A Transcendental Phenomenological Study: Identifying the Unmet Needs of Homeless Veterans With or Without Mental Disorders From a Healthcare Provider Perspective

Thomas Labarron Scott

Department of Community Care and Counseling, Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

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Approved by:

Thomas Vail, PhD., Committee Chair

Frederick Milacci, EdD., Committee Member

Abstract

This study explores the experiences of healthcare providers in addressing the unmet needs of homeless veterans and individuals experiencing homelessness in San Antonio, Texas. Data analysis revealed three overarching themes: access to resources, lack of desire for housing, and job satisfaction/discharge status. Under the access to resources theme, barriers limiting access to needed assistance for homeless Veterans and other people experiencing homelessness were identified, including limited support, agency challenges, lack of self-care, and moving forward. Theme two highlighted challenges addressing the lack of desire for housing among some homeless individuals and subthemes such as limited services, holistic approaches, community involvement, and limited service and shelter. The third theme, job satisfaction, and discharge status, highlights approaches, that assist providers in effectively serving homeless Veterans, regardless of discharge status and eligibility. Theoretical frameworks guided this transcendental phenomenological study, aiming to understand the needs of homeless populations from the provider's perspective, focusing on the unmet needs of all experiencing homelessness. Findings identify the repeated nature of unmet needs among the homeless populations and the importance of continuous support and new approaches in addressing homelessness throughout San Antonio, Texas.

Keywords: healthcare providers, homelessness, themes, unmet needs, limitations, veterans, support services

Dedication

I am grateful for the support that I have received from Melissa, who has played an instrumental role in promoting my growth. She has stayed up late with me, ensured that I stay on task, and proofread my work while also encouraging me to maintain a healthy balance between school, work, and life. Even when I was not present, she stepped up and pushed our son toward excellence, demonstrating that being present and being home are not the same. Her advice has been invaluable, and she has always encouraged me to write during the day instead of late at night, as it sounds much more collegiate. Thank you, Melissa, for your unwavering love and support.

I would also like to express my gratitude to my parents, Deacon Willie, and Jamesetta Mauldin, for always keeping me in line regarding life and education while also encouraging me to trust God's plan and never neglect family in my failures or successes. I am so thankful for the foundation that you have provided me with, and for allowing me to stand on your shoulders to reach my goals. I love you both to the moon and beyond.

Acknowledgments

All glory and honor to God and His Son Jesus Christ, who has guided me through the process of life and connected me with others to push me down this path of success. Many years ago, I was encouraged by my pastor and friend Dr. Jessie L Grice for not allowing life to stop him from going through this challenging and time-consuming process. This brought to mind Caleb when he took possession of the mountain at the age of eighty (Joshua 14, NASB). I was motivated at a more mature age to pursue this process, and with God's guidance, it was completed. I honestly believe that if He brings you to it, He will bring you through it. I know He is still working on me until this thing called life is over and I am called home to Him.

I must also acknowledge my wife, Melissa, who kept me motivated, encouraged, and strong as I fought this to completion, never allowing me to consider quitting. I thank God for you daily, and I am so honored that God placed us together for such a time as this to do life together. Thank you for loving me, being my sounding board, and hiding my multitude of faults as instructed by God. If He prepared anything better for me, He is holding it in heaven.

I would be remiss if I failed to acknowledge my committee. Dr. Thomas Vail honored me by being my committee chair and guiding me through the educational process. He made himself available to me at any time, including after hours. When the process was challenging, he would say, "If it were easy, everyone would do it." This forced me back on track and directed me further down the line. I cannot forget Dr. Tonya Hyde who stayed on me, encouraging me to register for a class or enroll and quit talking about going back, and go back. I would also like to acknowledge fellow ministers Rev. Lance Smith, Rev. Rodney Hopes, Rev. Maurice Steveson, Rev. James Keiler, Rev. Terry Yates, and Rev. Larry Reliford. It was

challenging but made easier with your supporting words. One of the key points that was shared by all to me was, “Don’t worry about anything; instead, pray about everything.” (Philippians 4:6).

Finally, I must again thank God for His renewed mercy and grace, timing this part of life perfectly, working from home during COVID-19, and keeping me, my family, and my friends safe during this time. He continues to promote me where I was qualified and reminds me daily “I can do everything through Christ, who gives me strength” (Philippians 4:13). He supplied my every need (Philippians 4:19), and all glory to God the Father and Son forever and ever. Amen!

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List of Abbreviations

American Counseling Association (ACA)

American Psychiatric Association (APA)

Clinician-Administered PTSD Scale (CAPS)

Coronavirus Disease 19 (COVID 19)

Calgary Homeless Foundation (CHF)

Evidence-Based Treatment (EBT)

Evidence-Based Psychotherapies (EBPs)

Housing and Urban Development–Veterans Affairs Supportive Housing (HUD-VASH)

Methylenedioxymethamphetamine (MDMA)

Post-traumatic Diagnostic Scale for DSM-5 (PDS-5)

Post Traumatic Stress Disorder (PTSD)

San Antonio Metropolitan Ministries, Inc (SAMMinistries)

South Alamo Regional Alliance for the Homeless (SARAH)

United Kingdom (UK)

United States (US)

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Chapter One: Introduction

Overview

This chapter will present the background, rationale, problem statement, and topic for this phenomenological study from a healthcare provider's perspective serving homeless Veterans in San Antonio with or without mental disorders. This qualitative study aims to investigate and gather data to learn about the real-life experiences of healthcare providers as they attempt to identify unmet needs. According to Moustakas (1994), this transcendental phenomenology study seeks to understand human experience. This chapter will also provide various interactions where healthcare providers serve Veterans and their families while identifying unmet needs. These needs fluctuate between women and men. Women's needs may range from dental care to legal assistance from the healthcare providers' perspective (Tsai et al., 2021). The providers share their experiences as they continue to serve and address the needs of the Veterans and others seeking care (Creswell & Poth, 2018). This study includes reaching out to other agencies and making referrals for services outside the scope of certain agencies with client knowledge or approval (McDonagh et al., 2005). The literature identifies challenges and barriers that may limit the healthcare provider's ability to serve those in need. These challenges may result in burnout and frustration for the Veteran and the provider (Wicks, 2010). Some of these challenges could be precepting events like post-traumatic stress disorder, depression, anxiety, or loneliness that may promote homelessness among Veterans.

There are multiple conditions that may contribute to homelessness shared by healthcare providers. These include a lack of affordable housing, low-paying jobs, mental illnesses, substance abuse, domestic violence, unemployment, and poverty (U.S. Conference of Mayors, 2015). The literature and healthcare providers suggest homeless persons have experienced an

above-average number of traumatic events (Lee & Schreck, 2005). These may be childhood trauma and different forms of physical abuse, having an estimated rate of 37%, and sexual abuse rates, estimated at 32% for females and 10% for males (Sundin & Baguley, 2015). In comparison, the childhood abuse rate among the general U.S. population is estimated at 3.3% for physical abuse. Generally, U.S. sexual abuse rates are 6.7% for females and 9.6% for males (Finkelhor et al., 2005).

De Vries et al. (2019) revealed nearly two-thirds (69.8%; 37) of homeless women and less than half (40.5%; 15) of homeless men reported being in an abusive relationship in their past also supporting interaction with healthcare providers according to their experiences with homeless individuals. The author is unsure if the respondents were the offenders or victims of abusive relationships due to the data not discussing this. Homeless individuals also reported mental health conditions from healthcare providers' perspective. The following four diagnoses were reported most frequently by healthcare providers include depression (22.2%), bipolar disorder (15.6%), anxiety (5.6%), and PTSD (4.4%).

Although there is a lack of research literature specifically addressing homelessness and the need for support among this population does exist in professional counseling journals. This lack of homelessness-specific literature in professional counseling journals is surprising since Section A.7a of the ACA Code of Ethics calls for support for their situation (De Vries et al., 2019). The code precisely states, “When appropriate, counselors advocate at individual, group, institutional, and societal levels to address potential barriers and obstacles that inhibit access or the growth and development of clients” (ACA, 2014, p. 5). A new barrier was identified with non-Spanish providers in San Antonio because all healthcare providers do not speak Spanish (Regional Needs Assessment, 2020). Previous studies have overlooked the perspective of

healthcare providers, such as physicians, nurses, and counselors serve the homeless population (Gallardo et al., 2020). This chapter will present the problem statement and the lack of training received by many of those providing care to homeless Veterans. The conclusion of this chapter will identify the research questions and the definition of terms used throughout the study.

Background

This study aims to learn from the experience of the healthcare providers serving homeless Veterans. These Veterans fought in wars, declared and undeclared in the last 35 years. Some Veterans never shared their wartime experiences connected to insomnia due to fear of nightmares (Lembcke, 2019). Veterans expect to receive care from providers for wounds sustained in past conflicts, as they should. Cox (2019) shares a story about the experience of one of her nursing students, Elizabeth, whose husband was injured in Afghanistan and expects treatment for his sustained injuries. Veterans injured mentally or physically while serving their country should receive treatment from trained healthcare providers before being discharged and not be labeled as broken, limiting their job opportunities (Kleykamp & Hipes, 2015). Many Veterans have sacrificed so much in defense of freedom shared by many. However, they are homeless, living on the streets, some by choice, and mentally abandoned, with many unmet needs, including dental care (Tsai et al., 2021).

Unmet needs may differ according to gender and race (Tsai et al., 2021). According to Tsai et al. (2021), Project Community Homelessness Assessment, Local Education, and Networking Groups (CHALENG) issued a national survey to assess the needs of homeless Veterans. The surveys were distributed as hard copies and through online survey portals to individuals at Veteran Administration (VA) homeless program sites nationwide. Surveys were used since some homeless Veterans may not have internet access due to personal issues, but

getting hard copies in their hands may help them learn more about factors contributing to their experiences. Adler et al. (2015) suggest when asking about common issues contributing to homelessness, data retrieved with 57% substance abuse, 53% unemployment, and 45% mental illness based on data collected from 254 providers at rural Veterans Affairs community-based outpatient clinics with an increase in the number of Veterans.

Tsai et al. (2019) report that homeless Veterans decreased after 2014, dropping from 7741 in 2013 to 3191 in 2016 for White male Army Veterans between the ages of 40 – 60, as reflected in an annual survey. This data was limited because the Veterans who participated were White males only. According to Tsai et al. (2018), this study identified the top five needs from 2012 to 2016 and therefore was not current and did not provide the latest data on homeless Veterans. The top five fluctuated from year to year. In 2012, there was legal assistance for eviction, registered sex offender housing, legal aid for child support, childcare, and assisted living for the elderly. In 2016 the needs were the same, adding financial guardianship, according to Tsai et al. (2018). Neither does Tsai et al. (2021) offer data on what took place afterward to assist in providing the care earned by Veterans for their sacrifices. Some Veterans' needs shared with healthcare providers may differ once they have returned home to find that life has changed due to their disability limitations (Da Silva, 2018), including amputations and loss of their support system like family. Da Silva (2018) reports that families may have moved on without them because of the lack of financial support, unfaithful spouses abandoned their military members (Williams, 2019), and the public no longer acknowledges their commitment to the nation even during war (Sagan & Valentino, 2019). One researcher suggests there have been occasions where Veterans could not find employment after returning from war (Destenay, 2021).

Prior to serving in the military, some Veterans may have had concerns sparked by the military draft, generating fear and anxiety toward the unknown. The mandatory draft ended, returning to the all-volunteer military in 1973 (Ettinger, 2018). Many individuals ran away, called draft dodgers and outcasts, while some hid behind the wealth of their families and still had successful careers and even became politicians or presidential candidates (Casement, 2020). The military can provide a wonderful way of life for many and has proved challenging for some. The military has become a way to find a real purpose in life, honoring their families and country, but for some pain and loss, including the loss of limbs or mental stability, leading to military discharge, requiring the assistance of healthcare providers (Caddick et al., 2019).

Serving the United States has been honorable for most but not all, including being dishonorably discharged from duty. Some were dishonorably released for violations of the Uniform Code of Military Justice (Feller, 2016). Some military members may feel that violence against another person or another country in support of the war would not be appropriate or against their spiritual beliefs (Bowman, 2019). The side effects from combat or violent war interactions could result in Post Traumatic Stress Disorder (PTSD) (Wade, 2019). PTSD is a subtype of dissociative disorder, and patients may be diagnosed. When the full diagnostic criterion for PTSD is satisfied, if an individual shows additional persistent and recurrent dissociative symptoms of depersonalization and derealization, feelings as if you are not real (Swart et al., 2020). Price et al. (2014) suggest that the level of dissociation will vary based on exposure, reducing the treatment response (Price et al., 2014). Not having their mental or physical needs addressed could negatively impact the Veteran even after receiving treatment from healthcare providers for a disorder, including borderline personality disorder, which does not guarantee success or shelter (De Jongh et al., 2020). Consequences of war may have a

different effect on one Veteran resulting in poor physical health, while affecting another differently with a sense of loneliness or depression, forcing the person to behave differently (Tsur et al., 2019) outside of their character, requiring the services of a healthcare provider.

According to Tsur et al. (2019), uncharacteristic behavior may contribute to a Veteran being homeless or isolated, not wanting to be around others, or lacking the ability to control themselves. The status of homeless Veterans has become a significant concern for the public (Tsai et al., 2018). The community may view homeless Veterans as undesirable members of society and would like to have them moved off the street corners and out of the parks (Brissette, 2019). Veterans face multiple barriers when seeking treatment, resulting in being homeless, living on the streets, and some by choice while receiving treatment. These barriers include a lack of information about services or providers to help address their needs. Other barriers are limited access to services and a lack of coordination across services (Hamilton et al., 2012). Even though Veterans are getting treatment for PTSD, some healthcare providers in San Antonio do not always follow the suggested treatment for PTSD (Finley et al., 2018).

Situation to Self

My motivation for conducting this study was to learn how homeless Veterans were getting their needs met and the role healthcare providers played in assisting them. I support this study because of the possible impact on homeless Veterans and the healthcare providers that serve them. As a Veteran, I think it may be helpful to study this phenomenon and its effects on the healthcare providers that care for Veterans. This study aims to understand how the healthcare provider perceives the homeless Veterans phenomenon as it relates to this population. It may be helpful to look at the healthcare provider's experience serving homeless Veterans with or without mental disorders. I will learn how to contribute to the well-being of those who served this

country and others in need of services. This newly gained knowledge from the healthcare providers will encourage further participation from me. I would listen to them as they share their experiences serving homeless Veterans. This study will assist me in learning more about homeless Veterans and how they deal with symptoms of mental disorders from the healthcare providers' perspective. I would compare the knowledge obtained from healthcare providers' shared experiences connecting them to other mental disorders, including PTSD, shame, loneliness, and depression, according to Liu et al. (2020). This phenomenological approach will guide my research, gather knowledge from healthcare providers' shared experiences, help serve the homeless, and identify the unmet needs of homeless Veterans from healthcare providers caring for them (Tsai et al., 2021).

