rather than a quantitative slant. However, the research on the prevalence of MHDs in veterans is almost entirely quantitative, with only minimal research briefly addressing the qualitative nature (Barry, 2015; Williston & Roemer, 2017). This lack of qualitative documentation into prevalence rates is a gap in the literature, especially regarding the SSM/V population, which the current phenomenological study will address.

Mental Health's Impact on SSM/V Academics

Driven by the prevalence of MHDs in veterans, these diagnoses present an issue in the college setting for the SSM/V population (Clark & Walker, 2020; Nyaronga & Toma, 2015). Based on these higher rates of mental anxieties, the literature clarifies that SSM/V experience significant and unique psychiatric symptoms compared to their civilian counterparts (Barry, 2015; Borsari et al., 2017). These MHDs subsequently impact SSM/Vs' academic achievement, including their health and overall functioning (Barry, 2015; Billman, 2016; Iverson, 2015).

In discussing SSM/Vs' MHDs in higher education, examining the differences between SSM/V and their civilian counterparts is necessary (Barry et al., 2014; Blosnich et al., 2015). Smith et al. (2017) directly examined this distinction among SSM/V and non-SSM/V in higher education. It was found that the SSM/V and civilian students with past exposure to a potentially traumatic event perform more poorly in their higher academic endeavors than students void of such traumatic events (Smith et al., 2017). Schonfeld et al. (2015) put forth that the driving factor causing the dysfunction was mental health complications that arose from the traumatic events.

This significant correlation between trauma and MHDs related to academic functioning corresponds to other studies (Borsari et al., 2017). Moreover, SSM/V have been found to have a greater degree of trauma and corresponding MHDs when compared to their civilian counterparts, which indicates more significant academic dysfunctions (Barry, 2015).

The prevalence of MHDs in the SSM/V population is high (Aikins et al., 2015; Barry et al., 2014; Pelts & Albright, 2015). However, the impact that each diagnosis has on SSM/Vs' academic performance is unable to be captured from research at this time (Barry, 2015; Borsari et al., 2017). Based on this educational impact limitation, the most common MHDs out of the 19 main categories in the *DSM 5* were explored. More precisely, depression, anxiety, TBI, substance use, and PTSD were explored, as they have been studied the most in the SSM/V population (Arminio et al., 2014; Schonfeld et al., 2015).

PC/E theory assisted in shaping and reviewing the literature that examined the impact MHDs have on SSM/V in higher education. Many SSM/V with a MHD do not believe that their classmates and instructors fully understand the extent to which their MHDs cause them difficulty in higher education (Albright et al., 2017). These findings directly correlate to Rogers's (1961) concept of empathy, which is the capacity to understand and feel what another is experiencing. Albright also argued that MHDs, especially depression, cause SSM/V to lose an overall sense of purpose in higher education, leading to high dropout rates. Given the importance of purpose in existential theory, these findings become more understanding and transparent. Nietzsche said, "He who has a *why* to live for can bear almost any *how*" (Frankl, 1985, p. 109). Based on this existential principle, individuals losing their sense of purpose in attending higher education—their *why*—will have a great deal of difficulty in dealing with the complications of their academic journey—their *how*.

Depression

Studies have shown that depression directly impacts SSM/Vs' participation in classroom activities, including required assignments, which impedes their educational attainment (Buzzetta et al., 2020; Romero et al., 2015). Bryan et al. (2014) posited that compared to their civilian counterparts, students dealing with the symptoms of depression are more likely to experience academic difficulties in higher education. Bryan et al. found that depression was linked with late assignments, exam failures, and skipped classes. Aikins et al. (2015) further suggested that depression causes SSM/V to lose a sense of purpose in attending higher education, subsequently finding it the most significant barrier to SSM/V obtaining academic achievement.

Posttraumatic Stress Disorder

Veterans diagnosed with PTSD struggle with maintaining employment, staying married, aggression, other physical and mental conditions, and academic difficulties (Barnard-Brak et al., 2011; Gregg et al., 2016). SSM/V with PTSD report having more difficulty focusing and completing assignments when compared to their non-veterans counterparts without PTSD (Ackerman et al., 2009; Jenner, 2017). Bryan et al. (2014) and Elliott (2015) concurred that students with PTSD often have lower GPAs than students without PTSD. Both found that SSM/V had lower levels of PTSD further in their education, which strongly suggests that PTSD leads to a negative impact on SSM/Vs' persistence in obtaining a higher education degree (Bryan et al., 2014; Elliott, 2015).

Traumatic Brain Injury

TBI has an adverse impact on SSM/V diagnosed with MHDs. TBI has been shown to impede concentration during class lectures and overall time spent studying outside the classroom (Elliott, 2015; Maguen et al., 2012). SSM/V with TBI experience "cognitive fatigue" in the

classroom and while completing homework, which often requires extended periods to recover (Smee et al., 2013, p. 25). Davies et al. (2019) extended this finding by saying that this inability to focus appropriately has been shown to directly encumber SSM/V with TBI to achieve academic success.

Substance Abuse

Substance use/abuse is higher in the SSM/V population when compared to their civilian counterparts on a college campus (Barry et al., 2012; DeCoster, 2018). These higher rates of substance use/abuse, especially alcohol abuse, in the SSM/V population negatively impact their academic performance (Barry et al., 2014; Elliott et al., 2011). This impact ranges from lack of school attendance, late assignments, higher dropout rates, and more significant MHDs (Barry et al., 2014). SSM/V with more complicated substance abuse-related disorders report a greater alienation on campus (Elliott et al., 2011). Borsari et al. (2017) reported that this alienation on campus subsequently leads to intensive, preexisting academic difficulties and serves as a barrier to seeking needed mental health care, both on- and off-campus.

Anxiety

Anxiety leads to various difficulties in the SSM/V population's academic pursuits (Grossbard et al., 2014; Ness et al., 2015; Weber, 2012). Ness and Weber (2015) further promoted a correlation between difficulties in SSM/V attending classroom instruction, taking exams, and interacting with peers on campus. Anxiety is inversely related to academic persistence in SSM/V (Grossbard et al., 2014; Ness et al., 2015).

Theoretical Connection to Impact

Barry et al. (2021) posited that comprehending the impact of MHDs on SSM/V is essential to assisting them in their higher education. The prevalence of MHDs in SSM/V is high

(Clark & Walker, 2020; Nyaronga & Toma, 2015), which correlates to adverse impacts on their academics (Borsari et al., 2017). However, as in the prevalence of MHDs in the SSM/V population, there is a significant gap in the literature related to impact, especially the minute amount of qualitative research into the subject under investigation.

Most research focuses on MHDs' quantitative impact on SSM/Vs' academics (Clark & Walker, 2020). Subsequently, the qualitative impact of MHDs on SSM/Vs' academics is lacking. Thus, in an overall qualitative realm founded on the driving principles of PC/E theory, there is a lack of understanding of how MHDs impact SSM/Vs' academics from the unique participants under investigation. This lack of insight is a current fault in the commentary literature and needs to be studied to fill the gap.

Supportive Services for Student Service Members and Veterans (SSM/V)

There is a need for academic institutions to aid in relieving the unique challenges of SSM/V (Aikins et al., 2015; Albright et al., 2017). This necessity for support is displayed in the literature, highlighting that those academic institutions offering specialized help to SSM/V are lacking (Barry, 2015; Blosnich et al., 2016). Additionally, the contemporary literature illustrates that SSM/V do not access support services to the necessary degree (Canfield & Weiss, 2015) and have divergent perspectives on the role and use of such services compared to non-SSM/V students (DiRamio et al., 2015).

Drawing upon the seminal psychotherapeutic works of Rogers (1961) and Frankl (1985), minimal effort has been spent regarding support in the form of psychotherapy-based interventions, primarily ones focused on relationships and purpose (Borsari et al., 2017). The most predominant services offered to the SSM/V population revolves around psychoeducation (Canfield & Weiss, 2015). The only specific psychotherapeutic interventions are brief (Borsari et

al., 2017; Yurasek et al., 2015) and lack longitudinal studies that focus on long-term interventions driven by PC/E theories (Albright et al., 2017; Barry et al., 2014).

Current Services Offered

Research has affirmed the need for college campuses to offer tailored services to SSM/V (Barry, 2015; Borsari et al., 2017). The precise needs and amenities this population might need range from financial support, psychological provisions, and disability amenities (Barry, 2015; Cass & Hammond, 2017). The demands for such noted supportive services for SSM/V are apparent (Albright et al., 2017; Bonar et al., 2015). However, higher education institutions still lack direct services (Barry et al., 2014; Flink, 2017). A study conducted in 80 universities in California found that few schools track the precise number, demographic characteristics, and most importantly, the support needs of SSM/V (Niv & Bennett, 2017).

Additionally, training for campus and community partners is recommended in almost 50% of the available literature on SSM/V (Bonar et al., 2015; Borsari et al., 2017). Some universities have commenced noted training. However, the training has focused primarily on PTSD and TBI, resulting in stereotypes that obstruct understanding and subsequent support (Canfield & Weiss, 2015; Elliott, 2015). In considering psychotherapy, the only brief interventions include psychotherapeutic interventions, which have been shown to effectively address substance use and MHD in the SSM/V population (Reyes et al., 2020; Romero et al., 2015; Yurasek et al., 2015).

Certain universities have begun to execute SSM/V tailored services to help with the academic transition (Norman et al., 2015; Selber et al., 2015). These services include psychoeducational counseling groups to help transition to higher education, stress, and sleep difficulties (DeCoster, 2018; Wisner et al., 2015). However, less than 10% of SSM/V seek

mental health services on campus, with over 90% of SSM/V seeking mental health treatment outside the campus infrastructure (DiRamio et al., 2015; Morris et al., 2020).

Utilization of Services

Regarding the use of university services by SSM/V, it is empirically noted that when compared to civilian students, SSM/V both use campus support services less frequently and visit academic advisors and faculty less often (Hom et al., 2017; Mahoney et al., 2021; Southwell et al., 2018). The utilization of campus services has been found to positively relate to SSM/Vs expectations for both degree completion and perception of university environments (Mahoney et al., 2021). The exact positive correlation was not found in civilian counterparts (Southwell et al., 2018). Studies have shown that SSM/V are less skilled at navigating available services than their civilian counterparts (Bonar et al., 2015; Canfield & Weiss, 2015). Additionally, SSM/V often have trouble adapting to a civilian world after the hierarchical environment of the military, which often results in an unwillingness to ask for assistance and difficulty managing time and responsibility (Canfield & Weiss, 2015; Robertson & Eschenauer, 2020). SSM/V frequently reported experiencing challenges in the transition from a military-style of technical learning and hierarchical organizational structure to a university learning environment that is less structured and more informal (Bonar et al., 2015; Canfield & Weiss, 2015; Niv & Bennett, 2017).

Research has indicated that SSM/V report many barriers to seeking assistance in mental health care at the university level (Barry, 2015; Canfield & Weiss, 2015). Bonar et al. (2015) and Canfield and Weiss (2015) were more explicit in citing barriers for not wanting to seek treatment among SSM/V—the fear of it appearing on their military records, embarrassment, concerns that it might harm their career, anxieties that the visit would not remain confidential, difficulty scheduling appointments, and being seen as weak. Lastly, many SSM/V choose not to seek

mental health treatment at higher education institutions because they believe no individuals are trained or competent to address their unique needs (Canfield & Weiss,2015; Niv & Bennett, 2017).

Future Support Needs for Student Service Members and Veterans

It is noticeable that SSM/V need specialized support to succeed in college (Barry, 2015; Bonar et al., 2015). Relationships and support are at the forefront of aiding SSM/V (Barry, 2015; Campbell & Riggs, 2015). From the PC/E perspective, the importance of relationships in helping the SSM/V population is made even more apparent. Many universities and colleges are trying to address the SSM/V community; however, many breaches and continuous obligations endure (Barry et al., 2014, 2021). How the importance of relationships can be delivered in higher education in helping SSM/V has yet to be thoroughly explored (Ness et al., 2015; Niv & Bennett, 2017).

Existing Empirically-Based Support Services Offered

Social support and strong relationships correlate to academic adjustment and success with SSM/V (Barry, 2015; Niv & Bennett, 2017). Social support established in war from one's unit positively predisposed academic fine-tuning among SSM/V (Campbell & Riggs, 2015; Elliott et al., 2011). Additional studies have found that perceived support from one's military unit for active-duty service members is almost five times more persuasive than perceived social support from other noteworthy relationship sources (Campbell & Riggs, 2015; Hammond, 2016; Whiteman et al., 2013).

Other studies have examined the effects of self-reported MHDs on relationships and self-regulated learning (Eakman et al., 2019; Fredman et al., 2019; Ness et al., 2015). On a global level, these specific studies included service members from all military components, including

active duty, reserves, and the National Guard. The studies had several key findings regarding PTSD and the importance of services provided to the SSM/V population. First, the endorsement of positive relationships moderated the overall impact of PTSD symptoms (Eakman et al., 2018; Fredman et al., 2019). Secondly, it was discovered that this affiliation declaration directly and significantly moderated the negative relationship between mental disorder indicators and maladaptive academic goal orientation (Ness et al., 2015; Fredman et al., 2019).

Studies examining technology have begun to display promising results in better supporting SSM/V (Albright & McMillan, 2018; Cate & Albright, 2015). Two crucial fundamental discoveries were noted in exploring virtual training, where non-SSM/V participants and SSM/V role-played difficult situations in higher academics. First, Cate and Albright (2015) argued that non-SSM/V showed significant and sustained increases in cultural competency and evaluated knowledge of referral support services for veterans.

Secondly, SSM/V positively benefited from virtual training interactions and likely drew upon identified support services after the virtual collaborations (Albright & McMillan, 2018). Corresponding to the findings of Albright and McMillan (2018) and Cate and Albright (2015), online mentoring and advising of SSM/V was effective in sustaining the SSM/V population (Cass & Hammond, 2015; Spencer, 2016). Online mentorship and skills training has been shown to have the strongest correlation to SSM/Vs' persistence in higher education (Hammond, 2017).