Problem Statement

The problems affecting homeless Veteran's unmet needs continue to increase from the healthcare provider perspective. The overall count of people experiencing homelessness was 3,155, a 5.3% increase from 2022, which reported 2,995 homeless people. According to the report, there are 253 sheltered families in San Antonio and Bexar County, a 28% increase from last year. The count includes families with one child or more (Hernandez, 2023). In the study, data was collected from the healthcare providers at facilities that serve homeless Veterans and helped by identifying the needs of the homeless Veteran. With homelessness increasing, there is a need for trained healthcare providers and better self-care for themselves as they continue to serve homeless Veterans. The lack of proper self-care could result in issues for both the Veteran and the healthcare provider, such as drug abuse or some other mental illness. Self-care is so critical that the National Association of Social Workers created a policy called the *Professional Self-Care and Social Work* (Miller & Owens, 2020). If self-care is not employed when serving

others, there could be a negative impact on the services provided. There are differences between a need and a want, but they are not always clear. Homeless Veterans need shelter, food, and safety that are currently going unmet. Requirements like needs are constant, while a want can change daily from a car to a home (Rivera, 2013). Healthcare providers offer services to assist homeless Veterans with unmet needs as they share data from their experiences. Healthcare providers will share a unique point of view as they interact with homeless Veterans to discuss their unmet needs.

Veterans have given so much to this country in their service, resulting in homelessness. This study aims to identify the unmet needs of homeless Veterans in San Antonio, Texas, as shared from the healthcare provider's perspective and services provided to assist in meeting the homeless Veteran's needs. As the literature suggests, homelessness and homeless Veterans with mental illnesses are a public concern (Crocq & Crocq, 2000). Some Veterans are women and have no place to call home homeless after being discharged from the military. These numbers may rise further among women since more women join the military, increasing the need for more healthcare providers (Kenny & Yoder, 2019).

The research problem is that homeless Veteran's basic needs are going unmet, and this study will look at this concern from a healthcare provider's perspective. They will share their experiences identifying and understanding the requirements that should be met for the homeless and themselves (Tsai et al., 2018). For the research and addressing research questions, the inquirer will identify what led to the providers becoming counselors to the homeless and identifying needs, retrieving data from the healthcare provider's perspectives by getting their real-life experiences. This research will address how healthcare providers assist homeless Veterans by providing access to organizations to help meet the Veteran's needs. According to

Finley et al. (2018), some healthcare providers have fallen short in providing care to those in need after serving their country. Many healthcare providers make assumptions about the needs of homeless Veterans. The homeless needs change based on race, culture, and gender. Women's needs trend toward shelter and dental care (Tsai et al., 2021). More training is needed to recognize these needs as healthcare providers learn to conduct self-care, minimizing the effect of burnout and other conditions limiting their ability to care for others.

Unfortunately, some untrained healthcare providers are offering treatment to Veterans, possibly causing harm. Healthcare providers should train under supervision or a trained therapist (Sessa, 2017) to confirm proficiency. Training also includes knowing when to make a moral referral based on ethical reasoning (Craig, 2017). Tully et al. (2021) reflected limited research on caring for homeless Veterans and those with other healthcare issues. Current studies lack input from the providers' shared experiences serving homeless Veterans while providing self-care for themselves. As a resource for healthcare providers, church involvement as agents of God and serving the homeless would be beneficial.

However, research will identify resources that are combined to meet the needs of homeless Veterans with mental illnesses or physical limitations and healthcare providers that serve them, merging local resources, including church leaders and the government helping (Guo et al., 2016) will minimize the homeless possibility for those suffering from mental disorders. After getting more committed involvement from local government and church leaders, the reach to service the homeless Veterans will go much further in addressing self-harm. Brown et al. (2019) state that self-harm is a high-risk factor for those suffering from mental health conditions, and there is evidence to support and demonstrate that treatment of mental disorders is associated with reductions in self-harm.

Purpose Statement

The purpose of this transcendental phenomenological study is to describe various healthcare provider's experiences interacting with homeless veterans in San Antonio, Texas. In addition, this study attempts to identify the needs shared by healthcare providers that serve homeless Veterans diagnosed with or without mental illness. Documenting the shared experiences of homeless Veterans by healthcare providers will assist in reaching the objective by identifying the needed services, including dental care, clothing, and shelter (Creswell & Poth, 2018). Healthcare providers will present their information voluntarily in an interview format and utilizing focus groups. The interviewee or participants may choose to stop participating at their leisure, if they feel uncomfortable with the process. Interviews are the primary way to gather data from healthcare providers during this study. The interviewer wants to avoid negative consequences while interacting with the interviewee, implementing techniques and training obtained over the years. Finley et al. (2018) documented that untrained healthcare providers offer services to Veterans and non-veterans without training, resulting in unpleasant outcomes. In meeting the Veteran's needs, Finley et al. (2018) add that some healthcare providers have not achieved the objective of providing care to those in need after serving their country. The outcome results in provider burnout, which may be fallout from not taking care of themselves or not being appropriately trained to care for a homeless population.

This qualitative phenomenological study is needed to identify the experiences of healthcare providers as they try to work with homeless Veterans and assist in meeting their needs (Ijadi-Maghsoodi et al., 2021). This study also provides an opportunity to serve homeless Veterans and non-veterans by gathering data to draw attention to their needs, including shelter and food. Giving the homeless food or money has become a crime in some cities (Bailey, 2016).

Some researchers think medication or healthcare is the answer to stabilizing their lives, limiting the engagement of Christians (Paudyal et al., 2017). The study could also assist with identifying Veterans' unmet needs by getting treatment and maintaining any positive relationships they may have with healthcare providers (Guo et al., 2016). The phenomenological study approach is the best way to get the desired data.

According to Brown (2018), the best method to gather data would be to conduct interviews to identify the needs of the Veteran as shared by healthcare providers in their own words. Data collected during one-on-one and face-to-face interviews and focus groups will be applied to assess the needs of homeless Veterans from the healthcare provider's perspective (Roberson et al., 2018). More research is necessary to escape the assumptions made by society, which has wrongly determined the needs of Veterans suffering from homelessness and mental illnesses. The homeless population among Veterans seems to be growing at an alarming rate, with their needs going unmet. This phenomenological study may draw attention to homeless Veterans and their basic needs. Creswell and Poth (2018) describe a phenomenological study as an ordinary meaning of several individuals and their lived experiences of a phenomenon. Phenomenology aims to identify an individual's experiences with a phenomenon or condition (Creswell & Poth, 2018). A close relationship exists between phenomenology and case study as they both focus on real-life experiences, but transcendental phenomenological study is the method of choice. Creswell and Poth (2018) focus on the phenomenological study approach, exploring a real-life problem impacting homeless Veterans with or without mental disorders and the healthcare providers assisting them.

Significance of the Study

Multiple articles and studies will be used to gather data about homeless individuals and services provided by healthcare providers to homeless Veterans. The data has fallen short regarding the provider's perspective on caring for homeless Veterans with or without mental disorders, including depression and PTSD. Dell et al. (2020) suggest elevated numbers of PTSD in those suffering from major depression. Unfortunately, these concerns are diagnosed more frequently in Veterans than non-veteran clients. Some researchers suggest PTSD is overdiagnosed in some veteran-served facilities and believed to be underdiagnosed by other researchers (Tully et al., 2021). During this research, it is helpful to be familiar with the interviewee's background of their experiences serving those diagnosed with PTSD or other mental illnesses that may be useful to identify unmet needs, even if underdiagnosed. With a lack of diagnoses, resources may not be available if Veterans do not acknowledge their issue to their providers. The lack of being diagnosed by healthcare providers may severely impact homeless Veterans, forcing them to go without needed treatment. Not getting proper treatment could result in depression or suicide for housed or homeless Veterans. Some researchers suggest that treatment reduces suicidal ideation for those with PTSD diagnoses (Stanley & Joiner., 2020).

This study aims to provide some understanding of the unmet needs of the homeless Veteran from the healthcare provider's perspective. This study will identify local facilities and healthcare providers that have experience serving homeless Veterans with or without mental disorders. In this study, there will be interviews and focus groups with 3 - 5 healthcare providers from various facilities in the San Antonio area to gather data, describing and identifying the specific unmet needs of homeless Veterans in the healthcare provider's own words (Miller & Rollnick, 2013). The data will provide relevant input to identify the unmet needs of homeless

Veterans from the healthcare providers who assist the homeless Veteran population. After collecting data from the focus groups, new techniques may be generated for the providers to consider while serving homeless Veterans. This study aims to identify the unmet needs of homeless Veterans with or without mental disorders from the healthcare provider's perspective as they share their experiences. This data will focus directly on the unmet needs stated by the Veteran, minimizing any assumptions by the healthcare provider.

Research Questions

Qualitative research and phenomenology, specifically, seek to understand and describe real-life experiences (Creswell & Poth, 2018) through interviews and focus groups as participants reflect and share their experiences about this phenomenon. Therefore, the following research questions are selected for this phenomenological study to solicit information from healthcare providers. The participants will describe their experiences to the interviewee during the process while being observed answering the following questions:

Research Questions

1. How do healthcare providers describe their experiences helping homeless Veterans in San Antonio, Texas? The rationale for this question is to get the healthcare providers to share their experience treating homeless Veterans in the local area with or without mental disorders. This question will also open dialogue to share their background serving Veterans with PTSD (Dondanville et al., 2020).
2. How do healthcare providers describe the challenges or barriers related to serving homeless Veterans? The rationale for this question is to understand how healthcare providers handle challenges and barriers in treating Veterans with mental disorders and

how they navigate through barriers including communication, transportation, and fear (Conner et al., 2009).

3. How do healthcare providers describe the most effective strategies used to assist homeless Veterans in meeting their needs? The rationale for this question is to learn how strategies are developed and shared to address the unmet needs of homeless Veterans with or without mental disorders (Webb & Gazso, 2017).

Definitions

Several terms used in the study are of interest related to my research and are defined here. These terms will or may appear throughout the research as provided in the framework for the study, and they may be used uniquely as a part of the study.

1. *Anxiety* – "an excessive and unreasonable fear or anxiety of scrutiny or negative judgment by other people" (Penninx et al., 2021, p. 2).
2. *Barriers* – For the sake of this study affordability, lack of trust, lack of understanding, poor therapeutic relationship, and accessible transportation (Ramsey et al., 2019)
3. *Burnout* - "emotional exhaustion, depersonalization, or low personal accomplishment" (Rotenstein et al., 2018, p. 7).
4. *Depression* – is "a common illness that severely limits psychosocial functioning and diminishes the quality of life" (Malhi & Mann, 2018, p. 1).
5. *Experiences* - caring for patients who are homeless and gaining knowledge from that interaction encourages professional growth (Doran et al., 2014).
6. *Healthcare Provider*- A healthcare provider is a person or entity that provides medical care or treatment. Healthcare providers include doctors, nurse practitioners, midwives,

radiologists, labs, hospitals, urgent care clinics, medical supply companies, and other professionals, facilities, and businesses that provide such services (Davis, 2022).

7. *Homeless* – “someone living in shelters, on the streets, in vehicles, or any other place not meant for human habitation” (Tsai et al., 2020).
8. *Loneliness* – is "a unique condition in which an individual perceives himself or herself to be socially isolated even when among other people." (Cacioppo & Cacioppo, 2018, p. 1).
9. *Memoing* – “a practice of logging thoughts regularly so that the researcher documents his or her impressions, reflections, questions, and ideas as they evolve throughout the study” Boyle & Butler-Kisber, 2019, p. 396).
10. *Needs*- are things that remain constant (Rivera, 2013, p. 1).
11. *Posttraumatic Stress Disorder* – is "an exposure to terrifying, usually life-threatening events, such as combat, rape, or confinement to a concentration camp" (Tully et al., 2021, p. 1).
12. *Shame* – is "a reaction to the risk of public exposure of an individual's defects or secret" (Bateman & Engel, 2016, p. 4).
13. *Sofa Surfing* – "entails not having a permanent residence and often moving between the homes of their friends or extended family or sleeping on floors or sofas/couches" (Harpin, 2020, p. 2).
14. *Wants*- “a current of future desire” (Rivera, 2013, p. 1).

Summary

Chapter One starts with an introduction supported by an overview. Healthcare providers share experiences working with homeless Veterans with or without mental disorders, including PTSD, which will be addressed throughout the chapter. The background shares information

about Veterans who fought in wars declared or undeclared with various side effects. Unfortunately, some of the effects will result in unmet needs and homelessness seeking the service of healthcare providers. These needs change between race and gender (Tsai et al., 2021). Before entering the military, the government promises to care for Veterans and meet their needs (Kleykamp & Hipes, 2015). Several Veterans' needs went unresolved, causing homelessness and limited healthcare from untrained providers in their area of need. Further reading in this chapter speaks to identifying those unmet needs evaluated by healthcare providers. Some Veterans return home to no family, disrespect, or thanks from a grateful nation and without shelter after giving so much to their country.

Veterans have given more than many, putting lives in harm's way and creating several unmet needs. Homeless Veteran's real-life experiences have led to them sharing the phenomenon of homelessness with healthcare providers as they seek services. The problem statement identifies unmet needs and the lack of research from a healthcare provider's perspective, sharing their story and life experiences with the researcher. The purpose of this transcendental phenomenological study is to describe various provider's experiences interacting with homeless Veterans in San Antonio, Texas. The significance of the study is that it will contribute to existing literature identifying and understanding the unmet needs of Veterans from a healthcare provider's perspective, offering a more meaningful life for those suffering from homelessness and mental disorders while minimizing the gap in the literature concerning the experiences of healthcare providers. Lastly, research questions used are to gather information from the healthcare providers as they share real-life experiences related to serving homeless Veterans with or without mental disorders.

Chapter Two: Literature Review

Overview

The following section examines the theoretical framework that will drive this study. The study aimed to identify unmet needs from the healthcare provider's point of view, sharing their experiences treating homeless Veterans. Chapter Two will focus on multiple areas, including depression, anxiety, shame, and loneliness, and their effect on the homeless population. Similar literature reviews have determined some significant causes of homelessness and how this phenomenon affects healthcare providers that offer services to homeless Veterans. Chapter Two will continue with the treatments identified as an unmet need to provide the needed care to Veterans in the local area, especially those with PTSD who may benefit from Cognitive Behavioral Therapy (CBT) and Evidence-Based Psychotherapy (EBP) from healthcare providers if it is determined to be a need.

In Chapter Two, the definition of homelessness provides continuity as it relates to services provided by healthcare providers. The current chapter will also address the training received by healthcare providers expected to provide services to homeless Veterans suffering from the effects of mental disorders and their symptoms. This phenomenological study plans to identify the unmet needs of homeless Veterans from the perspective of healthcare providers and the frustration that results in other issues like burnout, not just for the Veteran but for healthcare providers that aid them as well. The impact on untrained providers could result in a negative or positive outcome on the Veteran's desire to seek services. The literature review highlights a gap where the focus was on the experiences of the healthcare provider who served homeless Veterans with or without mental disorders.

Theoretical Framework

The importance of this transcendental phenomenological study is to focus on the experiences of healthcare providers as they attempt to identify the unmet needs of homeless Veterans, both males and females, in San Antonio, Texas. In comparison, Salem et al. (2017) focused on the perspective of healthcare service providers, but towards women only with one type of treatment in mind. Many healthcare providers have often generated treatment plans from past treatment cases rather than gathering data from the Veterans needing service with no training (Finley et al., 2018). Healthcare providers will share their experiences and interactions with homeless Veterans gathering data to identify unmet needs for them with or without mental disorders. In this section, the healthcare providers will share thoughts on the phenomenon called homelessness that occurs among homeless Veterans, including women, since they are among the fastest-growing populations (Salem et al., 2017). Women's needs are different than men requiring more personal attention like dental care and permanent housing (Tsai et al., 2021). According to Fleury et al. (2021), several needs go unmet. When one need gets met, another one takes its place. The result is an increase in needed services from healthcare providers to address, applying to homeless Veterans, focusing on those with mental disorders.

Post-traumatic stress disorder may contribute to homelessness and depression in several ways, like substance abuse and loneliness (Stanley & Joiner, 2020). One disorder is a causal risk factor for the other and has some common biosocial vulnerabilities, even though depression and PTSD manifest differently (Dell et al., 2020). Depression can be a consequence of suffering from PTSD, but PTSD can be a symptom of someone suffering from issues that may contribute to depression or homelessness. Anxiety can be a contributor to PTSD. Anxiety could contribute to depression due to problems accompanying a marriage or relationship when PTSD is present

(Hald et al., 2020). One of the symptoms of PTSD may be the effects of shame because of the loss of a relationship or the destruction of a marriage based on the Veteran's PTSD mental disorder.

Shame can cause a person to withdraw from family and friends, creating an atmosphere of loneliness. Loneliness has been overwhelming for many during the past few years, from 2020 to current, due to the pandemic (Liu et al., 2020). Unfortunately, this has been problematic for those suffering from mental disorders, causing them to withdraw from society. Society provides the access needed to identify and treat Veterans with disorders that include PTSD and loneliness. The healthcare providers in the community must be ready to serve those in need of their services and monitor the effects of their care or impact on the homeless Veterans, confirming that no harm happened to any of the patients they are caring for at any given time (Carvalho et al.,2015).

Creswell & Poth (2018) suggest this study must look at the reality of this phenomenon of homeless Veterans using objectivity. When gathering data, multiple perspectives are needed when compiling research to support the services provided for homeless Veterans. Biblical and moral realism guides some researchers in their studies. Some may assume that most people support the perception that everyone should have primary healthcare. The citizens of the United States of America live in one of the wealthiest nations in the world, and yet every citizen does not have primary healthcare and is homeless. Combating homelessness can be addressed as a nation to provide shelter for all citizens, including the services of healthcare providers. The Bible tells believers to look out for their interests but not forget about the needs of others (Philippians 2:4, NASB). Moral realism suggests it is the right thing to do, and it is good to assist those who cannot afford it. There is assistance to help those that are ready to serve homeless Veterans.

Related Literature

San Antonio has ten separate city council districts that serve multiple functions. The districts share city-wide awarded grants totaling $501.2 million and one valued at $4.7 million to support homeless outreach. This budget includes funding for lease and continuous operation of homeless hotels in areas with an increase in people experiencing homelessness in City Council District 1. These grants are awarded to the various districts with $66.6 million to support rental assistance to prevent evictions or homelessness and another $20 million for households at risk of homelessness. The overall count of people experiencing homelessness was 3,155, a 5.3% increase from 2022, which reported 2,995 people. According to the report, there are 253 sheltered families in San Antonio and Bexar County, a 28% increase from last year. The count includes families with one child or more (Hernandez, 2023). South Alamo Regional Alliance for the Homeless (SARAH) suggests the increase in homelessness is due to families with children reported by Katie Vela, executive director of SARAH (Hernandez, 2023). During the process of this research, SARAH was rebranded, changing its name to Close to Home.

Close to Home is the lead Continuum of Care (CoC) agency for San Antonio and Bexar County. As the CoC, Close to Home secures and distributes funding for direct service providers in the housing and homeless community and provides guidance to strengthen policies and programs. Close to Home is responsible for collaborating with, listening to, and collecting data from the housing and homeless community to ensure everyone has a place to call home. Close to Home's vision is to envision San Antonio and Bexar County communities where everyone has a safe place to call home (SARAH, 2023). In partnership to house everyone, Close to Home brings together stakeholders invested in halting and ending homelessness by addressing the causes and challenges that influence homelessness – housing, mobility, and mental health. Close to Home's key responsibilities include allocating $13M annually to service providers, managing the

communities, and coordinating access to Homelink. Homelink is a program that connects people who are homeless to housing resources while completing reports and conducting research for the community and HUD on the state of homelessness. Close to Home is committed to building a homeless response system that focuses on equity and ensuring those with lived experience are involved in decision-making (SARAH, 2023). Data collected from other providers and facilities that interact directly with the client or patient needing care are San Antonio Metropolitan Ministries, Inc (SAMMinistries), Audie Murphy Veteran Administration (VA) Medical Center, Haven for Hope, and American GI Forum.

SAMMinistries has over 80 employees and is supported by thousands of volunteers to assist families at risk of being evicted or those currently homeless. SAMMinistries was created due to the death of a man found on church grounds in 1981, drawing into action members of First Presbyterian Church in downtown San Antonio. SAMMinistries became incorporated by 11 downtown congregations into what is known today as SAMMinistries. They work hand in hand with other agencies, including the VA (SAMMinistries, 2023).

The VA offers a wide range of services from healthcare providers to Veterans seeking assistance like Podiatry, Prosthetics, Mental Health, and Vocational Rehabilitation. The VA also provides transitional and supportive housing and Housing and Urban Development–Veterans Affairs Supportive Housing (HUD-VASH). HUD-VASH, created in 1992 for homeless Veterans, was expanded under the Obama administration, which led to a decrease in homeless Veterans (Evans et al., 2019). The HUD-VASH program created issues for some formerly homeless Veterans, including social isolation and loneliness, according to Winer et al. (2021).

Haven for Hope provides services to homeless Veterans and others in need. Their mission is to offer hope and new beginnings by coordinating and delivering an effective system of care

for people experiencing homelessness in San Antonio (Haven for Hope, 2023). They connect those experiencing homelessness with accessible resources, streamlining the paperwork, and making it less challenging for those who want help. By streamlining the process, they have made it possible to make referrals without complicating the effort or duplicating unnecessary paperwork, giving the healthcare provider more time to identify and address the client's needs.

American GI Forum is a not-for-profit organization that focuses on assisting and extending a helping hand to homeless Veterans and others experiencing homeliness, this includes children and single mothers by providing shelter and life skills. American GI Forum is committed to all in need of shelter and jobs as they assist with education and basic skills when needed. This organization has been operational since 1972, serving Veterans from all branches of the military and their families. American GI Forum is the largest Federally Chartered Hispanic Veteran organization in the U. S. with chapters in 40 states. This charter allows them to take on 25 percent non-veterans as members. The American GI Forum National Veterans Outreach Program offers job counseling, employment services, chemical dependency counseling, and community reintegration programs. These services are offered to non-veterans and others to assist with unmet needs.

The unmet needs of people experiencing homelessness range from dental to legal concerns (Zur & Jones, 2014). Unfortunately, homelessness creates home insecurities for those who gave so much to this country. Molinari et al. (2013) suggest older Veterans have more significant employment and health concerns than younger Veterans. As many as 8.5 percent of Veterans have experienced homelessness (Raad et al., 2020). Homeless Veterans are disrespected daily by those blessed to have homes, jobs, and better lives because of the sacrifices made by the few for the good of the many (Neuhaus, 2018). Homelessness continues to be a

significant social problem in the United States, with approximately 630,000 people lacking safe housing each night (Petrovich & Cronley, 2015). Unfortunately, homelessness is not unique to the U.S.

There are also homeless challenges in the United Kingdom (U.K.), with an estimated 250,000 people homeless in England alone (Smith et al., 2018). California is ranked as the state with the highest homeless population in the United States (Rizvi et al., 2021) and California promotes homelessness as they pay the homeless $105 to return home (Gaus, 2023). Some homeless people are unsheltered, sleeping in cars, parks, abandoned buildings, camps, or the streets (Zur & Jones, 2014). Many citizens of all nationalities have served in the military in the United States of America or part of a coalition, including civilian contractors and the National Guard (Lesho, 2011), with the expectation of serving and honoring their country, family, and friends, not expecting to be homeless afterward needing the assistance of healthcare providers.

Veterans have suffered from various mistreatment throughout the years, including not being wanted or not being provided for after service. The outcome may contribute to developing mental health issues, including Post Traumatic Stress Disorder (PTSD), anxiety, and depression, to name a few. Bender et al. (2015) suggest several factors contribute to the onset of PTSD, depression, and substance use disorders that may result in homelessness. When PTSD affects U.S. ethnic minorities, the mental illness is usually undertreated, especially in Asian groups (Chang et al., 2017). Many have sought to serve these homeless heroes, but in many cases, the desire to give to them was only temporary, seasonal, or conditional based on their appearance (Lenhard, 2021). Several Veterans experiencing homelessness are diverse groups, having different unmet needs and requiring healthcare providers, multiple resources, and support to avoid becoming homeless (Tsai et al., 2021).

Tsai et al. (2019) report that homelessness among U.S. Veterans is of public concern, and homeless Veterans represent an essential population requiring help from public health, federal policy, and society. Homelessness is overwhelmed with hopelessness not just in the U.S., but in Spain, with a negative impact on Veterans suffering as a result of using mental health services (Fajardo-Bullón et al., 2021). The lack of housing has created unmet needs for those requiring mental health care and substance use disorder treatment (Zur & Jones, 2014). Some unmet needs for women included emergency shelters, transitional housing, and dental care (Tsai et al., 2021). The unmet needs for men were health care, housing, and social services. Southern California and Nevada have an increasing population of homeless Veterans (Gabrielian et al., 2013). The lack of housing or unmet needs did not create mental disorders and require services. De Jongh et al. (2020) suggest PTSD is the result of one or multiple traumas, with sexual abuse being accountable for over 90 percent.

Post-Traumatic Stress Disorder in Veterans

Post Traumatic Stress Disorder is a response to a specific traumatic event, manifested as re-experiencing the event in the here and now, avoidance, and a sense of current threat (Bondjers et al., 2019). Homelessness is a public crisis especially for those with PTSD (Crone et al., 2023). PTSD has been around for years and has many names (Crocq & Crocq, 2000). In the 1980s, the American Psychiatric Association (APA) developed a criterion for PTSD. Before then, PTSD was titled Soldier's Heart, Shell Shock, Battle Fatigue, Combat Neurosis, and Vietnam Syndrome (Wade, 2019). Before and after diagnosis, this population had challenges and disadvantages with barriers and complications in their interactions. After returning home, the public witnessed the psychological trauma of Veterans **(**Wade, 2019). The media would try to spin PTSD or the image of a military member in uniform locked into a stare with a positive focus to encourage civilian

action towards the war (Wade, 2019). Unfortunately, there was no positive spinning on the negative actions of Veterans suffering from PTSD and its symptoms, given exposure to this mental health platform (Hall et al., 2019). Before being medically discharged in 2005, Lance Corporal Miller assaulted a sailor and was released from the Marines, resulting from PTSD (Wade, 2019). One thing to consider is how many other Veterans or military members were in a similar situation due to a mental disorder. Raman et al. (2021) suggest that substance use and violent behaviors are related to PTSD. The episode may occur during a declared war or not; nevertheless, the outcome is just as fatal.

Post-Traumatic Stress Disorder has been around for years, as supported in Deuteronomy 20, affecting military members who served in battle. The Greek word for trauma is wound. Adsit (2017) recommends replacing the word wound in the Bible with the word trauma. The diagnosis of PTSD is received with a score of two symptom clusters after meeting at least four criteria for PTSD (Johnson et al., 2020). PTSD and anxiety are related to specific trauma (Sapolsky, 2004). PTSD can impair cognitive performance and alter both brain structure and functions as has been documented (Zhu et al., 2021). Trauma can be fatal as it affects the brain and other parts of the body, creating severe medical issues for the individual and family. Trauma promotes the need for more effective treatment strategies (De Lange, 2017). Zhu et al. (2021) suggest that exercise could have the potential to exert a positive impact on people with PTSD.

Some violent PTSD clients may create several types of traumas, restricting a person's liberties or movement to murder (Levers, 2012). These conditions are not new; it has existed since Adam and Eve. One of the first traumatic situations mentioned was when Cain caused trauma to his brother Abel to the point of death (Genesis 4:8). Trauma has taken on many

different names. Traumas and PTSD are more common in war or combat, including Shell Shock, 100-yard Stare, and Combat Trauma, also called Deployment-Related Stress.

According to Engelhard et al. (2007), only a tiny minority of soldiers are known to have full-blown Deployment-Related Stress PTSD. The combat trauma spectrum has multiple sections, combat or operational stress reactions, acute stress disorder, and post-traumatic stress disorder (Adsit, 2017). Briere and Scott (2015) state that PTSD is the best-known trauma-specific diagnosis in the DSM-5. Post-traumatic stress is not only limited to the military population. PTSD could have affected Mary after witnessing the crucifixion of Jesus. There is a sense of confidence saying that she may have seen a crucifixion before, but it never touched her spirit more than when she witnessed the death of her firstborn son (Mark 15:21-41). Trauma may not appear serious until it knocks on your door, making it personal.

Post Traumatic Stress Disorder and Violence

Several people have suffered trauma at the hands of themselves or battle buddies, as Vanessa Guillen did, creating trauma for her family, which led to the introduction of the I Am Vanessa Guillen Act (White, 2021). The effect of trauma can last a lifetime, with constant thoughts and assumptions of what truly happened, far exceeding the impact of some natural disasters. Natural disasters, like typhoons or earthquakes, can sometimes be anticipated, but not so often with PTSD (Antonioli et al., 2022). Parsons et al. (2018) agree that PTSD affects more than just the patient. PTSD affects family members, especially children, contributing to their behavior and emotional problems. Parsons et al. (2018) add PTSD is a mental disorder impacting non-military members and military Veterans who actively served during wartime and peacetime.

Another contributing factor to PTSD has been women who were sexually assaulted by their spouses. Sexual violence was more likely to lead to PTSD and possible homelessness than

any other traumatic event (Pincus et al., 2022). PTSD often goes undiagnosed due to the lack of reporting by victims, and the developing world, with limited psychiatric resources, may also be underdiagnosing the condition. PTSD was sometimes a self-reported measure according to the Post-traumatic Diagnostic Scale for DSM-5 (PDS-5) (Pincus et al., 2022). PTSD can manifest after any assault, including assault by an acquaintance, pastor, or stranger (Bender et al., 2015). The result can lead to trust issues, promoting withdrawal and depression when not treated properly by a trained therapist or church counselor. The sufferer may suspend striving for connection in an already challenging relationship or may end the relationship altogether (Laddis, 2019). Veterans with mental challenges are in the community, church, and the military.