Lastly, cognitive-behavioral, mind-body relaxation, and psycho-educational interventions have been extensively studied to help higher education students, resulting in positive outcomes (Miller et al., 2016; Ness et al., 2015). However, these interventions have only been fully applied to higher education students, not explicitly to the SSM/V population (Nyaronga, 2019; Williston

& Roemer, 2017). These interventions are a sizeable shortcoming for the SSM/V population, in that a correlation and overall generalization to the population cannot be confidentially obtained.

SSM/V Support Needs Moving Forward

SSM/V have extensive trauma-loaded pasts and equivalent MHDs (Bryan et al., 2015; Currier et al., 2018; Xue et al., 2015). However, there is an absence of analysis in the research programs designed to help the SSM/V population (Darcy et al., 2018.). Though there has been an increase in services and corresponding accessibility to campus services for SSM/V, many provided services are not evidence-based (Cate & Albright, 2015). Most importantly, providers who do not have adequate military and cultural competency levels lack the needed clinical ability to afford appropriate treatment and services (Albright et al., 2017).

Given that the current literature suggests that SSM/V choose not to draw upon the free or low-cost counseling or health centers through the university system (DeCoster, 2018; Niv & Bennett, 2017), promising efforts have begun to be made to incorporate government resources, such as the VA, into the campus (Canfield & Weiss, 2015; Messerschmitt-Coen, 2021). One such initiative is the Veterans Integration to Academic Leadership (Coll & Weiss, 2016; Norman et al., 2015). These alternative avenues of providing mental health services to SSM/V on campus to increase and facilitate treatment engagement are promising ideas. However, there still needs to be a detailed evaluation of the efforts that have not yet been made to support this population (DeCoster, 2018; Giampaolo & Graham, 2020).

Theoretical Connection to Support Services of SSM/V.

Compared to the prevalence and impact of MHD on the SSM/V population, there has been a much greater wealth of qualitative research conducted in the literature for SSM/V support services (Barry et al., 2014, 2021). These studies have shown that SSM/V are often unwilling to

seek mental health services for various reasons, almost predominately revolving around issues of stigma (Bonar et al., 2015; Canfield & Weiss, 2015). While more qualitative studies examining support services for SSM/V are promising, much more research needs to be conducted (Ness et al., 2015; Niv & Bennett, 2017).

Guided by PC/E theory, a significant shortfall in the qualitative research of SSM/V support services is the examination of how relationships and purpose, which are a sizeable protective measure for SSM/V and veterans (Barry, 2015; Ness et al., 2015), can be utilized and incorporated more effectively to help the population in an academic setting (Barry, 2015; Borsari et al., 2017). SSM/V view the importance of relationships and purpose in academics as fruitful in their educational journey (Borsari et al., 2017). This identified gap in the literature is one the current study will seek to fill.

Summary

Within this literature review, three primary themes and subsequent subthemes were identified in the research of SSM/V to include MHD prevalence, impact on academics, and need for support services. While the overall prevalence of MHDs in veterans is evident in the quantitative research, little qualitative knowledge is known about the prevalence of MHDs in the veteran population, including the SSM/V population. Directly related, the impact of MHDs on the academics of SSM/V is quantitively lucid in the literature; however, the overall qualitative impact is very much limited, with a significant gap in the existing literature. Lastly, many quantitative and qualitative support services are offered to SSM/V in higher education, but they lack two key components. First, the supportive services study primarily examines higher education students and SSM/V, not directly exploring SSM/V with a MHD. Secondly, there is a lack of qualitative studies on how relationships, purpose, and protective measures are viewed

uniquely by SSM/V in higher education. All three of the noted gaps in the literature drove the present qualitative study, seeking to add needed documentation requirements to the literature.

CHAPTER THREE: METHODS

Overview

The purpose of this phenomenological study was to document how SSM/V with a MHD living in California describe their higher educational experience. Chapter Three outlines the research design and selected methods utilized in the study. Next, the chapter delineates the data collection and analysis procedures, including the researcher's role. To conclude, a discussion on the study's trustworthiness is verified, with an ending dialogue of ethical considerations.

Research Design

A transcendental phenomenological qualitative study captured 13 SSM/Vs' higher education experiences with a VA MHD rating. Creswell (2013) stated, "Qualitative research begins with assumptions and the use of interpretive/theoretical frameworks that inform the study or research problems addressing the meaning individuals or groups ascribe to social or human problems" (p. 44). Several key reasons to perform a qualitative study include exploration, complexity, context, explanation, and measurement difficulty (Peterson, 2019). As it relates to the present study of SSM/V, the complexities the population experiences are a predominant need for conducting a qualitative study. As discussed in Chapter Two, MHDs in SSM/V and corresponding academic challenges in higher education are clearly outlined in the literature (Borsari et al., 2017). However, the support services to help support SSM/V, especially those with MHD, are lacking (Barry, 2015). Secondly, both on a macro and micro level, SSM/V with MHDs are complex issues (Smith et al., 2017), requiring much more understanding of how to better support their unique challenges in higher education.

Phenomenology

Phenomenological research is one of the five main approaches to qualitative inquiry and research design (Creswell & Poth, 2018). Per Creswell and Poth (2018), "…[P]henomenological study describes the common meaning for several individuals of their lived experiences of a concept or a phenomenon" (p. 75). Creswell and Poth also reported that while a leading qualitative research method, phenomenological thought is also a philosophy, making it essential to understand the phenomenological approach as both a research approach and philosophy when drawing upon it.

Considering the philosophical approach to phenomenology, Husserl (1859-1938) and Heidegger (1889-1976) are two crucial figures (Horrigan-Kelly et al., 2016). Husserl emphasized describing the lived phenomenon. Heidegger stressed the interpretation of the phenomenon (Qutoshi, 2018). The *epochè* concept emerges from Husserl's approach (Cerbone, 2020). This study's impetus was to understand SSM/Vs' experiences with a VA MHD rating and not to interpret their experiences, so Husserl's approach was drawn upon more heavily. Specifically, a transcendental phenomenology design was undertaken.

Transcendental Phenomenology

Moustakas (1994) is most often considered the founder of phenomenological research (Neubauer et al., 2019). Moustakas theorized that examination should concentrate on an experience's entirety and search for its essence. In viewing behavior and corresponding experiences, Moustakas viewed experiences as assimilated with the phenomenon and the person undergoing the phenomenon (Englander, 2018). Moustakas's ideas and approach, which align with Husserl (2012) philosophy, were used. Driven by Husserl's philosophy, greater importance was placed on understanding the participants' essences rather than interpreting the essences

(Moustakas, 1994). Following Moustakas (1994), four prime procedures were followed in the study, including *epochè*, phenomenological reduction, imaginative variation, and synthesis.

Research Questions

Central Research Question

How do student service members and veterans with a mental health disorder living in California describe their higher educational experience?

Sub-Question One

Out of the 19 *DSM 5* core disorders in the overall veteran population, what five mental health disorders do student service members and veterans with a Veteran Affairs mental health rating perceive as most prevalent among the student service member veteran collegiate population?

Sub-Question Two

What are the academic impacts of mental illness for student service members and veterans with a Veterans Affairs mental health disorder rating in higher education?

Sub-Question Three

What support services do student service members and veterans with a mental health disorder rating identify as helpful and/or lacking in their higher educational pursuits?

Setting and Participants

The purpose of this section is to describe the setting and profile of participants in the study. The setting will be described in sufficient detail to visualize the general location of the study adequately. The profile of participants will be described to sufficiently articulate the criteria for participation in the study.

Setting

The State of California was the setting where participants engaged in the study. California has the most prominent military population of any state in the U.S. (Defense Manpower Data Center, 2021). Approximately 128,373 service members in California are on active duty, encompassing 6,567 from the Army, 44,838 from the Navy, 55,101 from the Marine Corps, 17,243 from the Air Force, and 4,624 from the Coast Guard (Defense Manpower Data Center, 2021. In addition, California also has the most significant reserve force, totaling 56,167 service members. The breakdown in reserve forces is 11,975 from the Air Force, 30,152 from the Army, 7,791 from the Navy, 5,423 from the Marine Corps, and 826 from the Coast Guard (Defense Manpower Data Center, 2021).

Participants

Thirteen currently serving SSM/V with a VA disability rating for mental health living in California and enrolled in higher education were selected for this study. Following a phenomenological research slant, all study participants had experienced the phenomenon under inquiry and could efficaciously communicate their subsisted involvements (Creswell & Poth, 2018). Participants were selected through purposeful sampling based on these guiding phenomenological foundations. Specifically, purposeful sampling was used to locate 13 currently serving SSM/V with a VA MHD rating presently enrolled in higher education. Criterion sampling and maximum variation were utilized to select participants for the study. Criterion sampling was obtained by selecting participants currently serving in the armed forces as active duty and reserves (including the National Guard), actively attending higher education, having a VA MHD rating, and actively enrolled in higher education. The maximum sampling variation was accepted by selecting participants based on gender, age, rank, and military branch.

Research Positionality

In the research positionality section, my motivation for conducting this study is detailed. To discuss this motivation, two key areas will be explored. First, my interpretive framework of social constructivism is explained. Secondly, my ontological, epistemological, and axiological philosophical assumptions are explored.

Interpretive Framework

For this study, a social constructivism interpretive framework was drawn upon (Mertens, 2015). Social constructivism is driven by the assumption that humans construct their unique realities from their immediate surroundings (Schwandt, 2007). This reality construct is divergent from post-positivism interpretive frameworks, driven by a single reality belief (Mertens, 2015). Rather than starting with a strict theory, queries are inductively utilized to develop a pattern of meaning in social constructivism (Schwandt, 2007).

Directed by the social constructivism paradigm, my goal as a researcher was to understand the subjective world and experiences of the SSM/V population (Creswell & Poth, 2018). Taking this notion of understanding in social constructivism, I did not seek objective truths. Instead, I looked at the experiences of the SSM/V population with a MHD through a multiplicity of perspectives (Adams, 2006). I uncovered new understandings through these divergent perspectives, which led to enriched and positive outcomes for SSM/V.

Philosophical Assumptions

Philosophical assumptions are beliefs that underlie the research process (Creswell & Poth, 2018). Contrasting with interpretive frameworks, philosophical assumptions tend to be consistent throughout one's life, centering on individuals' values and belief systems and contrasting with interpretive frameworks (Creswell & Poth, 2018). Ontological, epistemological,

and axiological assumptions will be addressed. It is hoped that articulating my positionality on the philosophical assumptions will aid readers in understanding the lens through which I view the world and approached the research in this study.

Ontological Assumption

Ontological assumptions involve an individual's beliefs on the nature of reality (Creswell & Poth, 2018). In conducting research, both researchers and the participants in the study hold diverse realities (Schwandt, 2007). Subsequently, in performing qualitative research, the aim was to capture and report these various realities (Creswell & Poth, 2018). I believe that God's truth serves as the singular foundational reality as a Christian. While I believe that a central reality exists in God's word, it is also believed that there are divergent secondary realities. In the overall understanding of God's singular reality, this study worked to capture the subordinate realities of SSM/V with a MHD in higher education.

Epistemological Assumption

Epistemological assumptions refer to an individual's beliefs about the nature of and knowledge of learning (Guba & Lincoln, 1988). In qualitative studies, researchers attempt to get as close as possible to the participants being studied (Creswell & Poth, 2018). Per Guba and Lincoln (1988), qualitative researchers do their best to diminish the "distance" or "objective separateness" from the participants in the study (p. 94). As an LCSW conducting daily psychotherapy, my epistemological assumptions are very much in line with being as close to the participants being studied as possible. Studying the SSM/V population, I removed any emerging barriers to capture the most accurate data.

Axiological Assumption

The axiological assumption designates the degree to which a researcher's values are both known and brought into the study (Creswell & Poth, 2018). In contrast to quantitative research, researchers need to communicate their ideas regarding the context and setting of the research for qualitative inquiries. In sharing these values, the researcher needs to have insight into their views and biases to avoid interfering with the study (Creswell & Poth, 2018).

Being an LCSW that provides psychotherapy services to SSM/V, especially ones with a MHD attending higher education, I have a strong drive to help this population. Additionally, being a SSM/V with a MHD myself, I can relate to the population on a very tangible level. While expected to have these biases towards the population, it was essential for me as the researcher to be continually aware of my values and beliefs towards this population and appropriately bracket them to seek the truth of the information I was gathering.

Researcher's Role

As qualitative studies require, being a human instrument required much insight into the experiences and predispositions of the SSM/V population. I have been in the California National Guard (CNG) as a Behavioral Health Officer (BHO) for over 10 years. I teach as an Assistant Adjunct Professor at the University of Southern California (USC). As an LCSW and BHO in the CNG, I teach clinical coursework in treating military service members, veterans, and family members.

Being a SSM/V with a VA MHD and disability, I have a potent connection with the phenomenon, with many corresponding thoughts and feelings. Driven by this connection, I have a strong desire to see SSM/V with mental health diagnoses succeed in higher education and obtain needed services to overcome their difficulties. Given this experience of being an active SSM/V, I brought to the study many preconceived notions. Subsequently, I was cognitively

aware of these thoughts in the research endeavor and was continually conscious of any countertransference concerns.

Finally, my grandfather died while serving his country in the Vietnam War. Whenever I think of my grandfather's sacrifice, John 15:13 always comes to mind. "Greater love has no one than this: to lay down one's life for one's friends" (*New King James Version*, 1979, John 15:13). My Grandfather and all service members embody this passage from John 15:13. Therefore, driven by this sacrifice, I wanted to help SSM/V and honor their sacrifice and dedication to this nation and God's words.

Procedures

This section will outline the produces used to conduct this study. The intent is to outline the procedures to the extent that the study could be replicated from the description. This explanation will include necessary site permissions, information about securing Institutional Review Board (IRB) approval, soliciting participants, the data collection and analysis plans by data source, and how the study achieved triangulation.