The church has been serving the homeless and underserved who have been sexually abused or assaulted for many years, encouraging others to deal with their trauma (Holmes et al., 2005). The church sometimes has to protect those who do not want it, as with Teddy Henderson, a homeless man who froze to death a mile from six churches (Oliver et al., 2015). Inappropriate or not, being more persuasive could have resulted in saving the life of Teddy. Unacceptable or not, clearly defined decisions have been the downfall of many, including religious and civilian leaders. One church leader admitted to an incident where he assaulted a young lady while serving as a youth minister at his church and confessed to the act (Blair, 2018). He violated his call to help God’s people and his absolute morals, which should address sex before marriage with anyone (Geisler, 2010). Unfortunately, in some cases, leaders place themselves in these situations. The pastor positioned himself in a ministry-ending position when he agreed to take the young lady home alone instead of allowing someone else to do so. He could have taken several members of the class home instead of placing himself in the presence of one. There are more incidents where church leaders take advantage of their position over Veterans and other

church attendees. The leaders' inappropriate relationships force themselves on vulnerable single Veterans instead of helping them with their PTSD concerns or helping them embrace the gift of singleness from God (Köstenberger & Jones, 2010). Where the researcher grew up, it was common to see pastors and deacons with women other than their wives, and this contributed to the lack of trust for these men serving as God's agents. The mistrust continues today, even in the military, contributing to PTSD.

Military leadership is to train and protect military members, even from homelessness, as they prepare them for discharge and protect them from attacks like sexual assault, trauma, and misconduct by those who vow to protect and educate them (Papp & McClelland, 2021). The crime of assault happens far too often in the military. It has been titled Military Sexual Trauma by the Veteran Health Administration (Pavao et al., 2013). Sexual assault has been documented and reported by homeless women and men during their military service. Military sexual trauma directly relates to developing PTSD in military members (Farahi & McEachern, 2021). Sexual trauma is among the traumatic events with the highest risk for developing PTSD compared to civilian sexual assault (Pavao et al., 2013). Some of the military sexual assault victims become sexually or physically assaulted victims outside of the military, and this behavior was promoted by military leaders (Sadler et al., 2001). White (2021) reports that a high percentage of cases formerly claimed were victims of being discharged after reporting sexual assault. This type of crime is not resolved but passed up the chain of command. Some Colonels or Generals are relocated or terminated due to death or traumatic assault after exposure.

Post-traumatic stress disorder, trauma, and low self-esteem have run rampant through our society today with school shootings, bullying (Rowhani-Rahbar & Moe, 2019), and not forgetting the effects of COVID-19 deaths on the homeless population. The world was scared,

anxious, and nervous, but the word of God tells its followers not to be anxious about anything. However, in everything by prayer and supplication, God will provide us peace which passes all understanding (Philippians 4:6-7, NASB). According to Floyd (2017), the word trauma encourages people to locate the word wound in the Bible and replace it with the word trauma to identify trauma in the Bible. One study suggests an 82.7 percent chance that a person will experience a traumatic event, with PTSD being much higher in low-income and urban communities (Pincus et al., 2022). Low self-esteem presents issues but can be improved and stress reduced by refocusing one's attention (Eva & Thayer, 2017) and, in some cases relocating.

Relocating Homeless Veterans

Relocating after a violent episode may create new barriers for the homeless Veteran, like not having proper photographic identification could be challenging for many. Smith et al. (2018) address barriers and facilitators relating to the relocation process for homeless Veterans. The process involves several participants and staff members moving from specialist homeless healthcare centers to mainstream general practices (Smith et al., 2018). The process promotes relocating and integrating patients or participants from specialist homeless healthcare centers. Smith et al. (2018) suggest promoting trustworthiness from the homeless participants and encourage their buy-in towards the relocating process. Limitations, including recruitment, can accompany this. Those recruited represented a narrow demographic. Another limitation is response bias, and their responses may have been a factor in the research if those participants responded with socially desirable answers. Homelessness is not only those on the street but also those that bounce from sofa to sofa. The act of moving from sofa to sofa is known as sofa surfing.

The consequence of relocating is unfavorable because clients do not want to interact with unfamiliar staff members and feel like second-class citizens after developing relationships with the current members (Smith et al., 2018). It is helpful to create a comfortable environment when working with people experiencing homelessness or those with mental disorders. Berke et al. (2021) suggest that using evidence-based therapies for PTSD can reduce aggressive behavior problems even after relocating. These therapies are effective for Veterans with PTSD 18 years of age and older, diagnosed according to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (*Berke et al., 2021). DSM 4th edition included present-centered therapy and a group format with twelve sessions weekly for 90 minutes. Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE) were also helpful in reducing PTSD symptoms (Dondanville et al., 2021). CPT and PE are to be effective with patients with comorbid conditions, including substance abuse, which leads to some other form of abuse (Osei-Bonsu et al., 2017). Guo et al. (2016) provide historical data for a small sample group that reported being physically, sexually, and verbally abused. These could have contributed to their homelessness and lack of care, causing those involved to slip into depression. If members of a sample group have challenges getting to work, this may contribute to their lack of focus during therapy (Osei-Bonsu et al., 2017).

Depression does not just affect people experiencing homelessness. Depression is the most commonly reported mental disorder (Ding et al., 2018). Depression affects those in secure home environments with unlimited resources. Depression has no age limitations or respect for a person, but the symptoms are more severe in the older population (Stein et al., 2019). The Bible tells its followers that Elijah, one who interacted with the Lord directly as a prophet, one of the heroes of the Bible, suffered from depression. His suffering was so bad that he wanted to die,

asking the Lord to take his life in 1 Kings 19. Depression has been connected to many deaths in the United States, mainly by suicide, and is a risk factor for suicidal ideation and attempts (Cha et al., 2018). Depression is a recurrent disorder, and its prevalence and duration increase the older the individual becomes. Depression creates significant challenges in reducing the quality of life, deteriorating physical health, high risk of suicide, and increase in death due to physical diseases (Altay et al., 2018). Tsai et al. (2018) say Veteran suicides have increased among those not seeking government assistance through the VA.

Stanley and Joiner (2020) stated that in the United States, nearly 50,000 individuals died by suicide in 2018. This article states that people with PTSD symptoms were at higher risk of suicidal thoughts and nonfatal and fatal behaviors, with a decrease after attending treatment (Stanley & Joiner, 2020). Stanley and Joiner (2020) also support Written Exposure Therapy (WET) as a form of therapy for clients with suicidal symptoms as it reduces the presence, how often, and the severity of several indicators of suicidal risk. There have been concerns about identifying the risk of PTSD among people experiencing homelessness in conjunction with the recent pandemic in the United States (Liu et al., 2020). Dialectical behavior therapy prolonged exposure (DBT PE) was also developed as a primary treatment for trauma-connecting people with PTSD and suicidal symptoms (Stanley & Joiner, 2020). There is no permanent treatment to eradicate COVID-19, only annual shots.

Suicide and Post Traumatic Stress Disorder

Suicide prevention for active-duty members and Veterans is a topic of concern in the US, especially in areas that house this population (Hirono, 2019). Is suicidal ideation related to Veterans with PTSD, home loss, and food insecurity? The topic of suicide among Veterans with mental disorders may be a subject worth revisiting in future research. Dell et al. (2020) suggest

that PTSD and depression are distinct but connected through common vulnerabilities. Both symptoms require further research to identify the impact on Veterans in a homeless environment. While exploring the area of homelessness, it would be beneficial to address any trauma or traumatic events that may have contributed to the Veteran's inability to maintain a home or shelter. Divorce could contribute to depression and anxiety, which is relevant in public health and societal perspectives (Hald et al., 2020). Depression from a childhood event never resolved would make it more likely that depression would be more prominent as it manifests itself with various symptoms in Veterans during adulthood. Unfortunately, some symptoms may result in death by suicide. Mergler et al. (2018) suggests treatments for comorbid PTSD and other consequences of childhood trauma, even thoughts of suicidal ideation, should be integrated into Substance Use Disorder (SUD) treatment programs.

Cha et al. (2018) reported that 8.5 percent of deaths worldwide for individuals between the ages of 15 to 29 were due to suicide. Suicide victims may see this as a way to escape an overwhelming problem, but from their point of view provides no other option. Veterans have experienced increased suicide rates that have exceeded that reported for other US adult populations (Monteith et al., 2022). Does suicide have a connection to bullying in Veterans with PTSD? Bullying is known to have fatal consequences, leaving family members broken and possibly forcing them to become homeless. One author defined *bullying* as forcing your will on someone by harassment, name-calling, humiliating, and smearing (Natalier et al., 2021). The data was relevant because survivors may develop anxiety or PTSD due to childhood bullying or physical attacks. Childhood bullying could be a risk factor for developing more severe or chronic PTSD after subsequent traumatic exposures in Veterans (Mukherjee et al., 2020). The side effects of such bullying could still be present and display themselves as an outcome of the stresses of life,

including homelessness. Homeless Veterans may display symptoms of shame because of home insecurities and the continued desire to seek permanent shelter, even when not visually present (O'Brien, 2018).

Shame

The earth is massive and shared by many, full of beautiful things God has provided His people. Some things come with pain, and others with joy. People welcome joy: in some cases, the pain should be embraced and learned from by those affected (Thiessen, 2022). Unfortunately, this could lead to depression symptoms or avoidance with various consequences, including shame (Carvalho et al., 2015). Even great people from the Bible suffered from one or both conditions. Job authored some scripture during his depressive episodes (Job 30:16-20, NASB). The inquirer could only imagine the shame as Elijah cried out to God to take his life (1 Kings 19:4, NASB), and Jeremiah cried out with a broken heart (Lamentations 2:10, NASB). God has provided His people with the resources to address depression, loneliness, and shame.

Shame can go hand in hand with other mental disorders, including depression and addiction (Lyons et al., 2018). Lyons et al. (2018) report that doctors may feel shame due to distress. They believe they can cope with these feelings without assistance (Hirono, 2019). When it becomes a dominant emotion, the result can be maladaptive or passive (Carvalho et al., 2015). Carvalho et al. (2015) suggest that individuals with this emotion are known to keep their heads down, avoid making eye contact, and seek to hide from others who may know their behavior. Unfortunately, this could lead to depression and, or loneliness with various effects increasing the feeling of shame, which generally goes together with feelings of anxiety and depression (Westerlund, 2022). Shame and depression are linked, and shame is also connected to one’s

identity (Oliveri et al., 2019). A homeless Veteran may feel lost without a place to call their own, enhancing the feeling of shame.

Shame may affect women differently than men, more so on Veterans and their bodies. Women also reported higher body shaming than men (Wollast et al., 2020). Oliveri et al. (2019) suggest that women's self-beratement manifests itself as shame, and women are made ashamed just for being women, while men do not suffer from this issue. Even in the Bible, men or sons were celebrated more than women. The Bible shouts out the birth of sons, starting with Cain, but rarely embraces the birth of daughters. Unfortunately, women are not immune to homelessness and deal with similar conditions as their male counterparts. Shame is identified as one of the most destructive feelings related to sexual abuse (Porter, 2008) and must be treated accordingly towards homeless Veterans, men, and women. There must be better options to serve this homeless population. What options can be accessible to address the homeless conditions of Veterans?

In a perfect world, the infliction of shame and guilt to silence the victims would not have a place to harm those Veterans already suffering after providing service to their country (Kleiven, 2018). A recommendation to assist homeless Veterans is that the local hotel owners and hotels on military installations can provide housing to homeless Veterans with mental disorders. The initiative could begin in 30-day increments or longer, on a case-by-case basis, and would offer them shelter and an address for employment purposes. The installations could provide meals as well as showers in this undeveloped program. This program could assist in meeting some of the homeless Veterans' unmet needs. Veterans' unmet needs can be devastating to family members and the Veteran. Stanley and Joiner (2020) say PTSD strains the family or partner relationship, creating challenges with attending social activities and communication, with

the partner feeling shame. Due to this loss of social support from family and friends, survivors describe their feelings of rejection, loneliness, and isolation (Ross et al., 2021). The interaction or lack thereof encourages the Veteran to seek assistance, if not for themselves, then for their loved ones.

Treating Post-Traumatic Stress Disorder

Training in trauma and CBTs are successful therapy treatments for Veterans suffering from disabilities and anxiety (Giannaki & Hewitt, 2021). CBT is more effective in treating Veterans with post-traumatic stress disorder than present-centered therapy (McDonagh et al., 2005). CBT reduces traumatic-related symptoms in Veterans. The therapist's goal is to assist the Veterans in realizing that thoughts are automatically triggered, which can become repetitious (Levers, 2012). Martin et al. (2021) recommend using CBT as a first-line psychological treatment for Veterans with PTSD. CBT is a broad term encompassing several specific therapies (Martin et al., 2021).

Group Therapy for Veterans

Group therapy is beneficial for Veterans to get involved in their treatment by listening and sharing with others with similar issues or concerns (Beck et al., 2021). Group psychotherapy provides several benefits, from hope to interpersonal (Briere & Scott, 2015). In group sessions, a Veteran can get a clearer understanding and possible resolution, or at minimum, valuable coping skills that are beneficial outside the group environment. There is also a high dropout rate before the group starts (Senf-Beckenbach et al., 2022). A Veteran can often relate to fellow group members because of group cohesiveness and similar homeless experiences (Crone et al., 2022). The CBT model focuses on how a client's thoughts create or dictate the feelings and behaviors that occur afterward, modifying negative thoughts into positive ones and positively impacting

PTSD symptoms (McDonagh et al., 2005). Under the umbrella of CBT is Dialectical Behavioral Therapy (DBT), a combination of cognitive-behavioral practices, Zen principles, and acceptance (Levers, 2012). The term dialectics means the opposite. DBT treats borderline personality and helps treat trauma (Levers, 2012). Mindfulness can also be used as a standalone intervention or with standard treatment for PTSD (Reffi et al., 2019). It focuses on current situations involving and removing distractions (Briere & Scott, 2015). Mindfulness intervention occurs in an environment serving the entire group and in a mindfulness program that consists of a group setting with a heterogeneous group of Veterans with a high prevalence of PTSD (Kearney et al., 2011).

Eye Movement/Desensitization Reprocessing (EMDR)

Eye Movement/Desensitization Reprocessing (EMDR**)** is used for Veterans with PTSD and administered by an expert therapist (Kearney et al., 2011). EMDR is a treatment developed in the 90s and is known to help reduce trauma-related symptoms of PTSD. The goal of EMDR is to reprocess the event that causes the issue for the client. The process is a part of talk therapy (Levers, 2012). Another goal of the therapist is to assist the client with reframing their experience, not erasing it, and encouraging a more positive future (Levers, 2012). A positive result of this review is that Wilson et al. (2018) identify Critical Appraisal Skills Programme (CASP) as a strength because all papers are analyzed using the CASP tool for systemic review, while the studies do not participate if they fail to meet the CASP criterion. The negative side of this is limitations, starting with a small sample with limited follow-up, making it challenging to synthesize findings, and the follow-up data is often different between studies (Wilson et al., 2018).

Clinicians or healthcare providers must seek to encourage evidence-based interventions that could provide individuals who are experiencing trauma from a diagnosis of a chronic illness or disability (Levers, 2012). While taking care of others, it is advised that healthcare providers take care of themselves with a helpful self-care program to avoid burnout from healthcare providers working on the Internet (Hermes et al., 2018). *Burnout is* a psychological state of physical and emotional exhaustion thought to be a stress reaction to a reduced ability to meet the demands of one occupation (Franklin & Fong, 2011). Burnout is a chronic form of stress that can harm anyone if not appropriately managed (Wicks, 2010). Some barriers or physical symptoms may manifest as headaches, backaches, upset stomachs, anxiety, frustration, and continual tiredness in the evenings and weekends (Brand et al., 2020). Sometimes these ailments can be so severe that they may require the assistance of a caregiver.

Some caregivers (counselors) work harder for those they serve than the individual does for themselves. Counselors take on others' stress, making it their own, creating challenges for themselves. It is not their job to fix anyone's issues; that is God's specialty. Counselors show up as a representative of God for some but must remember this is a God issue to resolve, not theirs, and they cannot fix it. Their situation could be something designed by God to serve a specific purpose, and counselors only muddy the waters when they try to insert themselves over God's will. Not only will the counselor fall short and become frustrated, but it could also lead to burnout and can burn out others (Moiety, 2017a). Burnout can manifest physically, creating headaches, loss of appetite, and heart problems (Moiety, 2017a), among other issues. These are reasons therapists and counselors are encouraged to take care of themselves and stay knowledgeable of new treatments to serve others better.

Evidence-Based Psychotherapies

Evidence-based psychotherapies are used to treat Veterans suffering from PTSD (Finley et al., 2018). Finley et al. (2018) report that psychotherapists in San Antonio provide care to Veterans and civilians with little knowledge about the attitudes and practices of PTSD. There are several therapists trained for one of the EBPs for PTSD. In training, healthcare providers must identify clients who meet the criteria for PTSD to offer treatment (Pincus et al., 2022). As reported, only roughly 15.0 percent provided services to Veterans and less than that provided care to those with PTSD. Chu (2011) suggested some topics in treatment, including the epidemiology of dissociative disorders, diagnostic criteria and differential diagnosis, treatment goals, an outline of phase-oriented psychotherapy, and a review of adjunctive treatment modalities. They also shared some concerns about boundaries. The boundaries are a valuable part of treatment and the relationship between the therapist and the client (Sanders, 2013). Boundaries are the stage for a successful session with patients whose diagnosis may lead to or contribute to boundary violations (Pettman et al., 2020). Boundaries are encouraged to protect the therapist and client since physical touching is a therapeutic tool (Sessa, 2017). Healthcare providers should not forget the ethical implications of not having boundaries set. Setting appropriate boundaries helps minimize the temptation to breach the developing relationship (Chu, 2011).

It is the therapist's job and responsibility to set boundaries and do no harm to the client (Sanders, 2013). Learning not to harm others can only be mastered by receiving sufficient and continuous training to recognize issues or prolong the exposure of clients and how to address them (Pincus et al., 2022). Therapists and counselors must learn to manage whatever comes their way from their clients while providing care. Finley et al. (2018) acknowledge the shortage of

mental health providers in rural areas. Training should be encouraged so these providers can access the latest information from available healthcare providers within their scope of practice. Finley et al. (2018) suggest healthcare providers using EBPs with no training create a weakness concerning providers serving any client from whom this training would benefit. The lack of preparation may generate concern about how untrained therapists or counselors can provide appropriate care without training.

There are more challenges than trained therapists. Some challenges or limitations to consider are translating results. Even though the sample has a high classification accuracy, it leaves room for misclassification and over or underestimated representation of the amount of EBP's (Maguen et al., 2019). According to Maguen et al. (2019), another challenge is determining who has PTSD and should get a PTSD EBP because of the massive national system. A Veteran diagnosed with PTSD; does not mean that is their primary disorder. Maguen et al. (2019) identify many strengths, including the large sample of Veteran representatives from the Iraq and Afghanistan wars involved with the Veteran Health Administration.

Methylenedioxymethamphetamine (MDMA)

When offering treatment, training is provided to trainees on methylenedioxymethamphetamine (MDMA) as a treatment for PTSD through the Multidisciplinary Association for Psychedelic Studies. Training and supervision will occur under a trained MDMA therapist (Sessa, 2017). Supervised training promotes the skills set and strengthens the education and treatment services these therapists provide, making them more marketable as they continue to serve in their mental health positions. There are complex conditions with the quality of care in the community for Veterans with PTSD (Finley et al., 2018). This research also identified the delivery of high-quality care, and outside providers have

been slow to adopt EBPs for PTSD clients (Finley et al., 2018). Another treatment that may be worth considering is cannabis use. House Bill 1438 provides treatment and funding to treatment facilities to treat substance abuse (Albano, 2021). Cannabis can be used for medicinal purposes and recreationally. In May 2019, the Illinois General Assembly passed the Cannabis Regulation and Tax Act, House Bill 1438, with the governor signing the legislation in June. Legal sales for marijuana started in January of the following year (Albano, 2021). The use of cannabis may be a barrier for many. For those under twenty-one, cannabis is still illegal in most states, along with driving under the influence of cannabis use. HB1438 does not change the current law or address any additional methods for how to test for THC impairment in drivers (Traina, 2019).

Most barriers have limitations, even the use of cannabis. Cannabis treatment comes with restrictions, including the height a plant can grow to how many plants can be in a domicile (Dominguez, 2019). Cannabis use can relieve PTSD symptoms in the short term but may be harmful when used long-term (Cameron et al., 2014). PTSD is associated with a greater craving for cannabis than among users who do not have a PTSD diagnosis (Romero-Sanchiz et al., 2022). Another barrier is not learning from those who decline EBPs, especially in support of training (Hundt et al., 2018). Therapists and counselors must do their part to maintain and seek out post-graduate training and training accumulated by experience to serve the people, minimizing barriers limiting care (Litam et al., 2021). One benefit of MDMA is that it possesses moderate abuse potential, less than other stimulants (Sessa, 2017). When treating homeless Veterans or civilians with mental disorders, healthcare providers must consider barriers such as affordability, lack of trust, lack of understanding, poor therapeutic relationship, and accessible transportation (Ramsey et al., 2019), which may limit successful treatment.

Servicing Homeless Veterans with Mental Disorders

In treating homeless Veterans with mental disorders, the healthcare providers or counselors may need to involve many resources or specialties like mental health, medication management, or family members (Rauch et al., 2022). Some of these resources may require contacting family or friends of the Veteran for approval if the mental capacity to understand what is happening is a challenge. This section may result in multiple referrals to other specialized therapists with more experience in a particular area of concern. If referrals are necessary, the therapist or counselor should know whom the Veteran will see (Sanders, 2013). The referral should not be a surprise to the participant. The referral should be with the client's approval and explained why it is needed (McDonagh et al., 2005). A homeless Veteran with a mental disorder may need the assistance of others, including a family member, but not minimize his/her role as father or mother if they are parents (Stanley & Joiner, 2020). Mental disorders are not just a Veteran's issue but an issue for all involved in their care. The spouse or partner may see a decreased satisfaction in their relationship with a partner living with the diagnosis (Stanley & Joiner, 2020), promoting the other into feeling depressed, anxious, and guilty for feeling the way they may feel. Seeing the effects of mental challenges like PTSD on a spouse could encourage a Veteran to seek treatment (Dekel et al., 2005).

Veterans receive treatment for PTSD and other disorders, but some community-based mental health providers in San Antonio do not offer the needed services due to a lack of training (Finley et al., 2018). In comparison, some treatments may support Veterans with PTSD in addressing alcoholism, depression, and anxiety. Crone et al. (2022) suggest that the VA is the gold standard for those returning from war or military conflict. Some Veterans may feel several emotions compounded by shame when they are homeless, having no place to call home

(Carvalho et al., 2015). Another effective treatment for homeless Veterans with PTSD is mind-body exercise. The mind-body exercise approach helps improve PTSD symptoms, including depression and anxiety. Mind-body training is an adjunctive treatment for homeless Veterans with PTSD (Zhu et al., 2021). In general, depression has been an issue for many, not just the homeless Veteran population (Crone et al., 2022). The need to combat depression successfully is paramount. One study suggests the increased risk of suicide for people suffering from depression was due to suicide by a loved one or friend (Pitman et al., 2017).

Anxiety and Post Traumatic Stress Disorder

Anxiety and PTSD have been a contributor to suicide among Veterans. In an investigation, Brake et al. (2017) report that 57 percent of people with PTSD acknowledged suicidal behavior after trauma exposure. Brake et al. (2017) suggest that another factor contributing to suicide is disgust with the feeling toward oneself. *Substance abuse* is an issue that is often associated with PTSD among Veterans, especially alcohol. Hien et al. (2010) suggest alcohol misuse happens among older women and state that women who misuse alcohol do not reduce their PTSD symptoms as desired. Homeless Veterans often suffer from several concerns besides substance use, such as health issues. Due to the continued use of alcohol, there may be liver issues after excessive substance abuse (Wenzel et al., 1995), contributing to other disorders.

Ding et al. (2018) researched the history of mental disorders and found the majority of White males at 58.9 percent, followed by Black males at 34 percent, served in a war zone. Ding et al. (2018) report that 76.7 percent of the participants have at least one mental health diagnosis, including drug addiction, with the most common diagnosis being depression. It is worth noting that some Veterans have non-drug-related mental disorders (Ding et al., 2018). Some literature

suggests homeless Veterans are at a higher risk for experiencing mental disorders than their non-veteran counterparts. This author believes the outcome may contribute to Veterans' homelessness, leading them to live on the street by choice or circumstance. Ackerman et al. (2020) define *homelessness* for a Veteran as having ever found it necessary, during or after military service, to sleep for any length of time in a shelter, on the streets, or in another non-residential setting because of having no other place to stay. Unfortunately, many barriers contribute to homelessness in the United States. This action excludes staying with friends, family, and others under the current definition.

Barriers and Homelessness

Multiple barriers promoting homelessness include discrimination, poor health, lack of medical service, and feeling uncomfortable with police surveillance and control (Campbell et al., 2015). Discrimination is still an issue today, even towards people experiencing homelessness, preventing them from seeking healthcare through systematic barriers people must overcome to access healthcare (Thorndike et al., 2022). Thorndike et al. (2022) also mention healthcare needs and other restrictions, including disabilities that could hinder accessing healthcare providers. Campbell et al. (2015) suggest these barriers or weaknesses could contribute to financial barriers, lack of identification, and emotional barriers. Emotional barriers relate to the fear of receiving sad news. This article also discusses an affluent and well-to-do city with a 10-year plan to end homelessness.

Campbell et al. (2015) suggest that the Calgary Homeless Foundation (CHF) invites people experiencing homelessness as part of the development of services to address their unmet needs, including regular employment and stable housing. The loss may result in depression for all, with an additional impact on men. They appear unhappy with limited interest in activities

(Andreeva et al., 2015). Getting employment and overcoming employment barriers, especially for those facing homeless mothers, will draw them closer to normalcy (Groton & Radey, 2021). Job encourages them to do more and achieve more by making money, contributing to a healthy diet, and promoting nutrition (Wiewel & Hernandez, 2022). Having money assists in paying their way, giving them a sense of accomplishment, regaining their dignity and respect, and a sense of fairness (De Vries et al., 2019). Every Veteran deserves respect despite their mental disorder, disability, or standard of life. All Veterans deserve to be honored, provided social justice, and treated like everyone who has served this country (Scott & Wolfe, 2015).

Sadly, homeless Veterans also suffer from burnout, a chronic form of stress that can identify issues to avoid before reaching certain levels of burnout (Wicks, 2010). According to Wicks (2010), there are many symptoms to avoid including frustration, depression, apathy, helplessness, and impatience, to name a few. These symptoms are higher among people experiencing homelessness. When limiting these concerns, there must be a focus on self-care to manage the multiple basic stress levels (Wicks, 2010). In managing stress, that individual should get the proper amount of sleep; without enough sleep, the rest of one's day will suffer. Eating correctly and getting involved in an exercise routine are ways to manage stress (Wicks, 2010). Managing stress may be challenging when it comes to homelessness. Therapists and counselors must utilize the resources available to them to maintain a fitness program to be prepared for duty and employment to serve Veterans and others God has assigned to them (Casement, 2020). God has instilled in His people the need for others as they assist by pointing out weaknesses or blindspots to serve Him better and avoid emotional and physical burnout (Wicks, 2010). Another way to address or minimize stress, burnout, and depression is counseling.

There are several barriers providing limitations for people experiencing homelessness. These include financial, educational, healthcare, and many more, including cultural and language barriers (Thorndike et al., 2022). There appear to be barrier issues even among those who provide care, as with physicians and police officers, as the officers force people experiencing homelessness out of the parks and off the corners (Brissette, 2019), whose job is to serve and protect. Barriers at all levels must be discussed if the primary care of people experiencing homelessness is to be better (Campbell et al., 2015). It is essential to consider cultural and language barriers (Bee, 2019).

Another common barrier is communication and the challenges that come with several dialects. Barriers also apply to emails, telephone calls, letters, and the barriers accompanying each (Bee, 2019). This writer participates as a volunteer at a local church and provides counseling services, including stress and anger management, coping skills, and marital counseling. They all have several types of barriers. There is an additional service to provide resources and contact information regarding agencies and organizations that can assist in giving back to the community. In each form of serving, some communication issues can exist. Tiwary et al. (2019) suggest that poor communication can lead to adverse outcomes during counseling sessions, including decreased adherence to treatment, patient dissatisfaction, and inefficient use of resources. Communication is shared to enhance understanding and is beneficial when used tactfully. The word of God states, "No one can tame the tongue; it is a restless evil and full of deadly poison" (James 3:8), but counselors should try to manage what is said and how they say it.

Pastoral Counseling for Veterans

Counseling sessions have been known to help address multiple concerns, even for those of homeless Veterans. To develop a productive session, the counselor or therapist must lay out the expectations for the client and ask the client to share their expectations with the counselor while creating the expectation that something interesting will happen (Svinicki & McKeachie, 2014). The interaction should first consist of building trust. Due to the issue's sensitivity, privacy should be protected, with the counselor or pastor's plan to not harm (Sanders, 2013). Counseling may go hand in hand with individual or family involvement to assist the client with moving forward. Each session will open and close with prayer. If the participant approves, prayer will take place before every session. Praying is powerful, working as a Christian counselor. It is normal to pray over the participants and their family members who are a part of the therapeutic process (Rundio & Wong, 2022). A comfortable location should be free of distractions, including cell phones. Social distancing is maintained, as needed, between the counselor and the family or couple during the pandemic. The session will begin with the counselees sharing what they expect to get out of the session, followed by the counselor sharing their expectations with the individual or family while promoting social relationships (McReynolds & Yalamanchili, 2021).