Permissions

First, the research proposal was submitted to Liberty's IRB for approval on December 5, 2021 and approved on February 2, 2022. The study was for all SSM/V with a MHD VA rating that volunteered for the study. Given that the setting was for all SSM/V with a MHD living in California, there were no external gatekeepers or specific research sites from which approval needed to be obtained.

Recruitment Plan

After obtaining Liberty IRB approval, the plan was for a study recruitment letter (Appendix A) to be posted on social media. However, within two days of obtaining IRB

approval, 37 participants contacted me directly to participate in the study without me having to post anything on social media. Subsequently, interested participants were sent the contact information form (Appendix B) and the participant screening demographics form (Appendix D). Appendix B and Appendix D served as screening documents. Potential participants completed Appendix B and Appendix D and e-mailed them back to me.

Along with Appendix B, Appendix D was used to ensure a diverse participant pool. Appendix D did not collect study data; therefore, potential participants completed it before signing the consent form. Appendix B and Appendix D were discarded if a disqualifying answer was given.

Upon obtaining 13 participants that met eligibility requirements, selected participants were sent an e-mail again with the informed consent form (Appendix C) and participant demographic form (Appendix E). Participants completed Appendix C and Appendix E and sent them back to me. The informed consent form had to be signed before any participant could participate in the study. Though participants had 30 days to return the information, I received all required information within eight days.

Data Collection Plan

In this study, a transcendental phenomenological qualitative research approach was used. Given the rigorous inquiry of qualitative research, various data collection techniques were utilized in this study. Interviews, focus groups, and writing prompts were used to collect data for the research. An initial pilot occurred for the interview, focus group, and writing prompt questions to ensure they best captured the data sought by the study's research questions. Following the pilot interviews, focus groups, and writing prompts, no changes were needed. Being the human instrument as the researcher, as required in qualitative research (Lauterbach,

2018), I sought to understand and describe the experience of SSM/V with a VA MHD rating, emphasizing the support services that can help them in their academic journeys.

Individual Interviews

In phenomenological studies, interviews are one of the primary methods of collecting data from participants (Hoffding & Martiny, 2016). There were 17 interview questions (Appendix F) in this study. Driven by my psychotherapeutic background, interview questions occurred face-to-face over a secure online Zoom format, were open-ended, and followed psychotherapeutic practices. Each interview ranged from 50 to 60 minutes. Interviews were primarily drawn from person-centered techniques, including empathy, unconditional positive regard, and congruence (Rogers, 1961). The questions were developed to answer the single RQ and three SQs of the study.

The following open-ended questions were used in the interviews (Appendix F):

1) To start the interview, please describe something unique about yourself.
2) Describe the factors that contributed to joining the armed services.
3) Describe the factors that contributed to you attending higher education.
4) Overall, how would you describe your experience in higher education?
5) How do you find purpose in your higher education pursuits?
6) How do you view the importance of relationships you have developed with fellow students?
7) Overall, how would you describe your time in the military?
8) How do you find purpose in your military service?
9) How do you view the importance of relationships you have developed with fellow service members?

10) How do you view the prevalence of MHDs in SSM/V?

11) What has been your overall experience of having a MHD?

12) What has been the impact of your MHD in attending higher education?

13) What has been your experience in utilizing support services in higher education for the complications of your MHD?

14) What additional services could higher education institutions provide to help with your MHD?

15) What barriers do/did you experience in obtaining needed assistance from institutions of higher education?

16) Project yourself driving home from this interview. Are there things you wish you would have shared more regarding mental health prevalence, mental health impact, and needed support services?

17) What additional questions or information would you like to share with me?

The first question was designed to lower barriers and develop a rapport with the participants. Rapport-building is essential in conducting interviews, primarily phenomenological studies (Hoffding & Martiny, 2016). Questions two through eight captured the participants' military and higher education experiences, which were divergent for each participant. Questions five, six, eight, and nine are directly related to the founding principles of PC/E theory, which focuses on relationships and purpose (Frankl, 1985; Rogers, 1961). Questions 10 through 12 were designed to capture participants' perspectives, understanding, and experience with the impact and prevalence of MHD, which is currently lacking in the literature for SSM/V (Barry, 2015; Borsari et al., 2017). Questions 13 through 15 aimed at understanding participants' experiences with higher education support services. At present, there is minimal research into

how SSM/V view support services on campus (Albright et al., 2017; Bonar et al., 2015), with the few studies that have been conducted showing a pessimistic view of such services (Canfield & Weiss, 2015). Finally, questions 16 and 17 were guided by psychotherapeutic techniques (Yalom, 1995), assuring that all participants' information was shared.

Individual Interview Data Analysis Plan

Individual interview data analysis included coding software and transcendental phenomenological analysis (Moustakas, 1994). The interviews occurred over Zoom, which has a secure transcription service. All participants had the opportunity to review their interview questions for accuracy. After obtaining transcription, the data was imported into Microsoft Excel coding software for initial coding. After the initial round of coding (horizontalization), the invariant constituents were further coded in Microsoft Excel as needed. In analyzing the individual interview data, *epochè* (Moustakas, 1994) was highly relied upon. By employing *epochè*, the analysis remained unbiased.

Focus Groups

Focus groups are regularly used in conjunction with qualitative research interviews to understand the participants' experiences (Gill & Baillie, 2018). Corresponding to psychotherapeutic groups (Yalom, 1995), focus groups allow individuals with a shared experience to discuss the phenomenon under investigation, create supportive relationships, and subsequently, develop a greater understanding of the incident under investigation (Gill & Baillie, 2018). This phenomenological study used Zoom's secure online format to generate discussion for five focal group prompts. There were three separate groups of four to five participants each.

The following focal group prompts were conducted via the Zoom secure online format: (Appendix G):

1) What else would you like to share as a current SSM/V with a VA disability mental health rating?
2) How do you view the prevalence of MHDs in SSM/V?
3) What has the impact of your MHD had on your higher education pursuits?
4) What has been your experience in utilizing support services in higher education for the complications of your MHD?
5) If a miracle occurred and higher education institutions could provide you one support service to better help you in your education, what would that service be?

The focus groups allowed participants to share additional details they may have left out of the interview process and hear from other participants. Given that it has been shown that service members are reluctant to share their experiences with a MHD (Brown & Bruce, 2016), the first questions of focus groups were designed to overcome this barrier and allow participants to detail their experiences more fully. In addition, research has shown that individuals often feel more comfortable sharing additional information in a group setting (Yalom, 1995). Therefore, questions two through four were like the questions in the individual interviews regarding the prevalence, impact, and support services utilized for their mental health complications. By asking these questions again in the focus group format, participants provided additional and greater depth of information than was provided in the interview. Finally, question five was based on a solution-focused therapeutic technique (Roth, 2019), which helped participants think creatively and identify services they may not have thought of before.

Focus Group Data Analysis Plan

The focus group data was captured over Zoom, which has a secure transcription service. All participants had the opportunity to review focus group responses for accuracy. The

participants' written focus group responses were placed into Microsoft Excel for coding. In Microsoft Excel, Moustakas's (1994) transcendental phenomenological analysis analyzed the data by reducing the information into significant statements. Microsoft Excel coding specifically included preparing and organizing the data, reviewing the data, creating initial codes for the data, reviewing codes, revising the themes, and cohesively presenting the themes.

Writing Prompts

Writing prompts are extremely helpful in obtaining data in qualitative research. Writing prompts have been found to allow individuals to freely share their ideas without any undue restraints placed on them during interviews (Liu & Stapleton, 2018). Participants were encouraged to use free association in responding to the prompts within this research study. Free association is a technique based on psychoanalytic thought, in which a relaxed subject is encouraged to report all passing thoughts and emotions without any restrictions or reservations (Barratt, 2017). Participants were uncensored with their responses through this free association encouragement, leading to more accurate data of the experience being lived.

The following writing prompts were e-mailed to participants, which they e-mailed back upon completion (Appendix H):

1) Please describe how your current personal relationships impact your higher educational pursuits both positively and negatively. (Please limit your response to one page.)
2) Please describe your purpose in attending higher education. (Please limit your response to one page.)
3) Out of the 19 main categories of mental health disorders in the *DSM 5,* which are the top five you view as most prevalent in the SSM/V population?

The two writing prompts supplemented one another, focusing on relationships and purpose in PC/E theories (Frankl, 1985; Rogers, 1961). The rationale for the first prompt was to capture the impact of relationships in attending higher education for the SSM/V population. The second question aimed to capture their purpose in attending higher education. The third question was to identify SSM/Vs' perspectives on the top five *DSM 5* diagnoses in the SSM/V population.

Writing Prompts Data Analysis Plan

Writing prompt data analysis began by placing the data in Microsoft Excel for coding, where it remained for the remainder of the analysis. Moustakas's (1994) imaginative variation and synthesis procedures were used to analyze the writing prompt data and the data obtained from individual interviews and focus group responses. The analysis obtained the textural and structural descriptions of the data captured.

Data Synthesis

Per Creswell and Poth (2018), there are divergent categories of qualitative analyses, each serving a different purpose and end state. Phenomenology is one of several qualitative approaches to inquiry. As a research method, the phenomenological drive describes what all participants have in common as they experience a phenomenon (Creswell, 2013; van Manen, 1990). Phenomenological analysis was drawn upon in each of the three data analysis plans in the study. A synthesis of transcendental phenomenological analysis was used to ensure triangulation and that the entire body of data generated a single set of themes.

Transcendental Phenomenological Analysis

Moustakas's (1994) transcendental phenomenology procedures entail identifying a phenomenon to study, bracketing out one's biases, and collecting data from individuals who have experienced the phenomenon. Following this method, I analyzed the data in the study by

reducing the information to significant statements and combining the identified themes. Subsequently, I developed textural-structural descriptions to convey a global essence of the experience. In performing transcendental phenomenological analysis, *epochè*, transcendental phenomenological reduction, imaginative variation, and synthesis of composite textural-structural descriptions were drawn upon.

Transcendental Phenomenological Reduction

The first step in transcendental phenomenological reduction is horizontalization (Moustakas, 1994). As recommended in the literature (Konecki, 2019), I began horizontalization as I received the transcripts rather than waiting for all transcripts to be completed. Transcripts were placed in Microsoft Excel for initial coding and further analysis. I examined each transcript by listing every expression relevant to the experience (Moustakas, 1994) and assigning each expression a code. Each expression, or horizon, was treated with equal value (Patton, 2015).

Subsequently, invariant constituents were determined through the reduction process by testing each expression for two requirements: (a) Does it contain a moment of the experience that is a necessary and sufficient constituent for understanding it? and (b) Is it possible to abstract and label it? (Moustakas, 1994). Horizons that met these requirements were clustered into core themes, and those that did not were eliminated. Once the themes were validated against each participant's transcript, each participant's individual textural descriptions were constructed using the relevant, validated invariant constituents and themes (Moustakas, 1994). At this stage, the goal was to uncover what was experienced as part of the experience (*noema*).

Saldana (2015) developed a specific coding method that was powerfully extracted upon to assist the transcendental phenomenological analysis. A code in qualitative inquiry is a word or short phrase that symbolically assigns a summative attribute for a portion of the captured

language or visual data (Saldana, 2015). In employing Saldana's coding approach, four steps were completed: analytical writing, first cycle coding, second cycle coding, and finally, post-coding and writing transcripts. Through each step of the coding process outlined by Saldana (2015), the goal of exploration and obtaining the experiences of SSM/V in higher education with a MHD VA disability rating was sought.

Imaginative Variation

As individual structural descriptions were being constructed, individual textural descriptions and imaginative variation were employed. As I approached this analysis step, I engaged my imagination and was open to different perspectives as I looked for possible meanings (Moustakas, 1994). At this stage of the data analysis, my goal changed from uncovering how the experience was experienced (*noesis*), to providing "a vivid account of the underlying dynamics of the experiences, the themes and qualities" (Moustakas, 1994, p. 135) connected with the SSM/V population.

Horizontalization is the phenomenological study process where significant statements, sentences, or quotes are captured to help the participants understand (Flynn & Korcuska, 2018). As recommended in qualitative research, the analysis began with horizontalization while the data was still being collected for the study (Konecki, 2019). To start horizontalization, noted coding software was used to examine each transcription. Statements related to the experience were recorded and assigned to each documented expression with a code. Doing so ensured that each horizon was viewed as an equal value in describing the experience. In the process, unrelated statements were excluded. Once each expression was identified, it was placed in Microsoft Excel.

Subsequently, invariant constituents, individual textural descriptions, individual structural descriptions, individual textural-structural descriptions, and an overall composite story were captured (Moustakas, 1994). The process of reduction and elimination determined invariant constituents. Following Moustakas (1994), reduction and elimination were determined by assessing if a statement in the collected data was essential for understanding the experience. Secondly, was it possible to abstract and label the data? Horizons that satisfied these two obligations were clustered into separate themes. Those that did not meet the two requirements were excluded from the study.

Upon obtaining invariant constituents, each participant's textural descriptions were assembled. At this point in the research, the goal was to discover what was experienced as part of the participant's experience, known as noema expressions, which was applied to back the individual textural descriptions (Moustakas, 1994). Subsequently, individual structural reports will be erected based on the unique textural stories' results and imaginative variation. The goal is to take a creative approach to explore divergent perspectives to understand potential meanings through imaginative variation. This imaginative variation was used to understand the *how* of the experience, also known as *noesis*, to narrate the underlying undercurrents of the incidents (Moustakas, 1994). Next, construct textural-structural descriptions were used to obtain the meanings and essences of each participant's experience in the study. Finally, data analysis was concluded with a composite description of the built purposes and essences drawing from the individual textural-structural reports.

Synthesis of Composite Textural and Composite Structural Descriptions

In the synthesis stage of analysis, my central research question and three sub-questions were answered. This process occurred by contrasting the textural-structural description of the

meanings and essences of the experience for each participant. In the final stage of synthesis, a composite description of the meanings and essences of the experience were developed from the individual textural-structural descriptions. As a result of the thorough examination of all participants' invariant meanings and themes, my analysis goal was to uncover a united description of the meanings and essences of the experience, which answered the central and sub-questions of the research (Moustakas, 1994).