There will be an opportunity to ask about their spiritual needs. The spiritually wounded must have their spiritual and physical needs met (Ames et al., 2021). Veterans often feel guilt, problems with forgiveness, and moral challenges due to military trauma (Starnino et al., 2019). According to Starnino et al. (2019), Search for Meaning (SFM) is a program for Veterans with PTSD that has spiritual or even moral impacts from combat trauma. There are tools used to measure the effects of trauma. Starnino et al. (2019) state Spiritual Injury Scale (SIS) is a self-reporting tool used to examine the level of complexity an individual may have with several

spiritual injuries. SIS investigates the degree of difficulty a person has with eight spiritual injuries: guilt, anger/resentment, sadness/grief, lack of meaning/purpose in life, despair/hopelessness, feeling that God has been unfair, concerns over religious reservation or mistrust, and anxiety about dying (Starnino et al., 2019).

Regrettably, there are consequences when care or services are not available to meet the needs of the Veteran, including emotional problems that guide them into thinking they have run out of options (Garnefski & Diekstra, 1997). Self-harm to the point of death has become an option for many, not just Veterans. According to Tsai et al. (2018), the Department of Veteran Affairs decided to move millions from fighting homelessness to fighting suicide in 2009, giving suicide priority. The transfer of funding was stopped by protestors (Tsai et al., 2018). The desire to prioritize is essential, but is it unreasonable to address them simultaneously? These are not the only factors contributing to homelessness and suicide; drug abuse or addiction are also factors in this fight. Tsai et al. (2018) suggest that many Veterans who commit suicide never receive care from the VA. There is a need for outreach, leaving the brick-and-mortar facilities behind and meeting the Veterans where they are. The Housing and Urban Development–Veterans Affairs Supportive Housing (HUD-VASH) program is helpful.

Housing for Homeless Veterans

According to Evans et al. (2019), the HUD-VASH program began in 1992 for homeless Veterans and was expanded under the Obama Administration to eradicate the phenomenon of homeless Veterans. The plan is to provide safe, affordable housing for Veterans with mental disorders (Evans et al., 2019). HUD-VASH is successful, causing a decrease in homeless Veterans of one percent. This program was less successful than many thought it could have been. The drop in homeless Veterans may have declined due to economic conditions, and the number

of Veterans may have been overstated (Evans et al., 2019). The issues minimizing the success of HUD-VASH may have generated a positive spin for homeless Veterans, showing them to be self-sufficient in a housed environment. Winer et al. (2021) suggest that project-based housing (PBH) and tenant-based housing (TBH) create new issues for formerly homeless Veterans like loneliness, social isolation, and social integration.

The challenges of being housed for Veterans are different than living on their own and are not the same for all Veterans. Homelessness worsens conditions from multiple mental and physical health issues (Crone et al., 2022). Some may seek a place to call home, while others run from the responsibility of paying bills, cleaning up after themselves, and living in one place for an extended amount of time, avoiding the strains of having a home (McReynolds & Yalamanchili, 2021). There may be other factors or hidden barriers that might contribute to this situation. Substance abuse and mental disorders like PTSD with cognitive issues brought on by auditory and visual limitations create strong discouragement (McReynolds & Yalamanchili, 2021) to Veterans with these concerns about living alone and maintaining a social connection that is meaningful and healthy (Winer et al. (2021). Being alone or homeless could result from a negative relationship with parents or other family members, making loneliness a negative consequence of a bad relationship (Bower et al., 2018). Homelessness can cause loneliness resulting in a small network and could go hand in hand with isolation, contributing to more unmet needs (Bower et al., 2018). The most basic needs identified are food, clothing, socks and underwear, and housing (Fleury et al., 2021).

Veterans experiencing homelessness should have unmet needs acknowledged and identified as basic needs. Fleury et al. (2021) support the position, and it is challenging to address medical conditions for several reasons, including social interaction, survival, food, and

shelter. For people experiencing homelessness, the need may exist to provide safety and security to protect their medications (Franco et al., 2021). Protecting their belongings and themselves could result in physical harm, with physical safety being a primary concern (Tyler & Schmitz, 2018), even to death. Homeless people are traumatized and abused in many ways, even through trafficking. Kappler and Carli Richie-Zavaleta (2020) report that one in seven homeless young people are at risk of becoming trafficked victims or survivors. These individuals need legal assistance and physical protection as well, and this protection may involve protection from others and themselves (Tsai et al., 2021).

There is a massive disconnect regarding protecting people experiencing homelessness from being victims (Kappler & Carli Richie-Zavaleta, 2020). The underserved and the homeless are often taken advantage of in many ways. Sixty-seven percent of homeless individuals were single, and the remaining 33 percent were parents or members of homeless families (Thurman et al., 2021). The number of single parents experiencing homelessness must be more stressful because of the additional care needed for children, and stress connected with this extra challenge may create a higher rate of depression for homeless women or homeless mothers (Alhusen et al., 2017).

Homeless Single Veteran Mothers and Helpful Programs

Alhusen et al. (2017) provide some information from the single mother's perspective. This research did not consider single homeless fathers caring for their children, creating limitations. This research is extremely limited to women and their children with no father's involvement and appears unfavorable towards fathers in a similar situation or homeless. Alhusen et al. (2017) provide information that can strengthen the single fathers' relationship with children

under their care also as it relates to the Mindful Awareness Play (MAP) and the Support, Honor, Inspire, Nurture, Evolve (SHINE) program.

The article indicates positive benefits and outcomes from using mindfulness training in the parent-child relationship and has significant implications for families. Education has been beneficial to young single homeless mothers ranging from the ages of 26 to 45 (Guo et al., 2016). Alhusen et al. (2017) also suggest that positive parenting in homeless individuals happens when individuals possess effective strategies to reduce stress. The program helps enhance the relationship between homeless single mothers with their children with the assistance of other programs like SHINE.

According to Alhusen et al. (2017), the SHINE program can be helpful to homeless parents who are also Veterans with parenting skills. SHINE consists of ten sessions with the parents. The program caters to serving underserved Veterans living in poverty, homelessness, physical abuse, and those with mental health challenges. Parents report improved child conduct, mental health, communication, and closeness and are more connected with the mothers after the parent's involvement in the program (Hali & Antonacci, 2020). Homeless Veterans, especially women and those with young children face more challenges when seeking to provide for their families (Salem et al., 2017).

Homeless Single Veteran Fathers

A homeless father’s masculinity is affected due to their situation and his inability to provide for his family (Walsh, 2020). One underrepresented area in the literature is homeless families, especially homeless fathers (Schindler & Coley, 2007). According to Schindler and Coley (2007), mothers maintain the role of primary parent, with 16 percent of homeless families having a father in the unit. Homeless mothers and fathers face various barriers to employment,

transportation, childcare, and secure housing (Sherba et al., 2018). Discrimination is alive and well, even towards people experiencing homelessness. One Indigenous homeless mother admits to being discriminated against because of her brown skin. Prejudice leads to an indigenous male spending over a month in jail, accused of stabbing a White woman with no evidence to convict him (Caplan et al., 2020).

Rogers and Rogers (2019) state that many homeless fathers become disappointed due to the lack of access to services to help with life concerns outside of child support, addiction, and mental disorders. Rogers and Rogers (2019) suggest some fathers discuss more conditions that they believe encourage feelings of hopelessness for fathers, such as the complex nature of homelessness resulting from multiple issues of joblessness, mental health, trauma, bad rental history, and lack of education. Living as a homeless person is a highly challenging situation (Rogers & Rogers, 2019). As a person dealing with home insecurity for oneself and family, mental health and self-care may not take priority, despite how much it is needed. To take care of one's relationships and family, the person must take care of themselves, implementing a personal self-care program to address areas of concern, including exercising, eating correctly, and scheduling some quiet time (Wicks, 2010).

This researcher will encourage anyone to communicate with God through prayer and not sit around doing nothing. In his video Necessity of Self-Care, Dr. Wicks (2017) states that depression and activity cannot exist together. In Exodus 18, Moses's father-in-law heard of all the Lord had done for Moses and the Israelites, but Moses served the people to exhaustion. So, Jethro provided him with some helpful counseling by encouraging Moses to delegate some of his authority. The advice received allowed Moses an opportunity for some self-care time or activities or to spend more time with God, promoting his mental health. Mental illnesses affect the

individual and have a residual effect on the family, including alcohol and at least one non-drug-related disorder (Ding et al., 2018). Healthcare providers should use effective self-care before becoming exhausted to the point their work is affected, limiting the care they provide.

Many people, including families, refugees, and migrants, may find themselves homeless for multiple reasons, including personal safety, behavior concerns, or family conflicts (Hyde, 2005). The number of homeless people in the UK has continuously increased, with over four thousand sleeping rough, meaning street dwellings (Jagpal et al., 2020). Timms and Drife (2021) suggest that most single homeless individuals in England are men over twenty-five. PTSD and mental disorders are more dominant among men, but homeless women are more likely to experience PTSD and other mental issues, including suicidality and substance abuse (Caplan et al., 2020). Drug use contributed to 40 percent of all deaths of people experiencing homelessness in England and Wales in 2018 due to drug poisoning (Jagpal et al., 2020). People experiencing homelessness should consider the consequences of their behavior and drug use on their children.

There is an elevated rate of drug use documentation among homeless youth (Combs et al., 2020). Sadly, young people who experience home insecurities are involved in various health risk behaviors at higher rates than their housed peers. Youth experiencing homelessness are:

- 5.23 times more likely to miss school due to safety concerns
- 5.03 times more likely to be victims of sexual dating violence
- 5.88 times more likely to be victims of physical dating violence
- 4.63 times more likely to misuse prescription pain medicine
- 3.21 times more likely to make a suicide plan
- 7.19 times more likely to attempt suicide

School House Connection (2019) reported the above data. This document provides resources for those needing drug treatment and assistance, including people experiencing homelessness of all ages. Due to the lack of desire to use the resources available to help with challenges to serve as parents and address their mental health issues and drug use (Thorndike et al., 2022), they will continue to be in need. They know whether homeless young mothers and fathers need specific support services concerning substance use and abuse to address their unmet needs (Combs et al., 2020).

Effects of Homeless Veterans' Children on the Grandparents

Unmet needs may affect other family members, including parents or grandparents. Not only does the lifestyle or substance use of the homeless Veteran affect the children but abuse also affects the children's grandparents (Tsur et al., 2019). One consequence of substance use could be death by suicide, intentionally or not (Hoffberg et al., 2018), leaving the children with their grandparents and changing their lives forever. Grandparents play a vital role in the relationship between homeless parents and children who have limitations in providing for them at this unstable time in homeless parents' lives, changing their location and lifestyle to provide for grandchildren (Zhu et al., 2022). The death of one or both homeless parents can impact all affected, especially the children, forcing the grandparents to take on a parental role over their grandchildren, even if the children are older and living with their children (Zhu et al., 2022).

The loss of a child, homeless Veteran or not, can devastate the remaining family members. Their loss provides an opportunity for the family to engage in any remaining responsibilities like dependent children that result from the ability to meet the needs of the child or children (Hamdan et al., 2020). When taking on the responsibility of younger children, the guardian must prepare to serve the young family members. There are several resources

grandparents should become knowledgeable of, such as medical and educational history, to name a couple, as well as when to contact or interact with them to benefit the grandchildren (Zhu et al., 2022).

Surveys and Other Resources to Assist Veterans with at Risk Youth

According to Marchbanks et al. (2016), the Texas School Survey of Drug and Alcohol Use (TSS), the Texas Youth Risk Behavior Surveillance System (YRBSS), and the National Survey on Drug Use and Health (NSDUH), drinking patterns are generally categorized. Those categories range from experimenting with a substance even once to currently using it (within the past 30 days). Those surveyed on the TSS self-reported their drug use and, or misuse of legal and illegal drugs. The TSS, in turn, is used as the primary outcome measure in reporting on Texas substance use and misuse (Marchbanks et al., 2016). According to the Substance Abuse and Mental Health Services Administration (2020) (SAMHSA), Alcohol Use Disorder (AUD) is ranked as the most wide-reaching SUD in the United States by those as young as 12 years and older, followed by Tobacco Use Disorder, Cannabis Use Disorder, Stimulant Use Disorder, Hallucinogen Use Disorder, and Opioid Use Disorder (Marchbanks et al., 2016). Several symptoms can result from drug use, including panic symptoms, depression, and anxiety (DiPrete et al., 2019). Those effects can span from unfavorable social conditions and, or negative physiological changes on blood vessels provoked by substances of abuse (Dabhi et al., 2022), which may include disruptions in families, financial difficulties, loss of productivity, academic failure, domestic and child abuse, and criminal wrongdoings. Due to varying social attitudes and legal responses to consuming alcohol and drugs, this public health issue turns out to be complicated since alcohol is legal and cannabis is illegal in most states, with a few restrictions (Kiluk et al., 2019).

It is estimated in the United States that the total overall cost of substance abuse, including the loss of productivity and health and crime-related costs, annually exceeds $600 billion (National Institute on Drug Abuse, National Institutes of Health, 2011). There is often a connection found between substance use and crime. In the U.S., offenses such as domestic abuse, Driving While Intoxicated (DWI), drug and property offenses, and other conducts or acts considered harmful to society, alcohol, and drugs connect with approximately 80 percent of them leading to incarceration (National Institute on Drug Abuse, National Institutes of Health, 2011). Our nation's prison population has grown beyond capacity, and most inmates are in prison, in large part, because of substance abuse:

- High rate of offenders abusing drugs, including alcohol
- Roughly 50 percent of inmates are addicted to some drug
- An estimated 60 percent of those arrested test positive for drugs at the time

In the above situation, drifting grandparents, or elderly 50 and over (those serving from house to house or moving from place to place) have always been there to provide some form of support for their children and grandchildren due to the nonsupport, not providing for their children or by those that are not in a position to provide for themselves or others (Ruan & Zhou, 2022). The drifting grandparents devote much energy and emotions to their grandchildren and gradually obtain emotional attachment and spiritual fulfillment in the migrating home, despite any negative consequences (Ruan & Zhou, 2022). However, emotionally they are always eager to bridge the distance between the two residents (Zhu et al., 2022). Some parents, though they cannot predict the future, have a better understanding of their children's behavior (Dipietro et al., 2018) and guidance or lack of guidance if their child will contribute to society or be a menace to it.