Trustworthiness

Trustworthiness is equivalent to validity and reliability in quantitative research (Connelly, 2016). Four concepts must be implemented and practiced in obtaining trustworthiness in qualitative analysis, including credibility, dependability, transferability, and confirmability (Connelly, 2016). Reflexivity is critical (Palaganas et al., 2017). Reflexivity includes *epochè* and bracketing concepts, which encompass having the researcher defer discrimination into the obtained data to achieve reliability (Palaganas et al., 2017). Given the nature of qualitative research, which substantially raises researcher bias, reflexivity is of the highest standing and was incorporated throughout the research process to obtain trustworthiness.

Credibility

In qualitative studies, credibility is present when the research findings accurately illustrate the participants' viewpoints (Liao & Hitchcock, 2018). Credibility relates to the data's confidence, corresponding to the internal validity within quantitative research (Twining et al., 2017). Various techniques were drawn upon to increase the study's credibility, including extended participation, continuous observation, triangulation, and peer debriefing. Broad participation exemplifies prolonged investment and time to learn the participants' experience of the phenomenon, primarily emphasizing trust-building (Tracy, 2019). Continuous observation

requires spending adequate time with the participants to identify important aspects of the phenomenon (Smith & McGannon, 2018). Triangulation entails using various sources and methods to collect data to help the researcher obtain the most accurate information from the participants (Merriam & Tisdell, 2015). Peer debriefing entails sharing the researcher's analysis and conclusion with other researchers to help with the study's design and analysis (Merriam & Grenier, 2019). This study used focus groups, in-depth interviews, and participant transcriptions to establish extended participation, continuous observation, and triangulation. Peer debriefing was obtained by regular interactions with the dissertation committee, peers, and other field experts.

Transferability

As it relates to qualitative research, quantitative research's transferability is comparable to external validity (Creswell & Poth, 2018). In quantitative analysis, transferability is formed by delivering evidence that the study's discoveries could apply to other settings and situations (Ferrando et al., 2019). In-depth narratives and descriptions were employed to obtain transferability in this study (Creswell & Poth, 2018). Applying an in-depth description enables the allocation of information from one setting to another and allows readers to determine the transferability of the data and findings (Ferrando et al., 2019).

Dependability

Dependability is the verification that findings are consistent with the data collected. In qualitative research, dependability confirms reliability in quantitative analysis. In general terms, dependability helps assure the research is distinguishable and well recognized (Guest et al., 2012). There are several procedures to help obtain dependability in qualitative research. An audit trail was maintained to increase the dependability of this study. Audit trails are in-depth tactics to

help ensure findings are founded on participants' experiences and narratives, demonstrating how researchers collect and analyze the obtained data (Rodgers & Cowles, 1993). An audit trail in the form of a researcher's journal was used to increase dependability in this study.

Confirmability

Confirmability is important in qualitative research studies corresponding to dependability. In qualitative research, confirmability is equivalent to objectivity in quantitative analysis. Qualitative research is driven by the idea that researchers bring idiosyncratic perceptions to their studies. Therefore, confirmability ensures that the data and interpretations do not negatively impact the findings (Sumpton et al., 2020). Bracketing was incorporated to help show confirmability in this study. A reflective journal was drawn upon to incorporate bracketing. It is believed that dependability and confirmability were established using a research journal (audit trail) and reflective journal (bracketing).

Ethical Considerations

Ethical issues are present in all research studies and must be monitored throughout the research endeavor (Arifin, 2018). Given this inherent risk of ethical concerns in conducting research, researchers must continuously be aware of any complications that may arise and be adequately equipped to respond appropriately. An informed consent form was provided to all participants, including an introduction (purpose), background, procedures, risks and benefits, compensation, and contact information.

Maintaining the privacy of participants was of the utmost importance. Consequently, all participants were provided a pseudonym. Individuals with a mental health VA disability rating should be viewed as vulnerable (Carroll et al., 2017). Specifically, the questions being asked to

the participants could have led to an emotionally-triggering response. Therefore, a list of therapeutic resources was provided to each participant (Appendix I).

Drawing upon prior studies for guidance, all digital data was encrypted and stored in a computer, and paper copies were locked in filing cabinets (Bialke et al., 2018). Data will be stored for no longer than three years after dissertation and publication completion. Upon conclusion of the three years, all stored digital data will be wiped, and hard copies shredded.

Lastly, as an LCSW that works with this population daily, I am driven by an enduring personal and professional code of ethics to protect this population. Through the research endeavor, the participants were always interacted with through care, integrity, and support. Every effort was made to bring no harm to any participant, hoping that each participant benefited and grew from engaging in the study.

Summary

The transcendental phenomenological approach offered the underpinning for describing the essence of the experiences of SSM/V with a MHD in higher education. This chapter described the transcendental phenomenological research design drawn upon for this study. Research questions were offered, setting and participant collection methods established, and procedures delineated. Moreover, data collection and analysis procedures created trustworthiness, and ethical considerations were surveyed.

CHAPTER 4: RESULTS

Overview

The purpose of this qualitative phenomenological study is to document how SSM/V with a MHD living in California describe their higher educational experience. The purpose of this chapter is to present the results of applying a transcendental phenomenological analysis procedure to the data collected from 13 SSM/V through individual interviews, focus groups, and written prompts. The following section of this chapter describes the participants' demographic characteristics. Next, this chapter includes a description of the data analysis procedure applied to the data, followed by a detailed presentation of the findings. This chapter concludes with a summary of the results.

Participants

Eleven of the 13 participants were male and two were female. Eleven participants served in the Army, one in the Navy, and one in the Air Force. Seven participants identified as white, two as black, one as Latino, one as Asian, one as Pacific Islander, and one as Native American. Seven participants were married, and the remaining six reported that they were single/never married. At the time of the study, seven participants were working toward their associate degrees, three were working toward doctorates, two were working toward bachelor's degrees, and one was working toward a master's degree. The mental health VA disability rating condition was PTSD for five participants, depression for four participants, anxiety disorder for two participants, and insomnia for two participants. Table 1 indicates the individual participants' demographics.

Table 1

Participant Personal Demographics

Participant	Gender	Race or Ethnicity	Age Range	Marital Status
John	Male	Latino	18 – 30	Single
Mark	Male	White	31 – 45	Married
Julie	Female	Black	18 – 30	Single
Frank	Male	White	46 – 65	Married
Peter	Male	Pacific Islander	31 – 45	Married
Stewart	Male	White	18 – 30	Single
Joe	Male	Black	46 – 65	Married
Brian	Male	White	31 – 45	Married
Tom	Male	White	18 – 30	Single
Sally	Female	White	18 – 30	Single
Corey	Male	Asian	46 – 65	Married
Sam	Male	Native American	18 – 30	Single
Hunter	Male	White	31 – 45	Married

Table 2 indicates participants' education and employment status.

Table 2

Participant Education and Employment

Participant	Highest Level of Education	How Long Enrolled in College	Degree Currently Pursuing	Employment Status
John	Enrolled in college	2 years	Associates	Part-time
Mark	Enrolled in college	1 year	Bachelor's	Full-time
Julie	Enrolled in college	2 years	Associates	Part-time
Frank	Master's	10 years	Doctorate	Full-time
Peter	Bachelor's	6 years	Master's	Full-time
Stewart	Enrolled in college	4 years	Associates	Part-time
Joe	Associates	6 years	Bachelor's	Disabled
Brian	Married	7 years	Doctorate	Full-time

Participant	Highest Level of Education	How Long Enrolled in College	Degree Currently Pursuing	Employment Status
Tom	Enrolled in college	2 years	Associates	Part-time
Sally	Enrolled in college	2 years	Associates	Part-time
Corey	Enrolled in college	1 year	Associates	Full-time
Sam	Enrolled in college	1 year	Associates	Part-time
Hunter	Master's	12 years	Doctorate	Full-time

Table 3 indicates participants' service and disability status.

Table 3

Participant Service and Disability Status

Participant	Service Branch	Total Years of Service	Mental Health VA Disability Rating	Mental Health VA Disability Rating Condition
John	Army	5	70%	Depression
Mark	Army	27	100%	PTSD
Julie	Air Force	5	70%	PTSD
Frank	Army	35	100%	PTSD
Peter	Army	8	50%	Anxiety disorder
Stewart	Army	6	70%	PTSD
Joe	Army	15	50%	Depression
Brian	Army	9	70%	Insomnia
Tom	Army	5	75%	Depression
Sally	Army	5	50%	Anxiety disorder
Corey	Navy	40	100%	PTSD
Sam	Army	4	50%	Depression
Hunter	Army	15	80%	Insomnia

John

John is a 23-year-old Latino male who is single and working towards his associate degree. He has been enrolled in college for two years and is working part-time. He is currently serving in the Army National Guard as a Specialist (E4). John has five total years of service (TYOS). He has a 70% VA disability rating for depression. In describing his overall experience in higher education, John stated:

> Challenging! I have so much happening in my life that it is difficult to focus on my education. I must remain dedicated. Otherwise, I won't complete my education and get to where I want to be. It's challenging, but I believe I can do it with a little bit of effort.

Mark

Mark is a 45-year-old white male who is married and working towards his bachelor's degree. He has been enrolled in college for one year and is working full-time. He is currently serving in the Active Duty Army as a Command Sergeant Major (E9). Mark has 27 TYOS. He has a 100% VA disability rating for PTSD. In describing his overall experience in higher education, Mark stated:

> I've only got two semesters under my belt, but so far, good. It is a bit harder than I thought it would be, though. Being married, having kids, and working full-time, fitting school into my schedule is brutal. I was telling my wife the other night that I wish I would have done this when I was younger; I think it would have been a lot easier. But I have the drive; my old ass will be able to get through it.

Julie

Julie is a 24-year-old African American female who is single and working towards her associate degree. She has been enrolled in college for two years and is working part-time. She is

currently serving in the Air Force Reserves as a Staff Sergeant (E5). Julie has five TYOS. She has a 70% VA disability rating for PTSD/MST. In describing her overall experience in higher education, Julie stated:

> It has been a difficult one, especially with my daughter. But with my daughter now, it gives me all the more reason I need to continue to get my degree. I want to make sure I can provide her with the best life possible. It is just really hard to stay focused with all the other demands in my life.

Frank

Frank is a 59-year-old white male who is married and working towards his doctorate. He has been enrolled in college for 10 years and is working full-time. He is currently serving in the Active Duty Army as a Colonel (06). Frank has 35 TYOS. He has a 100% VA disability rating for PTSD. In describing his overall experience in higher education, Frank stated: “I have been in school much of my life. It is always challenging, but I have always enjoyed it. I’m a lifelong learner. I also always like to challenge myself, and the school provides the perfect opportunity to grow.”

Peter

Peter is a 33-year-old Pacific Islander male who is married and working towards his master’s degree. He has been enrolled in college for six years and is working full-time. He is currently serving in the Active Duty Army as a Captain (03). Peter has eight TYOS. He has a 50% VA disability rating for anxiety. In describing his overall experience in higher education, Peter stated:

> Though challenging, I enjoy it. I now have the GI Bill, so I’m getting it paid for, which is nice. I’m on a completely online program right now, which is much different from when I

> got my BA years ago. There is no instruction and no interactions with fellow students. I like the traditional format much better.

Stewart

Stewart is a 25-year-old white male who is single and working towards his associate degree. He has been enrolled in college for four years and is working part-time. He is currently serving in the Army National Guard as a Specialist (E3). Stewart has six TYOS. He has a 70% VA disability rating for PTSD. In describing his overall experience in higher education, Stewart stated:

> So far, good. However, it is a bit more difficult than I thought. I was never really a good high school student. So that makes college a lot more challenging for me. I'm a bit behind my fellow students. I must apply myself to succeed in higher education.

Joe

Joe is a 47-year-old African American male who is married and working towards his bachelor's degree. He has been enrolled in college for six years and is not working. He is currently serving in the Army National Guard as a Staff Sergeant (E6). Joe has 15 TYOS. He has a 50% VA disability rating for depression. In describing his overall experience in higher education, Joe stated:

> I've been in the nursing program for a year now. I have been having fun. I do regret I did not go back sooner. With a family and five kids, it isn't easy. However, being medically retired from the police department, attending school has become my full-time job, so I have time to complete it; however, with all the little ones running around the house, finding the time and space to complete my school can be extremely hard.

Brian

Brian is a 41-year-old white male who is married and working towards his doctorate. He has been enrolled in college for seven years and is working full-time. He is currently serving in the Army Reserves as a Major (04). Brian has nine TYOS. He has a 70% VA disability rating for insomnia. In describing his overall experience in higher education, Brian stated: "I don't know why I do what I do. It's demanding. My wife always asks me why I keep going back to school. While the experience in higher education is demanding, I love learning."

Tom

Tom is a 26-year-old white male who is single and working towards his associate degree. He has been enrolled in college for two years and is working part-time. He is currently serving in the Army National Guard as a Specialist (E4). Tom has five TYOS. He has a 75% VA disability rating for depression. In describing his overall experience in higher education, Tom stated: "Challenging and difficult. With my depression, I'm not enjoying it at all. Hopefully, I will start enjoying it more when my depression gets better."

Sally

Sally is a 28-year-old white female who is single and working towards her associate degree. She has been enrolled in college for two years and is working part-time. She is currently serving in the Army National Guard as a Sergeant (E5). Sally has five TYOS. She has a 50% VA disability rating for anxiety disorder. In describing her overall experience in higher education, Sally stated: "I have had a great experience in higher education. Not to brag, but I'm one of those straight-A students. However, being in the military and going to school is a bit challenging. Complex balancing the two."

Corey

Corey is a 64-year-old Asian male who is married and working towards his associate degree. He has been enrolled in college for one year and is working full-time. He is currently serving in the Active Duty Navy as a Master Chief Petty Officer (E9). Corey has 40 TYOS. He has a 100% VA disability rating for PTSD. In describing his overall experience in higher education, Corey stated:

> It has been a pain in the ass. I don't know how people like you do it. I just want my AA, and it is hard as shit. I'm not made for school. But again, I need to do something with my life.

Sam

Sam is a 22-year-old Native American male who is single and working towards his associate degree. He has been enrolled in college for one year and is working full-time. He is currently serving in the Army National Guard as a Specialist (E4). Sam has four TYOS. He has a 50% VA disability rating for depression. In describing his overall experience in higher education, Sam stated:

> More difficult than I thought. I enjoy the classroom instruction and the friendships I have developed, but I hate the homework. I wish I could just learn without taking tests and being graded. Whenever there are tests or exams, my depression and anxiety get bad. It's not fun.

Hunter

Hunter is a 40-year-old white male who is married and working towards his doctorate. He has been enrolled in college for 12 years and is working full-time. He is currently serving in the

Army National Guard as a Captain (03). Hunter has 15 TYOS. He has an 80% VA disability rating for insomnia. In describing his overall experience in higher education, Hunter stated:

> A doctorate degree is a bit more challenging than I thought. It is a lot different than my previous degrees. It is also all online, which I am not used to. I like the traditional format much better. I'm a person that likes to interact with others. The online format prohibits that considerably. While it is too late, I regret going to a strictly online program. I find a lot more enjoyment in education when I experience it with others.

Results

The data collected from 13 SSM/V through individual interviews, focus groups, and written prompts were analyzed using Moustakas's (1994) phenomenological procedure. Two hundred twenty-six invariant constituents were grouped into 29 preliminary themes during this step. Table 4 indicates the preliminary themes and the number of invariant constituents assigned to each of them. Table 5 indicates how the preliminary themes were grouped to form the major themes that indicated the essential characteristics of the participants' lived higher education experiences.

Table 4

Preliminary Themes

	Number of Invariant Constituents from Data Type Included:		
Preliminary Theme (code), alphabetized	Focus Groups	Individual Interviews	Writing Prompts
Anxiety Disorders			13
Challenging curriculum		6	
Challenging to balance obligations		5	1
Classes can trigger PTSD	1	3	
Confidential therapy or support groups are needed	3	5	
Dedicated services are needed	5	7	

Preliminary Theme (code), alphabetized	Number of Invariant Constituents from Data Type Included:		
	Focus Groups	Individual Interviews	Writing Prompts
Depressive Disorders			13
Discrepant data - Inadequate support network		3	2
Discrepant data - Overall impact of MHD on higher education is positive	1	1	
Dislike online education modality		4	
Family and friends are important supports			11
Feeding and Eating Disorders			2
Impulse Control- Conduct Disorders			1
Lack of information about support services	3	5	
Medication side effects negatively impact academics	1	3	
Mental health military service and school are all connected	3		
More experienced providers are needed	2	8	
Negative impact of academic challenges on MHDs	1	4	
Negative impact of MHDs on academic success	6	5	
Personality Disorders			5
Prevalence of MHDs is perceived as high	11	13	
Sexual Dysfunction Disorders			5
Sleep-Wake Disorders			9
Student-peer relationships are essential		12	
Substance Dysfunction Disorders			8
Support services were limited	2	3	
Support services were unavailable	5	7	
Support services were unprepared to work with a military population	2	7	
Trauma and Stressor-Related Disorders			9

Table 5

Grouping of Preliminary Themes into Major Themes

Major Theme (Composite Textural-Structural Description) Preliminary Themes Grouped to Form a Major Theme	Number of Invariant Constituents From Data Type Included: Focus Groups	Individual Interviews	Writing Prompts
Theme 1. Strong support networks were important for overcoming the challenges of higher education.		24	14
Challenging curriculum			
Challenging to balance obligations			
Discrepant data - Inadequate support network			
Dislike online education modality			
Family and friends are important supports			
Student-peer relationships are essential			
Theme 2. Anxiety and depressive disorders are perceived as having the highest prevalence.	11	13	65
Anxiety Disorders			
Depressive Disorders			
Feeding and Eating Disorders			
Impulse Control-Conduct Disorders			
Personality Disorders			
Prevalence of MHDs is perceived as high			
Sexual Dysfunction Disorders			
Sleep-Wake Disorders			
Substance Dysfunction Disorders			
Trauma and Stressor-Related Disorders			
Theme 3. MHD symptoms can hurt academic performance, and academic challenges can increase MHD symptoms.	13	16	
Classes can trigger PTSD			

Major Theme (Composite Textural-Structural Description) Preliminary Themes Grouped to Form a Major Theme	Number of Invariant Constituents From Data Type Included: Focus Groups	Individual Interviews	Writing Prompts
Discrepant data - Overall impact of MHDs on higher education is positive			
Medication side effects negatively impact academics			
Mental health military service and school are all connected			
Negative impact of academic challenges on MHDs			
Negative impact of MHDs on academic success			
Theme 4. Support services tailored for a military population are needed but lacking.	22	39	
Confidential therapy or support groups are needed			
Dedicated services are needed			
Lack of information about support services			
More experienced providers are needed			
Support services were limited			
Support services were unavailable			
Support services were unprepared to work with a military population			

Theme 1: Strong Support Networks Were Important for Overcoming the Challenges of Higher Education

All 13 participants contributed to this theme, and data supporting it was drawn from the individual interviews and the written prompts. The participants indicated that they experienced significant challenges as they pursued their higher education, including challenging curriculum and the difficulty of balancing their academic obligations with their personal and work

obligations. In their writing prompts, most participants expressed that family and friends were important support networks that helped them meet the challenges of higher education. In their individual interviews, most participants expressed that their relationships with their student peers were also an important support network. Two participants provided partly discrepant data, indicating that they did not have support networks. Still, these participants' experiences were consistent with those of the other participants in that they also indicated that support networks were desirable and important for meeting the challenges of higher education.

Six participants reported that higher education was challenging because of the difficulty of the curriculum. Stewart said of higher education: "It is a bit more difficult than I thought. I was never really a good high school student, so that makes college a lot more challenging for me. I'm a bit behind the other students." Corey used straightforward language in describing the curriculum in an interview response: "It is hard as s***." Hunter found the doctoral-level curriculum more challenging than the curriculum he completed for his bachelor's and master's degrees. Hunter said, "A doctorate degree is a bit more challenging than I thought. It is a lot different than my previous degrees."

Six participants expressed that they faced challenges associated with balancing academic and personal obligations. John said in an interview response: "I have so much happening in my life that it is difficult to focus on my education." Sally said in her interview, "Being in the military and going to school is a bit challenging. Complex balancing the two." Mark discussed the challenge of balancing higher education with family and work obligations in an interview response:

> I've only got two semesters under my belt, but so far, good. It is a bit harder than I thought it would be, though. Being married, having kids, and working full-time, fitting

school into my schedule is brutal. I was telling my wife the other night that I wish I would have done this when I was younger. I think it would have been a lot easier.

Three participants indicated that they found the online modality of their classes to be challenging. Hunter said of his doctoral program that the online format made it more challenging for him: “It is all online, which I am not used to. I like the traditional format much better. I’m a person that likes to interact with others. The online format prohibits that considerably.” Peter said in an interview response that the online format inhibited his ability to form connections with other students: “I’m on a completely online program right now, which is much different from when I got my BA years ago. There is no instruction and no interactions with fellow students. I like the traditional format much better.”

To meet the challenges of higher education, all participants reported needing support networks. Friendships with classmates were a support system that participants described as important and effective. John said in an interview response: “I think developing relationships with fellow students is a must. They are needed as a support system.” Julie said of her supportive relationships with other students: “They are vital to me. They support me in so many ways. They babysit for me all the time when I’m in class or working on homework. They also help keep me motivated when I consider dropping out.”

Participants also described their family and friends outside of the classroom as important support networks that helped them meet the challenges of higher education. Mark wrote in response to a writing prompt that his family and friends helped him stay motivated: “My family and friends motivate me to attend school. My wife especially supports me and has been [supporting me] our entire marriage. With her support, I feel that I can succeed in my higher educational pursuits, no matter the demands.” Tom wrote in response to a writing prompt that

family and friends helped him resist the negative impact of his MHD on his motivation to complete college: “If not for my personal relationships, I know my depression would have led me to drop out. My family and friends help me fight back against my depression, keeping me in school.” In response to a writing prompt, Frank wrote that his family’s and friends’ support was necessary to pursue his degree: “I love my family and friends. I thank them daily . . . for allowing me to go back to school. I lucked out and have the best family and friends a person could ask for.”

Theme 2: Anxiety and Depressive Disorders are Perceived as Having the Highest Prevalence

All 13 participants contributed to this theme via their focus group, writing prompt, and individual interview responses. Participants reported that they perceived MHDs as highly prevalent among SSM/V. Asked to indicate which MHDs they perceived as most common among SSM/V, all 13 participants cited anxiety and depressive disorders. Most participants also perceived trauma and stressor-related disorders, sleep-wake disorders, and substance dysfunction disorders as prevalent among SSM/V.

All 13 participants reported that they perceived MHDs as highly prevalent among SSM/V. Stewart said in a focus group response that, based on his experience, “I view the prevalence as high. All my close friends that I deployed with and are now enrolled in school have a VA disability mental health rating.” In the same focus group, Brian agreed with Stewart: “I view the prevalence of mental health disorders in student service members as high. And with so many veterans going back to school, that prevalence rate will continue going up.” In a different focus group, Julie said: “I think the prevalence is 100%. Anyone that puts on the uniform is going to have a mental health disorder eventually.” In the third focus group, P10 said

of the prevalence of MHDs that it was: “Overall, high. It is even worse for student service members and veterans, given the added demand of school difficulties.”

As a writing prompt, participants were provided with a list of 19 *DSM-5* MHDs and asked to select the five they perceived as most prevalent among SSM/V. The disorders are ranked in Table 6 according to the number of participants who circled them.

Table 6

Mental Health Disorders Perceived as Most Prevalent Among SSM/V

Mental Health Disorders (In Descending Order by Number of Participants Citing)	Number of Participants Citing MHD as Among the Most Prevalent in SSM/V
Anxiety Disorders	13
Depressive Disorders	13
Sleep-Wake Disorders	9
Trauma and Stressor-Related Disorders	9
Substance Dysfunction Disorders	8
Sexual Dysfunction Disorders	5
Personality Disorders	5
Feeding and Eating Disorders	2
Impulse Control-Conduct Disorders	1

Note. Participants were invited to select up to five MHDs, and all 13 participants selected five.

The participant responses indicated in Table 6 were notable for their high level of convergence. Of the 19 MHDs participants were asked to select from, only nine were cited by any participant. Of the nine cited, fewer than one-third of participants cited only two (eating disorders and impulse control-conduct disorders). All 13 participants cited anxiety disorders and depressive disorders, and more than half of the participants selected sleep-wake disorders, trauma and stressor-related disorders, and substance dysfunction disorders. Participants, therefore, indicated a high level of agreement among themselves regarding which MHDs were most prevalent among SSM/V.

Theme 3: MHD Symptoms Can Hurt Academic Performance, and Academic Challenges Can Increase MHD Symptoms

Twelve participants contributed to this theme via their focus group and individual interview responses. The participants indicated that for them, the academic impacts of MHDs included impaired concentration and heightened anxiety. Some participants stated that the side effects of medication used to treat MHDs could also impede academic performance. Academic stressors also impacted participants' MHD symptoms, such as heightened anxiety and triggering PTSD. These elevated symptoms then further impeded academic success. One participant provided discrepant data, indicating that his MHD positively impacted his academics by giving him additional motivation to succeed.

Twelve participants reported that they experienced a negative impact on their academics from their MHDs. Brian said in an interview response that his sleep-wake disorder interfered with his academics: "I have not been able to get my sleep right ever since I got back from deployment last year. It makes staying awake in class difficult. Additionally, I lack the energy to complete my homework to the necessary degree." In a focus group response, Sam said of the adverse effects of his depression: "My depression makes me doubt myself. And when I start doubting myself, I start struggling in school."

Three participants indicated that an additional way MHDs interfered with academics was through the side effects of medications used to treat their MHDs. In an interview response, Sally said of the impact of her MHD on her academics: "The main impact I see right now is the medication I am on. It makes me very tired, so focusing on my school efforts can be challenging at times." Joe reported a similar experience to Sally's in an interview response: "My medication

also comes with a lot of adverse side effects. It makes me tired, making it challenging to complete my homework."

Twelve participants also stated that academic stressors exacerbated their MHD symptoms and that their elevated symptoms, in turn, exacerbated their academic stressors in a self-amplifying feedback loop. In an interview response, John said of his experience: "My depression has hurt my higher education endeavors. My depression often kicks in when challenging assignments arise, and then I don't want to do any schoolwork." Joe said in a focus group response: "When I am struggling in school, my symptoms get worse. School for sure would be easier if I did not have my mental health complications." Three participants reported that attending classes could trigger their PTSD. Corey said in an interview response: "There are over 200 students in some classes. That triggers my PTSD." And Julie said in a focus group response: "Given my PTSD, I do not like being around people. I have had to drop out of classes because of my symptoms." Julie provided additional information about this experience in an interview response, stating:

> I often avoid or get anxious about class. There are many service members at my school and in my class. When I find out that someone is a service member, I get PTSD and often suffer panic attacks. I don't trust people in the military. Last semester, I dropped out of a class when I knew someone from my unit was in the same class.

Stewart provided discrepant data indicating that his MHD (PTSD) gave him the motivation to succeed in school. Stewart's responses were consistent with those of other participants in that he noted a negative effect on his concentration, but added that it was also a motivator: "While it certainly negatively impacts my ability to focus entirely on school, it motivates me to improve myself." Stewart further indicated that pursuing his degree had a

positive, therapeutic effect on his MHD, contrary to other participants who stated that higher education tended to exacerbate their MHD symptoms: “I am definitely fucked up. But I view my education as a way to better myself. Much like my therapy, school is a way to confront my difficulties and better myself.” The data did not indicate why P6 experienced the effects of his MHD on his academics and the effects of his academics on his MHD differently from other participants. Notably, PTSD was the most prevalent MHD among the 13 participants, with five participants suffering from it. The other four participants with PTSD all indicated adverse effects of their MHD on their academics and of their academics on their MHD.