Predictors Resulting in Homelessness

Multiple predictors are used to identify causes that may contribute to homelessness. These contributing factors are substance use, mental illness, and poverty (Giano et al., 2020). The most vital and consistent risk factors are substance use disorders and mental illness, followed by low income and other income-related factors (Tsai & Rosenheck, 2015). They all come with their issues. Other issues worth considering are single mothers in unstable living arrangements and stepparents not having a supportive relationship with their biological or stepchild or stepchildren. Some child-related situations are conduct disorders, violent behavior, and relationship problems (Amissah et al., 2022), where the parent or stepparent treats the child poorly or is unable or willing to provide dental and, or medical care (Rigby, 2020). Needed services may lead to outside agencies getting involved and providing social support or threatening to remove children from the parent/s. Harming a child is a crime and could potentially increase children's risk for both the experience of child abuse but also PTSD (Cross et al., 2018).

According to Giano et al. (2020), despite ongoing efforts and funding to reduce and eliminate homelessness, this remains an ongoing issue in the United States. With all the available predictors to determine the potential for becoming homeless or factors that assist in eliminating or eradicating homelessness for all, affordable housing may be adequate, not just for Veterans suffering from mental disorders (O'Regan et al., 2021). Lee et al. (2021) suggest that eradicating homelessness is a moving target, making it more challenging to hit, but this goal is obtainable. This goal is possible by starting with the basics and providing clothing such as socks, underwear, and T-shirts (Fleury et al., 2021). Most people do not consider the need for socks related to homeless people as a need to be addressed (Grotto, 2021).

People experiencing homelessness walk everywhere they go and in all types of weather, including rain and snow. Socks are a very well-needed commodity for the homeless walking everywhere because they only have a small number of them (Grotto, 2021). The need for clothing is devasting. Havlik et al. (2017) mention that her school received funding for basic needs, including socks, shoes, and other essential items. Grotto (2021) also adds that her school was able to provide $100 to the more specific needs of some students. Many students, possibly children of homeless Veterans, may have experienced bullying for not meeting their clothing needs, according to their peers (Petrovich & Cronley, 2015). The act of being bullied or abused in any way, including sexual abuse, may result in a traumatic event and be a contributing factor to homelessness (De Vries et al., 2019).

There are different forms of sexual abuse toward children under 17 years old (Mathews & Collin-Vézina, 2019). Mathews and Collin-Vézina (2019) provide a breakdown of the different forms of sexual abuse, also considering those with mental issues or special needs ranging from three to five years of age. The perpetrator may attack those who do not know or have the mental capacity to know right from wrong or even speak, especially children. Sexual abuse does not have limitations to which gender it prefers. Langberg (2003) suggests that female sexual abuse happens more to girls in earlier years and boys in later years. The memories of the abuse may generate shame and depression symptoms among adolescents, developing possible posttraumatic stress disorder for the age group (Carvalho et al., 2015). Sexual abuse is a crime (Rudolph et al., 2022) with many side effects on all involved, especially young, and old victims.

Summary

The theoretical framework for transcendental phenomenological study aims to focus on the experiences of healthcare providers as they identify the unmet needs of homeless Veterans

with or without mental disorders in San Antonio, Texas. This study provides information about mental conditions, even PTSD. *Major depression* is a diagnosis that impacts homeless Veterans suffering from multiple mental concerns. These disorders may include diagnoses such as depression, shame, loneliness, anxiety, even loss of relationships, and in some cases, the destruction of families. These conditions have also contributed to homeless Veterans feeling isolated and were more widespread with the outbreak of COVID-19 forcing the world into isolation. The pandemic showed the world that responders are more than just those in the medical community, expanding the need for healthcare providers. Chapter Two also shares information about getting self-care for healthcare providers.

The United States is one of the wealthiest countries on the planet and lacks the continuous commitment to providing the needed services to homeless Veterans with or without mental concerns. Veterans' basic needs are not being met and cannot be until first identifying the needs of homeless Veterans, especially those suffering from mental disorders in San Antonio. It is an excellent environment to initiate this study in the city since San Antonio is known as Military City USA and the homeless Veterans population. This study is unique because it allows the researcher to draw data from interviews and focus groups with healthcare providers at different facilities and review agency documentation needed when appropriate for this study.

This phenomenological study will gather information from healthcare providers as they share their perspectives and types of treatment to identify mental disorders. One form of treatment is CBT, which is known to be successful for people suffering from various forms of trauma. CBT allows the Veteran or sufferer to be cared for and monitored, as it works well with individuals who choose not to participate in group therapy and prefer to work one-on-one with the provider. Group therapy promotes engagement from those with similar issues or concerns to

address their needs better. Chapter Two is not limited to those forms of treatment. This chapter also shares information about EMDR and EPB and brings attention to burnout from healthcare providers and the Veterans or individuals receiving treatment. Another treatment that provides challenges is cannabis use because it is not legal in every state.

Chapter Three: Methods

Overview

The purpose of this transcendental phenomenological study is to describe various provider's experiences interacting with homeless Veterans in San Antonio, Texas. A phenomenology study aims to construct meaning out of the shared experience of participants while focusing less on the researcher's interpretation and more on participant's descriptions of their experiences (Husserl, 1962). This study aims to highlight the unmet needs of Veterans, as identified by the healthcare provider during the treatment or interview process. The research will focus on the experiences of the healthcare providers with their interaction with homeless Veterans to identify their unmet needs. These unmet needs may include avoiding treatment, permanent housing or shelter, and other mental health needs, including PTSD. Homeless Veterans may want to seek treatment or a healthcare provider may promote positive outcomes based on their shared real-life experiences, which are appropriate for this study. Interviewing the healthcare provider will be the primary method for collecting data for this transcendental phenomenological study.

Design And Methodology

A qualitative phenomenological study meets the needs of the inquiry because it provides an interactive setting or opportunity for understanding healthcare providers from their real-life experiences. A qualitative study aims to investigate and gather data to learn about the real-life experiences of healthcare providers as they attempt to identify unmet needs. According to Moustakas (1994), phenomenology study seeks to understand human experience. Zahavi (2019) suggests the focus should be on the *how* of an experience and not the *what,* overlooking or bracketing our subjective lives or opinions, guiding the researcher toward what happens for

someone in their situation. This study is appropriate because of the focus on the experiences of healthcare providers who serve homeless Veterans. The phenomenological method was selected because it aimed to investigate and learn about the real-life experiences of healthcare providers from their perspective of serving homeless Veterans (Creswell & Poth, 2018). This study purposefully sought to understand people experiencing homelessness, and their unmet needs, through the experience of healthcare providers and the services they offer to homeless Veterans. The case study is similar in its design but focuses on real-life case studies, with researchers studying real-life events or cases over a period of time (Creswell & Poth, 2018). Ethnographic Research examines shared patterns and addresses the entire culture or shared groups with more than twenty participants (Creswell & Poth, 2018). Case studies and ethnographies are not compatible with transcendental phenomenological study.

The rationale for this study is to collect data from the healthcare providers as they share their perspectives about serving homeless Veterans. The data will be retrieved by interviewing 3 - 5 participants from five of the local facilities and having these participants attend focus groups sharing their experiences serving homeless Veterans (Creswell & Poth, 2018). All healthcare providers can speak freely, sharing likes and dislikes about the process of serving homeless Veterans during the interview or focus group. The interviews are estimated to take roughly one hour after completing a brief questionnaire. The purpose of this transcendental phenomenological study is to describe various providers' experiences interacting with homeless Veterans in San Antonio, Texas.

The phenomenological approach focuses on and emphasizes the experiences of healthcare providers serving homeless Veterans (Paul, 2017). The data gathered will provide supportive information about the unmet needs of homeless Veterans from the healthcare

provider's perspective. Healthcare providers involved in this study will come from the local Veterans Administration, Haven for Hope homeless shelter, and other facilities within the local community. Homeless Veterans are in some cities in the southern part of the United States, where it is a crime to assist the homeless with food or money (Bailey, 2016). A non-profit food truck owner in San Antonio faced fines and jail time, while a 90-year-old director of a non-profit and two pastors got arrested in Ft Lauderdale for feeding the homeless. It should not be a crime to help those in need.

Research Question(s)

Research questions are a developmental process that assists the researcher and will be used to provide awareness in identifying the topic for research. The questions will guide the research for this transcendental phenomenological study is a dominant approach throughout the study. The questions will guide the researcher in constructing the appropriate research to investigate this study. The questions will focus on the actual or lived experiences of healthcare providers as they relate to this study. The questions for this study consist of semi-structured interview questions and historical thoughts of the participants after hearing the open-ended questions, minimizing, or limiting yes and no responses (Creswell & Poth, 2018). These questions will be exploratory and intended to produce reliable and valid participant data. The questions will focus on and center around the participants' real or lived experiences serving homeless Veterans. The questions will be as follows:

RQ 1. How do healthcare providers describe their experiences assisting homeless Veterans in San Antonio, Texas?

RQ 2. How do healthcare providers describe the challenges or barriers related to serving homeless Veterans?

RQ 3. How do healthcare providers describe the most effective strategies used to assist homeless Veterans in meeting their needs?

Setting

The setting for this phenomenological study is relevant and appropriate for the participants. Data retrieved from healthcare providers and facilities that interact directly with homeless Veterans including San Antonio Metropolitan Ministries (SAMMinitries), Audie Murphy Veteran Administration (VA) Medical Center, Haven for Hope, and American GI Forum, where healthcare providers are often present to meet the needs of homeless Veterans seeking help. Their names and locations are replaced with pseudonyms to maintain confidentiality and remove all personal demographics. In one-on-one in-person interviews and focus groups (post-pandemic), masks are worn but not preferred during this study. Other participants may be interested in completing the demographic data online. An online option is available for those interested in doing their interview through the Zoom platform or who do not have a home living with someone else. It would be worth noting for clarification that Veterans who are sofa surfing are considered homeless.

The facilities may provide free internet services to complete the questionnaire online for healthcare providers participating in the process. However, interaction, interviews, and focus groups will take place at the local facilities sites preferably, and when allowed to accommodate the healthcare providers, allowing an opportunity to collect data in their work environment. The participant's data from the interviews and focus groups will be recorded and transcribed. The healthcare provider will review the information gathered to confirm the correctness and clear up any confusion or misunderstood terms used during the interview.

Participants

This transcendental phenomenological study will include 3 - 5 interviews, and all participants will attend one focus group with at least three healthcare providers. The best candidates to participate in the study are those with five or more years of experience. All healthcare providers' or facilities' buy-in to the study is confirmed once the consent must be signed and returned. Healthcare providers will participate voluntarily in this study. Snowball sampling will be one method of gaining participation in this study. The snowball sampling technique may help invite others to participate in events by sharing the online link and by word of mouth for recruiting only those in the local area with online access (Havlik et al., 2017). The participants in this study are mental health providers who serve homeless Veterans in San Antonio. Anyone meeting the definition of a healthcare provider and serving homeless Veterans is eligible to participate. There are no pre-selected individuals and no gender or age restrictions. Participants should work as healthcare providers at a local facility. This study aims to interview healthcare providers with real-life experiences servicing homeless Veterans (Creswell & Poth, 2018). The healthcare providers will complete an in-person interview and a brief questionnaire to generate conversation about past experiences for this transcendental phenomenological study, not for data collection.

In this phenomenological study approach, Van Manen (1990) suggests gathering information from healthcare providers on their real-life experiences servicing homeless Veterans. The participants may include all genders and members from various areas in the local community. The age range is open to any healthcare provider 25 years or older who serves homeless Veterans in San Antonio, Texas, and is currently employed and works as a healthcare provider.

Procedures

Prior to beginning the study, this inquirer will apply for approval from the Institutional Review Board at Liberty University. Once approved and received from Liberty University IRB (Appendix D), I would contact the facilities to gain access to healthcare providers who may be interested in participating in this transcendental phenomenological study, complying with APA ethical standards. Once the participants are identified and approved, they will receive the consent form (Appendix C) to participate in the study. The interviews will consist of input and demographic (pseudonyms) information, including the participants' gender, age, marital status, level of education, and other information related to the services provided to homeless Veterans will be confidential. The procedure will involve gathering information from the South Alamo Regional Alliance for the Homeless (SARAH), San Antonio Metropolitan Ministries, Inc (SAMMinistries), Audie Murphy Veteran Administration (VA) Medical Center, Haven for Hope, and American GI Forum and possibly other providers. Once the questionnaire and focus groups are complete, interviews will begin. The focus groups and interviews are recorded, transcribed, and shared with the interviewee for correctness (Levers, 2012).

One-on-one in-person interviews and focus groups are conducted with participants in a location with limited distraction (Creswell & Poth, 2018). Participants may recommend other healthcare providers to participate in this study (Havlik et al., 2017) and be approved after confirming employment as a healthcare provider serving homeless Veterans. These participants may gain access to the interviewee by email or phone call to acknowledge interest in this transcendental phenomenological study. Gathering data by interviewing in person can also help build trust while retrieving information from the participants while maintaining their privacy. Data collection will happen in multiple ways, including notetaking, audio recordings, and

transcribed. During the transcription phase, pseudonyms will provide limited confidentiality and protect the participant's privacy. Afterward, the results will be shared with the participants for correctness and reliability (Levers, 2012), followed by generating a readable document for others to read.

The Researcher's Role

I am an Associate Pastor at one of the local churches. I serve members of all the military branches. I also counsel church members in a community saturated with military families. I am a Veteran, having served in the Air Force and Army for 27 years. A primary reason for the study is to highlight the unmet needs of homeless Veterans with mental disorders, primarily focusing on PTSD from a healthcare provider's point of view. Another reason is to draw attention to the lack of care toward Veterans from the San Antonio area. There is an opportunity to interact with healthcare providers and Veterans in the local community to identify unmet needs. This process starts with interacting and gathering data from those serving homeless Veterans by conducting interviews.

Additionally, I am a Licensed Chemical Dependency Counselor, a Board-Certified Alcohol and Drug Counselor, and a Mental Health Counselor. My desire to serve God and His people is dominant in my service to others. I aim to honor God and His people with the hope others may see God in me and desire a relationship with Him. This research will study the impact of why and how healthcare providers serve homeless Veterans in the local community. In my experience, after treating various age ranges from elementary to business professionals. Unfortunately, some of their families were homeless and needed care from healthcare providers like me for themselves and their families.

As a facilitator for this phenomenological study, my role as a Veteran and an interviewer is vital in collecting information. My experience as a Veteran and a provider will help conduct the research. My background will remove any personal biases from interfering with the data collection process. Data is analyzed using empathy as part of the conversation, interpretation, and projection (Creswell & Poth, 2018). Healthcare providers from the local area will participate in this transcendental phenomenological study, including those receiving care from the VA and other facilities that serve homeless Veterans. The participants were individuals that have never interacted with the researcher before the phenomenological study.