Theme 4: Support Services Tailored for a Military Population Are Needed But Lacking

All 13 participants contributed to this theme through their focus group and individual interview responses. All participants reported not receiving adequate services to treat and manage their MHDs from their institutions. Some participants had not sought services at their universities because they were unaware of whether the supports they needed were available. Other participants had sought services at their universities but were referred to external providers by school-based counselors who could not meet their needs. Some participants received support services from their universities but found them inadequate, either because the therapists were young and generally inexperienced or because the therapists were unprepared to work with SSM/V. Participants indicated a need for support services dedicated to SSM/V, such as counselors who were veterans themselves or trained to work with a military population and support groups for veterans and service members. No participants provided discrepant data.

The participants who had never attempted to access support services at their universities associated their experience with a lack of information about the available services. John said in an interview response: “I have never utilized services from higher education for the

complications of my depression . . . The most significant barrier is that I don't actually know what my school offers." Stewart expressed uncertainty similar to John's in an interview response: "I do not think my school offers any assistance for mental health difficulties. I have not asked around, but my school does not seem to be a place that would offer anything." In the same interview response, Stewart added that the most significant barrier he faced to seeking the support he needed was: "A lack of awareness or understanding of what my school offers." Frank said in an interview response that the most significant barrier he faced to seeking support services from higher education was: "A lack of awareness. I don't know what my school offers regarding mental health treatment." In a focus group response, Hunter suggested that universities like his should make a more significant effort to raise awareness among students of the available supports:

> I have no experience utilizing higher-education support services for my mental health complications. Schools need to make their services more accessible. They also need to focus on awareness. I have no idea what my school could offer to help me.

Five participants reported that they attempted to access support services at their universities but that the services were not able to help them. In a focus group response, Sally said: "I went one time, and I think I scared them with all my issues. They were nice in the support center, but they could not help me." In the same focus group, Corey agreed with Sally, saying,

> Same story here. No help at all. They connected me with an intern that was overwhelmed with my troubles. I left after about 10 minutes of talking to them. I feel bad doing that, but I knew it would be a waste of my time.

Like Corey, Peter reported that he was referred to an intern who was unable to help him: “Their support services suck. I went to get counseling at the support center. They connected me with an intern that was not a good counselor. They also had no idea about the military.”

Participants reported that they perceived demand among SSM/V for MHD support from higher education institutions. After stating that he only received minimal support from the military, Mark added: “If schools could offer more therapy services, especially individual therapy, it would help me a lot.” Like Mark, Joe suggested in an interview response that support services were needed through higher education to compensate for the lack of adequate services from the military:

> When I was getting the runaround with the active-duty services and the VA, the school did the exact same. While they said they wanted to help, they didn’t have the needed resources. After going to the school counseling center a couple of times, I just gave up. The whole experience just pissed me off.

Hunter indicated that confidential support from higher education was needed to supplement care from the VA, where some disclosures might have negative consequences: “I seek care through the VA. The military can see my VA records. Therefore, I don’t tell them everything. If schools could provide confidential therapy, that would be so helpful to me.” Julie reported a desire for in-house support services at her university instead of her referral: “While they say they are a counseling department; they appear only to refer out. It would be nice if they provided actual therapy by trained professionals in the school.” Brian said in a focus group response that many SSM/V needed support services from higher education and that such services should be provided: “Student service members are struggling to find needed resources more than

most populations. We are a vulnerable population. Given our dedication to this nation, we should be provided with the highest degree of care."

To meet the perceived demand among SSM/V for support services in higher education, seven participants suggested that dedicated services or accommodations for SSM/V were needed. In a focus group response, Joe said: "Schools need to offer counseling services directly tailored to the military culture." In the same focus group, Stewart suggested that universities should have personnel on staff who could assist or guide veterans in navigating the VA: "I had a tough time getting connected with VA services. It would be nice to have more people to help veterans get connected with the VA in higher education." John suggested in an interview response that dedicated support groups should be offered for SSM/V:

> I think a support group with fellow service members with mental health disorders would be great. I don't know why more schools don't do that. Apply the concept of the camaraderie developed in the military to the school environment. It would act as a support system, as we have in the military.

Corey said in an interview response that counselors who were veterans were needed to support SSM/V: "They need military veterans. We in the military relate to our own. Some young, 20-year-old therapists will not help service members and veterans in higher education." Sally corroborated Corey's perception in describing a need for counselors who were prepared to work with SSM/V: "Schools need trained professionals that know how to work with the military population. Ones that also know and have real-life experience with our challenges. Based on my experience, they had no idea what to do with me." Thus, participants perceived a high demand for support services in higher education that were dedicated to helping or at least prepared to help SSM/V. Participants further reported that this demand was not being met at their

universities. Supports for which participants expressed a need included more experienced counselors, counselors who were veterans or who were at least trained to work with a military population, support groups for SSM/V, and assistance in navigating the VA.

Outlier Data and Findings

Two participants provided discrepant data indicating that they lacked support networks. However, their responses were consistent with those of the other participants in that they also perceived support networks as important for meeting the challenges of higher education. Sam wrote in his writing prompt: “I do not have personal relationships. With my present depression, I avoid everyone.” Sam elaborated in an interview response, stating: “I avoid other students at all costs . . . But I hope I eventually will be able to develop relationships in school. I think they could serve as a sound support system for me.” Hunter reported in an interview response that he lacked relationships with fellow students, although he agreed with other participants that such relationships were an essential source of support: “I think relationships are a must. However, I have developed no relationships with fellow students, given the online format. I believe that is why I am struggling more with this degree than with my others.” Thus, all participants agreed that relationships with classmates, family, and friends were important and influential in meeting the challenges of higher education, which included the difficulty of balancing obligations and the demanding nature of the curriculum. Most participants reported that they had formed strong support networks of family, friends, and classmates. Participants who did not have strong support networks still regarded those networks as important and wanted to form them when conditions permitted.

Research Question Responses

The four identified themes were used to answer the central research question and three sub-questions. Using the identified themes, short and direct narrative answers to each research question will be discussed. The use of major themes to address the research questions is outlined in Table 7.

Table 7

Use of Major Themes to Address the Research Questions

Research Question	Major Theme Used to Address Question
Primary RQ. How do SSM/V with a MHD living in California describe their higher educational experience?	Theme 1. Strong support networks were important for overcoming the challenges of higher education.
SQ1. Out of the 19 *DSM-5* core disorders in the overall veteran population, what five MHDs do SSM/V with a VA MHD rating perceive as most prevalent among the SSM/V collegiate population?	Theme 2. Anxiety and depressive disorders are perceived as having the highest prevalence.
SQ2. What are the academic impacts of mental illness for SSM/V with a VA MHD rating in higher education?	Theme 3. MHD symptoms can hurt academic performance, and academic challenges can increase MHD symptoms.
SQ3. What support services do SSM/V with a MHD rating identify as helpful and or/lacking in their higher educational pursuits?	Theme 4. Support services tailored for a military population are needed but lacking.

This presentation of the findings is organized by research question. Under the heading for each research question, the theme used to address the question is presented in detail. Direct quotes from the three data types (individual interviews, focus groups, and written prompts) are provided as evidence for the findings.

Central Research Questions

How do SSM/V with a MHD living in California describe their higher educational experience? The participants' perspective was that strong support networks were important for overcoming the challenges of higher education. In an interview response to the importance of having classmates as a support network, Sally stated: "For anyone to successfully complete school, they need a robust support system. And the relationships I have developed with my fellow students have created that support system for me."

Sub-Question One

Out of the 19 *DSM 5* core disorders in the overall veteran population, what five MHDs do SSM/V with a VA MHD rating perceive as most prevalent among the SSM/V collegiate population? Anxiety and depressive disorders were perceived as having the highest prevalence among SSM/V among the participants. The participants also viewed the prevalence of MHD in SSM/V as high. In an interview response, John described the prevalence of MHDs among SSM/V as: "Extremely high. I think everyone in the military has some sort of mental health disorder. And those disorders are only aggravated when higher education demands get placed on you. I know that has been the case for me."

Sub-Question Two

What are the academic impacts of mental illness for SSM/V with a VA MHD rating in higher education? Participants noted that MHD symptoms can hurt academic performance, and academic challenges can increase MHD symptoms. In a focus group response, Mark said: "My VA disability for mental health [PTSD] really hampers my ability to focus, especially when it comes to homework." Considering academic challenges increasing MHD symptoms, Peter said in an interview response: "Whenever a new semester starts, I notice that my anxiety gets worse."

Sub-Question Three

What support services do SSM/V with an MHD rating identify as helpful and or/lacking in their higher educational pursuits? Participants believed that support services tailored for the military population were needed but lacking. In an interview response, Joe reported: “My school had no idea how to support me with my military demands and corresponding mental health difficulties.”

Summary

The primary research question was: How do SSM/V with a MHD living in California describe their higher educational experience? The primary RQ was partly answered by answering the three sub-questions from which it was derived. However, one major theme emerged during data analysis that addressed the primary RQ without addressing any of the sub-RQs. This theme was: Strong support networks were important for overcoming the challenges of higher education. All 13 participants contributed to this theme, and data supporting it was drawn from the individual interviews and the written prompts. The participants indicated that they experienced significant challenges as they pursued their higher education, including challenging curriculum and the difficulty of balancing their academic obligations with their personal and work obligations. In their writing prompts, most participants expressed that family and friends were an important support network that helped them meet the challenges of higher education. In their individual interviews, most participants expressed that their relationships with their student peers were also an important support network. Two participants provided partly discrepant data indicating that they did not have support networks, but these participants’ experiences were consistent with those of other participants, in that they also indicated that support networks were desirable and important for meeting the challenges of higher education.

Sub-question 1 asked: Out of the 19 *DSM 5* core disorders in the overall veteran population, what five MHDs do SSM/V with a VA MHD rating perceive as most prevalent among the SSM/V collegiate population? The theme used to address this question was: Anxiety and depressive disorders are perceived as having the highest prevalence. All 13 participants contributed to this theme via their focus group, writing prompt, and individual interview responses. Participants reported that overall, they perceived MHDs as being highly prevalent among SSM/V. Asked to indicate which MHDs they perceived as most common among SSM/V, all 13 participants cited anxiety and depressive disorders. Most participants also perceived trauma and stressor-related disorders, sleep-wake disorders, and substance dysfunction disorders as prevalent among SSM/V.

Sub-question 2 asked: What are the academic impacts of mental illness for SSM/V with a VA MHD rating in higher education? The theme used to address this question was: MHD symptoms can hurt academic performance, and academic challenges can increase MHD symptoms. Twelve participants contributed to this theme via their focus group and individual interview responses. The participants indicated that for them, academic impacts of mental illness included impaired concentration and heightened anxiety. Some participants stated that the side effects of medication used to treat MHDs could also impede academic performance. Circularly, academic stressors also impacted their MHD symptoms by heightening anxiety and triggering PTSD. These elevated symptoms then further impeded academic success. One participant provided discrepant data indicating that his MHD positively impacted his academics by giving him additional motivation to succeed.

Sub-question 3 asked: What support services do SSM/V with a MHD rating identify as helpful and or/lacking in their higher educational pursuits? The theme used to address this

question was: Support services tailored for a military population are needed but lacking. All 13 participants contributed to this theme through their focus group and individual interview responses. All the participants reported not receiving adequate services to treat and manage their MHDs from their institutions. Some participants had not sought services at their universities because they were unaware of whether the supports they needed were available. Other participants had sought services at their universities but were referred to external providers by school-based counselors who could not meet their needs. Some participants received support services from their universities but found them inadequate, either because the therapists were young and generally inexperienced or because the therapists were unprepared to work with SSM/V. Participants indicated a need for support services dedicated to SSM/V, such as counselors who were either veterans themselves or who were trained to work with a military population, as well as support groups for veterans and service members. No participants provided discrepant data. Chapter Five includes a discussion and implications of these findings.

CHAPTER FIVE: CONCLUSION

Overview

The purpose of this qualitative phenomenological study is to document how SSM/V with a MHD living in California describe their higher educational experiences. The problem addressed in this study was a lack of qualitative understanding and documentation primarily focused on the quantitative analysis of the difficulties SSM/V encounter in higher education (Barry et al., 2021; Borsari et al., 2017). The data collected from 13 SSM/V through individual interviews, focus groups, and written prompts were analyzed using Moustakas's (1994) phenomenological procedure for data analysis.

Discussion

After data analysis, the study findings revealed that participants indicated having experienced significant challenges as they pursued higher education. These difficulties included challenging curriculum and the difficulty of balancing their academic obligations with their personal and work obligations. Below, five discussion subsections will be covered: (a) interpretation of findings, (b) implications for policy and practice, (c) theoretical and methodological implications, (d) limitations and delimitations, and (e) recommendations for future research.

Interpretation of Findings

Participants reported that overall, they perceived MHDs as being highly prevalent among SSM/V. Most participants also perceived trauma and stressor-related disorders, sleep-wake disorders, and substance dysfunction disorders as prevalent among SSM/V. Participants also indicated that MHDs impacted academics through impaired concentration and heightened anxiety. Side effects of medication used to treat MHDs could also impede academic

performance. Lastly, participants reported not receiving adequate services to treat and manage their MHDs from their institutions. This section presents a specific discussion of the study interpretation findings. The section will begin with a summary of the thematic findings discussed in Chapter Four. Following, a series of interpretations deemed significant will be discussed.

Summary of Thematic Findings

Four themes were identified in this study, to include: Strong Support Networks Were Important for Overcoming the Challenges of Higher Education, Anxiety and Depressive Disorders are Perceived as Having the Highest Prevalence, MHD Symptoms Can Hurt Academic Performance, and Academic Challenges Can Increase MHD Symptoms, and Support Services Tailored for a Military Population Are Needed But Lacking. Each of the themes helps better understand the experience SSM/V with a MHD undergo in higher education, highlighting both the difficulties and help needed to moderate these complications. Below three interpretations of these themes will be identified and discussed.

Relationships are Key. To be successful in their academic pursuits and to adequately deal with the difficulties of their MHDs, the participants in the study needed strong relationships, especially the camaraderie that was developed and came from military-afflicted students. This interpretation from the present study relates to the current literature. For instance, Barry et al. (2021) and Bennett (2017) reported that social support and strong relationships correlate to academic adjustment and success with SSM/V. Additionally, according to Fredman et al. (2019), the endorsement of positive relationships moderated the overall impact of MHD symptoms. Secondly, it was discovered that this affiliation declaration significantly moderated the negative relationship between mental disorder indicators and maladaptive academic goal orientation (Fredman et al., 2019). Combined, these findings concur with the current study finding that solid

relationships are needed in overcoming challenges encountered by SSM/V in their higher education.

It is Not All About PTSD. All participants reported that they perceived MHDs as highly prevalent among SSM/V. However, the participants noted anxiety and depressive disorders as the most common. This leads to the interpretation that while PTSD and other trauma-related disorders are viewed as important and prevalent, they are not viewed as the most predominant MHDs in the veteran population, especially for the participants in the study. This interpretation is important, in that it is divergent from the current literature, which finds PTSD to be the most common MHD in the veteran population (Hunt et al., 2019).

The current literature finds PTSD and trauma and stressor-related disorders to be the most common MHD in veterans (Hammond, 2017; Hunt et al., 2019). PTSD is often called the "signature wound' of military veterans (Tanielian et al., 2008). This discrepancy between the current documentation on the prevalence of PTSD and the present study's findings of anxiety and depressive disorders being perceived as more common MHDs in the SSM/V population supplies a unique new knowledge and insight into the phenomenon that has yet to be fully detailed in the literature.

Giving a Voice is Essential. Throughout the study, all participants exhibited a willingness and an excellent degree of excitement participating in the study. They continually ended the interviews and focus groups with thankfulness and gratitude for being selected and having the opportunity to participate in the study. The participants wanted to share their story of being a SSM/V with a MHD, and this study afforded them the opportunity to do so. In totality, the interpretation is the SSM/V population wants and enjoys having a voice in describing their experience in higher education.

Prior research has primarily focused on the quantitative analysis of the difficulties SSM/V encounter in higher education (Barry et al., 2021). While important, this overly quantitative focus has led to a lack of qualitative understanding of how SSM/V describe their higher education (Borsari et al., 2017). By taking a qualitative approach in this study, the SSM/V participants were given a voice, which not only helped advance the current understanding of the population but helped the participants directly through their participation.

Implication for Policy and Practice

The study identified implications for policy and practice. These identified implications include specific recommendations for various stakeholders, including policymakers and administrators in higher education. The identified implications for both policy and practice will be discussed below.

Implications for Policy

This study has several policy implications. First, by seeking to describe *what* is experienced by SSM/V with an MHD in attending higher education and *how* it is experienced, these results may be helpful to institutions of higher education that serve SSM/V with an MHD in setting and implementing policies to better support SSM/V with MHDs in their institutions. Furthermore, this study's results have added to the documentation by providing significant insights related to the perceived prevalence of MHDs in the SSM/V population and the impact of MHDs on the academics of SSM/V. Finally, it emphasized the need for enhanced support services for SSM/V with a MHD in higher education. These findings are crucial to the government when passing laws governing students and veterans with MHD symptoms in all public institutions. The results are essential for higher education institutions to advance support

services for the SSM/V population and decrease the likelihood of SSM/V dropping out of college.

Implications for Practice

Several practical implications were advanced for this study. Based on the literature review, it was evident that SSM/V have unique challenges, including a history of trauma, substance abuse, and MHDs (Thomas et al., 2018). Grounded in this identified history, these past and present difficulties cause barriers and hurdles to academic achievement (Barry, 2015). This study's findings provide higher education leaders with new insights from the research participants' perspectives on identified issues, such as the challenges faced in accessing support services. Education leaders may find these results helpful in understanding these challenges and finding ways to help SSM/V with MHD symptoms receive adequate care. These results could be used in all schools accommodating SSM/V with MHD symptoms to navigate their higher education.

Theoretical and Empirical Implications

The four themes that emerged from this study describe the essence of the experiences of SSM/V with a MHD in higher education. The first theme, Strong Support Networks Were Important for Overcoming the Challenges of Higher Education, corroborates the PC/E theory. The second theme, Anxiety and Depressive Disorders Are Perceived as Having the Highest Prevalence, confirms the current literature that MHDs are perceived as high in the SSM/V population, but offers new insights into the importance of relationship and purpose in helping assuage MHD symptoms. The third theme, MHD Symptoms Can Hurt Academic Performance, and Academic Challenges Can Increase MHD Symptoms, extends previous research by highlighting that MHD symptoms not only hamper academic performance, but higher education

challenges also increase MHD symptoms. The four theme, Support Services Tailored for a Military Population Are Needed But Lacking, confirms the research on the needed support for SSM/V and extends PC/E theory on informing the topic.

Theoretical Implications

A person-centered, theoretical framework combined with an existential theoretical framework was used to explain and inform the research on SSM/V (Frank, 1985, Rogers, 1961). The findings from the present study expanded both theories. As participants described their experience of being a SSM/V with a VA MHD in higher education, the importance of relationships and purpose, the two key components of PC/E were clearly manifested.

PC/E claims that self-directed development occurs when an individual is in a relationship based on genuineness, acceptance, and empathy (Frankl, 1985; Rogers, 1965). By exploring the unique experiences of SSM/V with MHD in higher education through the lenses of PC/E framework, this study's findings provided invaluable insights into assisting the population in their academics, such as providing enhanced relationship and purpose-driven support services to the population. Furthermore, through the importance of relationships emphasized in PC/E framework (Frankl, 1985; Rogers, 1961; Rogers, 1985), this study added more to the literature by acquiring the unique experiences of SSM/V with MHDs in higher education; highlighting that the population is more likely to struggle in their higher education journey without relationships based on genuineness, acceptance, and empathy.

Participants reported that they perceived MHDs as highly prevalent among SSM/V. These findings are consistent with the previous literature regarding the prevalence of MHDs among the SSM/V population (Barry et al., 2021; Pickett et al. 2015). Considering prevalence, veterans with weaker relationships and social support networks reported a higher degree of

MHDs (Ness et al., 2015; Xue et al., 2015). These findings directly relate to Rogers' (1961) assertion of the importance of relationships in combating MHDs within clients and individuals. Examining suicide, veterans that believed they lacked a purpose were identified as more likely to attempt suicide (Bryan et al., 2015; Ray-Sannerud et al., 2015). As it relates to Frankl's (1985) theory of having a definite purpose for overcoming everyday life difficulties, veterans need help establishing internal purposes to succeed in their higher educational endeavors. This study's confirmation of PC/E underpinnings extends previous research and should be explored in future investigations.

Empirical Implications

The participants in the study highlighted the academic impacts of SSM/V having a MHD, including impaired concentration and heightened anxiety. Moreover, some participants stated that the side effects of medication used to treat their MHDs also impeded academic performance. Of unique significance, the participants in the study reported that academic stressors in higher education also had an adverse effect on their MHD symptoms, heightening their anxiety and triggering other symptoms. According to participants, these elevated symptoms further impeded academic success.

These study findings both support and add to the empirical literature. For example, studies that have examined the effects of MHDs on relationships and self-regulated learning in higher education have revealed several key findings (Eakman et al., 2019; Fredman et al., 2019; Ness et al., 2015). First, the endorsement of positive relationships moderated the overall impact of MHD symptoms (Eakman et al., 2018; Fredman et al., 2019). Secondly, it was discovered that this affiliation declaration directly and significantly moderated the negative relationship between MHD indicators and maladaptive academic goal orientation (Ness et al., 2015; Fredman et al.,

2019). These findings are consistent with the current study's results, which state that MHDs negatively impact the academic performance of SSM/V with MHDs, increasing the academic challenges among the population.

The novel contribution of the study regarding MHD impact is the finding that participants noted their MHDs not only created academic difficulties, but academic challenges also aggravated their MHD symptoms. The primary focus of the present literature is on the adverse effects MHDs have on SSM/V academic performance (Borsari et al., 2017). While this focus is important, there is a lack of existing literature on how academic struggles can negatively affect MHD symptoms (Barry et al., 2021). Based on the present studies finding that academic difficulties also exacerbate MHD symptoms in SSM/V, large implications can be taken for future research and examination.

Of further note, the participants in the study reported that they had not received adequate services to treat and manage their MHDs from their institutions. Some participants had sought services at their universities but were referred to external providers by school-based counselors who could not meet their needs. Most participants received support services from their universities but found them inadequate. Participants indicated a need for support services dedicated to SSM/V. Based on the highlighted challenges in accessing adequate support, these services included counselors who were either veterans themselves or trained to work with a military population, including SSM/V support groups. The interpretation of these findings is that support services are crucial to SSM/V with MHDs pursuing higher education. The implication is that the lack of these support services to SSM/V with MHDs poses a significant challenge; learning institutions need to provide these support services to their respective SSM/V with MHDs to succeed.

This study's findings support the current literature concerning the support services afforded to SSM/V with MHDs to counter higher education and academic performance challenges. For instance, Barry et al. (2021) reported that the precise needs and amenities range from financial support, psychological provisions, and disability amenities. The demands for such noted supportive services for SSM/Vs are apparent (Bonar et al., 2015). However, higher education institutions still lack direct services (Barry et al., 2014). According to Norman et al. (2015) and Selber et al. (2015), certain universities have begun to execute SSM/V tailored services to help with the academic transition. These services include psychoeducational counseling groups to help with stress, sleep difficulties, and the transition to higher education. However, fewer SSM/V seek mental health services on campus, with over 90% of SSM/V seeking mental health treatment outside the campus infrastructure (DiRamio et al., 2015; Morris et al., 2020). These research findings support the current study's findings, which indicate that students were unaware that support services were available on campus.

A final and large empirical implication of the study's findings is the divergence in the view of the prevalence rates of MHDs. Much of the previous research into the issue has indicated PTSD and other trauma-related disorders to be the most common MHDs in the veteran population (Hammond, 2017; Hunt et al., 2019). While the participants in this study found PTSD and other trauma-related disorders high, they did not view them as the most prevalent. The most predominant MHDs the participants noted in this study were depression and anxiety. This finding is important and should lead future research to expand their investigation into other MHDs beyond PTSD.

Limitations and Delimitations

Limitations are potential weaknesses in a study that are difficult to control (Creswell & Poth, 2018). Conversely, delimitations are purposeful decisions to limit or define the boundaries of the study (Creswell & Poth, 2018). Within this section, the limitations and delimitations of the study will be identified and discussed.

Limitations

Several limitations were encountered while conducting this study. First, this study was limited by the sample size. A small sample size of 13 participants was used to gather relevant data for analysis. The small sample size may pose a challenge in generalizing the study findings to other geographical settings or populations, presenting a biased representation of findings.

A second limitation of this study was the geographical scope or setting. The study was conducted in one geographical setting, which provides a challenge in transferring the findings to other locations. The use of one geographical location may not permit generalizability and transferability of findings because different geographical locations experience diverse conditions and characteristics that may not be present in the current setting of the study.

A third limitation of this study was the target population. The researcher used only SSM/V with MHDs rather than including other cohorts of students to compare their experiences in their higher education. Thus, the challenges highlighted by the study findings may not have captured other cohorts of students in higher education.

Lastly, the use of interviews was a limitation of this study. Given the stigma associated with MHDs in the SSM/V population, participants may not have provided completely transparent information regarding their experiences of challenges in their higher education.

Therefore, the researcher may not have had complete control of their responses, which could have resulted in several biased findings.

Delimitations

The key delimitation in the study was that participants were bounded by three specific requirements. First, participants were required to be currently serving in the military, including active duty, reserves, or the National Guard. Secondly, all participants had to have a VA MHD rating. Lastly, each participant had to be actively engaged in higher education. By limiting the study to these boundaries, it was assured that each participant in the study experienced the shared phenomenon under investigation (Creswell & Poth, 2018).

Recommendations for Future Research

This study has several recommendations for future research. The recommendations are primarily based on the limitations of the study. The sample size limited this study. A small sample size of 13 participants was used to gather relevant data for analysis. The small sample size may pose a challenge in generalizing the study's findings to other geographical settings or populations, presenting a biased representation of findings. The recommendation is that future studies should use a larger and more diverse sample size to generalize the findings.

The second limitation of this study was the geographical scope or setting. The study was conducted in one geographical setting, which provides a challenge in transferring the findings to other locations. The use of one geographical location may not permit generalizability and transferability of findings because different geographical locations experience diverse conditions and characteristics that may not be present in the current setting of the study. The researcher recommends more studies from different geographical locations to allow the transferability of findings.

The third limitation of this study was the target population. The researcher used only SSM/V with MHDs rather than including other cohorts of students to compare their experiences in higher education. Thus, the challenges highlighted by the study's findings may not have captured other cohorts of students in higher education. In this regard, future studies ought to use a target population with diverse student cohorts to ensure the generalizability of the study's findings.

Conclusion

The purpose of this study was to document how SSM/V with a MHD living in California describe their higher education experience. A transcendental phenomenological research design was utilized to obtain the essence of the lived experiences of participants in the study by providing them with an opportunity for their voices to be heard. A PC/E framework was drawn upon to guide the study. The data collected from 13 SSM/V through individual interviews, focus groups, and written prompts were analyzed using Moustakas's (1994) phenomenological procedure for data analysis.

SSM/V with a MHD encounter a unique and difficult journey in their higher education pursuits. Their MHDs not only make their academic challenges more difficult, but their academic struggles can also worsen their MHD symptoms. However, by giving the participants a voice in this study, the solution to help assuage these difficulties was found in themselves. By providing enhanced relationships and purpose, especially with one another, SSM/V with a MHD can overcome their difficulties and be successful in their higher education journey.

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APPENDIX A: STUDY RECRUITMENT LETTER

Dear Student Service Member and Veterans:

As a graduate student in the School of Education at Liberty University, I am conducting research as part of the requirements for a Doctor of Education. The purpose of my research is to describe the experiences of student service members and veterans with a Veterans Affairs MHD rating(s).

I am writing to invite you to participate in this study.

If you are currently serving as a service member in active duty, reserves, or National Guard, attending higher education (college or university), and have a Veterans Affairs (VA) Mental Health Rating (0-100%), I ask that you consider helping me with this study.

Participants will be asked to:

- Participate in an in-depth, one-on-one interview (about 50 to 60 minutes, videoconference via Zoom, audio recorded).
- Participate in a discussion board-based focus group (about 90 to 120 minutes, videoconference via Zoom, audio recorded).
- Complete a three-question writing prompt (about 50 to 60 minutes).
- Review interview transcripts for accuracy (about 60 minutes)

A consent document will be e-mailed to you if you meet the study criteria. The consent form contains additional information about this research and must be signed and returned to participate in this study.

Any personal, identifying information you provide will be kept entirely confidential. The use of any information you provide will be presented in such a way that protects your identity.

If you would like to participate, please contact me @ [redacted] by March 31, 2022. Upon contact, you will be sent a contact information and participant demographics form to determine eligibility for the study.

Sincerely,

Dustin Harris, LCSW, BCD
Doctoral Student
Liberty University
School of Education

APPENDIX B: CONTACT INFORMATION FORM

Are you currently serving in the military (active duty, reserves, or National Guard), have a Veterans Affairs (VA) Mental Health Rating (0-100%), and are currently enrolled in higher education (college or university):

Yes/No

Please provide:

1. Your Name:
2. The best times when you would be available for an interview are:
3. Your preferred method of contact to set up the interview is:
    a. Email
    b. Phone
4. Your email address is:
5. Your phone number is:

APPENDIX C: CONSENT FORM

Title of the Project: A Phenomenological Study of How Student Service Members and Veterans with Mental Health Disorders Describe Their Academic Experience in Higher Education
Principal Investigator: Dustin Harris, Ph.D. Candidate, Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. To participate, you must be currently enrolled in higher education (college or university), have a Veterans Affairs (VA) Mental Health Rating (0-100%), and currently serve in the armed forces as Active Duty, Reserves, or National Guard. All military components, including the Army, Navy, Air Force, Marines, and Coast Guard, will be eligible for the study.

Please take time to read this entire form and ask questions before deciding whether to take part in this research.

What is the study about, and why is it being done?

The purpose of the study is to describe the experiences of student service members and veterans with a mental health disorder living in California. With the information obtained, the goal is to give a voice to the population. It is hoped that the obtained knowledge in the study will be drawn upon to progress and implement support services to help student service members and veterans in their educational pursuits.

What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following things:

1. Participate in a 50–60-minute, one-on-one interview over Zoom. There will be 17 interview questions. All interviews will be audio-recorded transcribed into written format. As a participant, you will be able to review the interview transcript for accuracy.
2. Participate in a 60–90-minute focus group over Zoom with three to four other participants. There will be five focus group questions. All focus group responses will be audio recorded transcribed into written format. As a participant, you will be able to review your focus group transcript for accuracy.
3. Answer three writing prompts that will be e-mailed to you. There will be no minimum or maximum length to the writing prompts. The estimated time to complete the writing prompts is 50-60 minutes.

How could you or others benefit from this study?

Participants should not expect to receive a direct benefit from taking part in this study, but they will have the opportunity to have a voice in describing what student service members and veterans with a mental health disorder encounter in higher education and a subsequent purpose in impacting meaningful change. Furthermore, it is hoped that participants will develop a sense of camaraderie and support in sharing their experiences with other participants. Lastly, each

participant will be provided a list of resources and subsequent psychoeducation on obtaining needed assistance in their current academic pursuits.

This study will contribute to the literature by providing insight into the experience of student service members and veterans with mental health disorders. In turn, it is hoped that this obtained knowledge will be drawn upon to progress and implement support services to help the population in their educational pursuits.

What risks might you experience from being in this study?

The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life.

Some of the questions could lead to an emotionally triggering response. Therefore, a list of therapeutic resources will be provided to each participant. As a mandatory reporter, I must report any information shared on child abuse, child neglect, elder abuse, or intent to harm self or others through appropriate legal channels.

How will personal information be protected?

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher will have access to the records.

- Participant responses will be kept confidential using pseudonyms. Interviews will be conducted in a location where others will not easily overhear the conversation.
- Confidentiality cannot be guaranteed in focus group settings. While discouraged, other focus group members may share what was discussed with persons outside of the group.
- Digital data will be encrypted and stored in a computer, and paper copies locked in file cabinets. Data will be stored for no longer than three years after dissertation and publication completion. Upon conclusion of the three years, all stored digital data will be wiped, and hard copies shredded.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether to participate will not affect your current or future relations with Liberty University, other institutions of higher education, or your service in the military. If you decide to participate, you are free not to answer any questions or to withdraw at any time without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please get in touch with the researcher at the email address/phone number included in the next paragraph. Should you choose to withdraw, data collected from you, apart from focus group data, will be destroyed immediately and will not be included in this study. Focus group data will not be destroyed, but your contributions to the focus group will not be included in the study if you choose to withdraw.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Dustin Harris. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact him at [redacted]. You may also contact the researcher's faculty sponsor, Dr. Leldon Nichols, at [redacted].

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515, or email at irb@liberty.edu.

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted ethically as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the researcher using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to audio record me as part of my participation in this study.

_____
Printed Subject Name

_____
Signature & Date

APPENDIX D: PARTICIPANT SCREENING DEMOGRAPHICS FORM

1. What is your gender?
    a. Male
    b. Female
    c. _____ (Short Answer Space)
2. What is your age?
    a. 18 - 30 years old
    b. 31 - 45 years old
    c. 46 - 65 years old
    d. 65+
3. What is your ethnic background/race?
    a. Caucasian
    b. African American
    c. Latino or Hispanic
    d. Asian
    e. Native American
    f. Native Hawaiian or Pacific Islander
    g. Two or More
    h. Other/Unknown
4. Which of the following best describes your current relationship status?
    a. Married
    b. Widowed
    c. Divorced

   d. Separated
   e. In a domestic partnership or civil union
   f. Single, but cohabiting with a significant other
   g. Single, never married
5. What is your highest level of education?
   a. Enrolled in college
   b. Associates degree
   c. Bachelor's degree
   d. Master's degree
   e. Doctorate
6. How long have you currently been enrolled in college?
7. What institution of higher education are you attending?
8. What degree are you currently pursuing?
   a. Associates degree
   b. Bachelor's degree
   c. Master's degree
   d. Doctorate
9. What is your employment status?
   a. Employed full-time, working 40 or more hours a week
   b. Employed part-time, working less than 40 hours a week
   c. Not employed, looking for work
   d. Not employed, not looking for work
   e. Disabled, not able to work

10. In which military component do you serve?
    a. Active Duty
    b. Reserves
    c. National Guard
11. What branch of the armed forces do you serve?
    a. U.S. Army
    b. U.S. Navy
    c. U.S. Marine Corps
    d. U.S. Air Force
    e. U.S. Coast Guard
12. What is your rank?
13. What is your mental health VA disability rating percentage?
14. What is your mental health VA disability rating condition?
15. What are your total years of military service?
16. Do you utilize the GI Bill or other military benefits for your education?
17. What is your military occupational specialty (MOS) or area of concentration (AOC)?

APPENDIX E: PARTICIPANT DEMOGRAPHICS FORM

PARTICIPANT NAME:

1. What is your gender?
    a. Male
    b. Female
    c. _____ (Short Answer Space)
2. What is your age?
    a. 18 - 30 years old
    b. 31 - 45 years old
    c. 46 - 65 years old
    d. 65+
3. What is your ethnic background/race?
    a. Caucasian
    b. African American
    c. Latino or Hispanic
    d. Asian
    e. Native American
    f. Native Hawaiian or Pacific Islander
    g. Two or More
    h. Other/Unknown
4. Which of the following best describes your current relationship status?
    a. Married
    b. Widowed

   c. Divorced
   d. Separated
   e. In a domestic partnership or civil union
   f. Single, but cohabiting with a significant other
   g. Single, never married
5. What is your highest level of education?
   a. Enrolled in college
   b. Associates degree
   c. Bachelor's degree
   d. Master's degree
   e. Doctorate
6. How long have you currently been enrolled in college?
7. What institution of higher education are you attending?
8. What degree are you currently pursuing?
   a. Associates degree
   b. Bachelor's degree
   c. Master's degree
   d. Doctorate
9. What is your employment status?
   a. Employed full-time, working 40 or more hours a week
   b. Employed part-time, working less than 40 hours a week
   c. Not employed, looking for work
   d. Not employed, not looking for work

e. Disabled, not able to work

10. In which military component do you serve?

    a. Active Duty

    b. Reserves

    c. National Guard

11. What branch of the armed forces do you serve?

    a. U.S. Army

    b. U.S. Navy

    c. U.S. Marine Corps

    d. U.S. Air Force

    e. U.S. Coast Guard

12. What is your rank?

13. What is your mental health VA disability rating percentage?

14. What is your mental health VA disability rating condition?

15. What are your total years of military service?

16. Do you utilize the GI Bill or other military benefits for your education?

17. What is your military occupational specialty (MOS) or area of concentration (AOC)?

APPENDIX F: INTERVIEW PROTOCOL

Time of Interview:

Date:

Place:

Interviewer:

Interviewee:

Questions:

To start the interview, please describe something unique about yourself.

2) Describe the factors that contributed to joining the armed services.
3) Describe the factors that contributed to you attending higher education.
4) Overall, how would you describe your experience in higher education?
5) How do you find purpose in your higher education pursuits?
6) How do you view the importance of relationships you have developed with fellow students?
7) Overall, how would you describe your time in the military?
8) How do you find purpose in your military service?
9) How do you view the importance of relationships you have developed with fellow service members?
10) How do you view the prevalence of MHDs in SSM/V?
11) What has been your overall experience of having a MHD?
12) What has been the impact of your MHD in attending higher education?
13) What has been your experience in utilizing support services in higher education for the complications of your MHD?

14) What additional services could higher education institutions provide to help with your MHD?

15) What barriers do/did you experience in obtaining needed assistance from institutions of higher education?

16) Project yourself driving home from this interview. Are there things you wish you would have shared more regarding mental health prevalence, mental health impact, and needed support services?

17) What additional questions or information would you like to share with me?

APPENDIX G: DISCUSSION FORUM FOCUS GROUP PROMPTS

Questions:

1) What else would you like to share as a current SSM/V with a VA disability mental health rating?
2) How do you view the prevalence of MHDs in SSM/V?
3) What has the impact of your MHD had on your higher education pursuits?
4) What has been your experience in utilizing support services in higher education for the complications of your MHD?

APPENDIX H: WRITING PROMPTS

PARTICIPANT NAME:

Questions:

1) Please describe how your current personal relationships impact your higher educational pursuits both positively and negatively. (Please limit your response to one page.)
2) Please describe your purpose in attending higher education. (Please limit your response to one page.)
3) Out of the 19 main categories of mental health disorders in the *DSM 5,* which are the top five you view as most prevalent in the SSM/V population? (*19 DSM 5 Categories Listed Below*.)

(Anxiety Disorders / Bipolar Disorders / Depressive Disorders / Dissociative Disorders / Disruptive, Impulse Control, and Conduct Disorders / Elimination Disorders / Feeding and Eating Disorders / Gender Dysphoria Disorders / Neurocognitive Disorders / Neurodevelopment Disorders / Obsessive-Compulsive and Related Disorders / Paraphilic Disorders / Personality Disorders / Schizophrenia Spectrum and Other Psychotic Disorders / Sexual Dysfunction Disorders / Sleep-Wake Disorders / Somatic Symptom Disorders / Substance-Related and Addictive Disorders / Trauma and Stressor-Related Disorders)

APPENDIX I: RESOURCES

211
California 2-1-1 help number for information and referrals
California Department of Health Care Services (DHCS)
916-445-4171
California Department of Public Health, Office of Problem Gambling (OPG)
800-426-2537 (800-GAMBLER)
California Department of Veterans Affairs (Calvet)
800-952-5626
California Family Assistance Centers
800-449-9662
California National Guard 24-Hour Behavioral Health Line (24/7)
805-540-4460
California National Guard 24-Hour Chaplain Line
877-700-5662
California Veterans Assistance Foundation
888-805-2490
DoD Safe Helpline
877-995-5247 (24 hours)
Military OneSource
800-852-5626
Vet Center Counselors (24/7)
877-927-8387
977-WAR-VETS
VA Benefits
800-827-1000
Veteran Crisis Line
1-800-273-8255 press 1
US Department of Veterans Affairs (VA)
888-442-4551

APPENDIX J: 19 *DSM 5* MHD CATEGORIES

a) Anxiety Disorders,

b) Bipolar Disorders,

c) Depressive Disorders,

d) Dissociative Disorders,

e) Disruptive, Impulse Control, and Conduct Disorders

f) Elimination Disorders

g) Feeding and Eating Disorders

h) Gender Dysphoria Disorders

i) Neurocognitive Disorders

j) Neurodevelopment Disorders

k) Obsessive-Compulsive and Related Disorders

l) Paraphilic Disorders

m) Personality Disorders

n) Schizophrenia Spectrum and Other Psychotic Disorders

o) Sexual Dysfunction Disorders

p) Sleep-Wake Disorders

q) Somatic Symptom Disorders

r) Substance-Related and Addictive Disorders

s) Trauma and Stressor-Related Disorder