Data Collection

The interviews will serve as the primary source for collecting data from the participants, and the focus groups will serve as a secondary source. The data gathered from healthcare providers for this phenomenological study is used to identify the unmet needs of homeless Veterans with or without mental disorders as viewed from the healthcare provider's perspective (Creswell & Poth, 2018). The data retrieved from the participants' interviews will be captured and shared with participants. These interviews will include healthcare providers who assist homeless Veterans with care and well-constructed semi-structured interview questions. Participants will review the data collected to confirm the correctness of the data after being transcribed (Creswell & Poth, 2018). If the participant would like to present artifacts in the form of documentation to support their perspective, they may do so during the interview or focus group. This data will be collected and analyzed.

Five focus groups with a minimum of three healthcare providers, limited to five at the most, followed by interviews later during the week at their place of employment at five different sites in San Antonio, Texas, with a size deemed appropriate to have a discussion, yet small

enough for everyone to have an opportunity to speak. The focus groups will last roughly 60 to 90 minutes, and the semi-structured interviews last approximately one hour. Snacks will be available, but healthcare providers will receive no payment for their involvement. At the beginning of each focus group and interview, participants are informed that all sessions are documented by recording and secured to maintain confidentiality for one-on-one sessions, kept anonymous, and names replaced with pseudonyms. Prior to the kick-off of the study, approval must be in writing from the Institutional Review Board of Liberty University to conduct the study.

Interviews

This study will aim to interview 10 to 15 participants offering two options. One will take place in person at their places of employment, and the other via Zoom, both will be recorded. Interviewing healthcare providers and collecting data about their experiences with homeless Veterans gain more knowledge about their needs. Creswell and Poth (2018) suggest the transcendental phenomenological study deals with the experience of the interviewee, the healthcare providers, and their point of view, focusing on the research and follow-up questions resulting from their responses. This study will follow the method presented with interview questions, focus groups, and the shared experience of the participants. The sample will be 10 to 15 healthcare providers for this transcendental phenomenological study, as recommended by Creswell and Poth (2018). The questions below will guide the study to gather data from the healthcare providers' experiences with homeless Veterans with or without mental disorders, and the data will be recorded, transcribed, and presented to the healthcare providers for confirmation of correctness. *Guiding Question 1:* What interesting fact(s) can you share about your interaction with homeless Veterans? (Icebreaker) First, this section of the study will inform the interviewees

or healthcare providers that they can stop the interview whenever they desire to end this process (Campbell et al., 2015). The interviewer generated this question to make the participant comfortable and put him at ease for the interview. The participants are present because they want to be involved in this study, making it easier to promote the flow of communication. The interaction between the interviewees will provide a more open dialogue between the participant and the interviewer. The participant will be more engaged in the interview process after their buy-in. Once the participants share their experiences, follow-up questions may be required. *Guiding Question 2:* What led you to become interested in serving homeless Veterans? By answering this question, the interviewer will learn what caused the participant to get into this field of work, removing preconceived assumptions. The answer to this question will also assist with guidance to address unmet needs, including dental care and shelter (Tsai et al., 2021). This research aims to identify these unmet needs and extend to mental illnesses like PTSD (Crocq & Crocq, 2000). Current research shows it is easy to acknowledge the clear difference between the unmet needs by gender (Tsai et al., 2021). Unfortunately, this study's limitation will be the sample size of the participants.

The guided questions will facilitate the interview process as the participants continue to share their experiences helping homeless Veterans. Sharing their experiences will lead to follow-up questions regarding data collection. There may be more open-ended guided questions to promote the conversation in interviews with the healthcare providers. The questions are listed below. The order may change based on the participant’s interaction and the direction of the process. The collected information will be recorded, transcribed, and shared with the interviewees to confirm the correctness of the information collected (Level, 2012). *Guiding*

Question 3: What is it like serving homeless Veterans with mental disorders? What keeps you coming back to continue this work?

Guiding Question 4: How do you take care of yourself, avoiding burnout?

Guiding Question 5: What is it like providing supportive services to homeless Veterans and their families?

Guiding Question 6: Describe your experience guiding or referring homeless Veterans to other support services.

Guiding Question 7: What is it like for you to find assistance or support for homeless Veterans?

Guiding Question 8: What organizations have you reached out to on behalf of a homeless Veteran?

Guiding Question 9: Describe some of the challenges you may have experienced with accessing needed resources for homeless Veterans with mental disorders.

Guiding Question 10: What agency or organization was the most helpful in addressing the Veteran's unmet needs?

Focus Group

This focus group will begin with an icebreaker allowing participants to briefly share something about themselves and their experience with serving homeless Veterans. For the sake of this study, participants would be encouraged not to use their names but the pseudonyms they select. The participants will get consent forms acknowledging their approval to be recorded and participate in this study. Once the consent is signed and returned, they can participate and stop participating at any time. This focus group aims to gain knowledge about the participant's many experiences serving homeless Veterans. There will be rules to increase the groups' participation

because all participation is voluntary (Ram et al., 2020). The focus groups will start on time and last roughly one hour, and one person will speak at a time and respect other participants.

A qualitative transcendental phenomenological study utilizing focus groups with 3 - 5 participants, guided by a semi-structured interview. The results will assist with understanding the perspectives of the healthcare provider in five research sites serving homeless Veterans populations in San Antonio. Each focus group will address the three research questions, and sessions will last roughly one hour. The providers are asked to provide pseudonyms to maintain confidentiality (Salem et al., 2017). One focus group will be at each of the five sites, with at least three participants in each session.

By using focus groups and semi-structured interviews to learn about the service experiences of the providers, clarity will be provided during the research (Molinari et al., 2013). This study aims to collect data from the experience of healthcare providers serving homeless veterans. They will share their perceptions of homeless Veterans and discuss unmet needs. Each site will have one focus group and a semi-structured interview with the providers (Molinari et al., 2013). Salem et al. (2017) recommend giving participants a gift card. At the beginning of the focus groups and interviews, all participants are informed the focus groups and interview sessions will be recorded, and comments are kept confidential (Salem et al., 2017). Their names and individual responses are also to be kept anonymous, and they can discontinue at any time.

Data Analysis

Data collected will be analyzed separately by the facility of their origin described in Aguas (2022). This transcendental phenomenological study aims to describe various providers' experiences interacting with homeless Veterans in San Antonio, Texas. The phenomenological analysis began after the focus groups and face-to-face interviews were completed (Aguas, 2022).

1. “Transcripts and Initial Coding’ (Aguas, 2022, p. 10) - Data will be transcribed to get a sense of comprehension from the data gathered from one or more collection methods (Aguas, 2022).
2. ‘Significant Statements’ (Aguas, 2022, p. 11) – I will identify significant statements leading the development of the categories and theme and use the participant's words verbatim. I will list all the preliminary non-repetitive statements. I will discard the non-constructive statement (Aguas, 2022).
3. ‘Initial Categories and Subcategories from Various Coding Methods’ (Aguas, 2022, p. 12) – Data will be analyzed according to research questions, and coding used to reduce data into themes (Aguas, 2022). I will employ first-cycle methods to initiate the coding of data.
4. ‘Step 4. Refined Categories from Selective Coding’ (Aguas, 2022, p. 13) – Codes will be selective using specific and broad categories to include initial categories created in step 3 (Aguas, 2022).
5. ‘Initial and Final Themes from Final Categories’ (Aguas, 2022, p. 14) – I will list all categories relevant to the experience of serving the homeless while developing initial themes from the categories (Aguas, 2022).
6. Textural and Structural Description and Interpretation of the Phenomenon (Aguas, 2022, p. 15) – “Present the findings in a narrative format for the textural and structural description, and interpretation of the homeless Veteran's experiences from the healthcare provider's perspective. This textural account includes what the research participants experienced, how they experienced it, and what they interpreted’ (Aguas, 2022, p. 15).

7. Composite Description and Interpretation of the Essences of the Phenomenon (Aguas, 2022, p. 16) – I provide a description of the experience shared by healthcare providers serving homeless Veterans and adjust steps through refining the analysis (Aguas, 2022).
8. Validation from the Participants' Feedback (Aguas, 2022, p. 17) – I would validate the data analysis and confirm no personal biases are present. I will forward the research participants to make sure the themes reflect their lived experiences appropriately. I would acknowledge any changes made by the participants.

Trustworthiness

Trustworthiness of the data collected employs several techniques to create a description of the experiences shared by healthcare providers that serve homeless Veterans. Bell (2009) defines trustworthiness as a technique used in qualitative research to confirm the investigation has Credibility, Transferability, Dependability, and Confirmability (Krefting, 1991). The strategy shared in this section will assist in validating the data to confirm its trustworthiness. These tools will also help with interpreting the responses given by the participant to obtain what was meant by their verbal response. A researcher has these tools to confirm the research is worth completing and beneficial to the field.

Credibility

Credibility represents the accuracy of the presentation; many methodological strategies are required to ensure strong credibility (Krefting, 1991). Credibility is a result of the participants sharing their honest thoughts during the process of gathering data to contribute to the study. All participants will be asked the same questions with modifications. Data collected during the process begins with face-to-face, one-on-one interviews after the participants complete a brief questionnaire. This process will promote participation in the focus group interviews and the

study. There will be at least three participants in each focus group at each of the five sites. Follow-up interviews will be conducted for clarification and correctness (Bell, 2009). This process increases the reliability of the study and maintains consistency. The participants will review their responses for correctness once the data is transcribed (Levers, 2012). There will also be a triangulation mix of audience reactions using focus groups. This process involves reflexive triangulation from the provider's perspective, using member checks, the dissertation chair, the reader, and the researcher as we communicate about the process (Patton, 2015).

Transferability

Transferability addresses how applicable a study is in another context (Connelly, 2016) and provides a means of external validity (Williams & Morrow, 2009). One researcher suggests a second point of view on the application of qualitative data assessed. The study is successful when the findings fit into other contexts outside the study's original intent (Guba, 1981). Thick descriptions are used for the unobservable contextual understanding of the situation that makes it meaningful (Younas et al., 2023). Creswell and Miller (2000) associated thick description with participants, environment, and situations under study by providing maximum details concerning their interactions and experiences.

Dependability and Confirmability

Dependability and confirmability are another part of trustworthiness, supporting the stability at the time the study was conducted (Connelly, 2016). The dependability section discusses the stability of the data collected over time and the conditions of the study (Polit & Beck, 2012). The confirmability section of the study confirms the finding has repeatability as required by this study (Connelly, 2016). Confirmability is the degree to which the results are

consistent and could be re-accomplished. Dependability and confirmability are the goals of this transcendental phenomenological study research (Polit & Beck, 2012).

Ethical Considerations

When conducting a study, there are several ethical considerations to address when participants are involved. The number one priority is security concerns for the privacy of the individuals in the study. Pseudonyms disguise the participants' names and places of employment to provide confidentiality for the locations and affiliations and not harm. Participants will be encouraged to pick a pseudonym. The demographic information is modified using pseudonyms to protect the identity of the participants. Participants' demographic information required will be employment status as a healthcare provider treating homeless Veterans with or without mental disorders. Secondly, the researcher will seek to use a location at the participant's place of employment with minimum distractions and out of the way of walking traffic while gathering data from interviews. Once the interviews are recorded and transcribed, the participants will review the results for accuracy. Thirdly, participants will be permitted to stop or take breaks, if necessary, during the interviews or end the interview at any time. This information will be shared and written on the consent form and stated verbally during the interviews.

A potential issue that could exist is language barriers. If a healthcare provider speaks only Spanish, this includes any paperwork that may not be in their native language (Bee, 2019). Getting the paperwork in the participants' native language could address the language barriers. A translator could be to minimize this barrier. Another issue is if no translator is available during the interview to assist with any paperwork requiring completion (Heppner et al., 2018). Other issues could be honesty from the participants during the interview. Some participants may offer data that is favorable to their performance, possibly exaggerating their experience supporting.

The researcher must have the participant's buy-in; having their buy-in for this study increases the chance of sharing honest experiences.

Participants' data will be secure to maintain their privacy. Confidentiality will be preserved to protect the healthcare providers' privacy (Sanders, 2013). The researcher will confirm that the names used are pseudonyms, protecting the provider's identity and the personal data of participants and facilities. Data stored on computers will be password-protected, and hardcopies secured in a locked cabinet. Participants' data is protected, and pseudonyms provide confidentiality. With these levels of protection in place, there should be no issues getting approval from the IRB to conduct this research (Salem et al., 2017). If the researcher receives a no from any panel member, the study will not happen. Another potential issue is the lack of approval for the research timeline that the researcher would agree with (Crook, 2015). The researcher must have the interview questions submitted for approval also to confirm they will not harm the participants, themselves, or anyone involved in the phenomenological study.

Summary

Chapter Three began with the purpose of this transcendental phenomenological study and data given by healthcare providers for homeless Veterans' unmet needs. This study discusses Veteran unmet needs from the healthcare provider's perspective. This chapter shares information about the design and methodology and why the best approach for this study is a transcendental phenomenological study (Creswell & Poth, 2018). Chapter Three shares the research questions relevant to the healthcare providers in this study. These are open-ended questions to promote the forward movement in the interview process. Open-ended questions encourage the person to avoid Yes or No replies and to think before answering (Miller & Rollnick, 2013).

Chapter Three further shares information about the setting, which includes one of the local VA facilities. Interacting with healthcare providers at this location will be helpful because of the number of Veterans seeking care or assistance there. The participants will be interviewed face to face with a mask if needed due to possible COVID-19 infection (Creswell & Poth, 2018). Information or data gathered by interviews will be shared with the participants for correctness to verify the data and status of employment. The procedure of contacting participants will only take place once approved to do so by the IRB (Crook, 2015). After IRB approval, multiple techniques to collect data will be used, including interviews and face-to-face with the healthcare providers that serve homeless Veterans with or without mental disorders, including PTSD. Chapter Three will set the stage for conducting this transcendental phenomenological study. This section will conclude with the ethical procedures applied throughout the research. The data gathered in this section will lead to Chapter Four, where the results, recommendations, and the need for future studies are shared.

Chapter Four: Findings

Overview

This transcendental phenomenology study aimed to understand the unmet needs of homeless Veterans in San Antonio, Texas, through the lens of service providers. Chapter Four initiated the recruitment process, and targeted individuals who fit the study's criteria. Data collected were through semi-structured interviews and focus groups that involved providers from local institutions to acquire essential insights. The methodology for executing interviews and focus groups aligned with the guidelines provided by Creswell and Poth (2018). The communication to recruit participation was through emails to the management, requesting their formal interest on official letterhead.

Research Questions

1. How do healthcare providers describe their experiences helping homeless Veterans in San Antonio, Texas?
2. How do healthcare providers describe the challenges or barriers related to serving homeless Veterans?
3. How do healthcare providers describe the most effective strategies used to assist homeless Veterans in meeting their needs?

The data collected was analyzed to identify common themes among the participants from their experiences.

Participants

Sixteen interviews were completed with this study, with four focus groups. All the participants identified themselves as providers that served homeless Veterans. All sixteen interviews were transcribed and shared with all interviewees. The interviews scheduled were

completed, transcribed, and shared with the interviewee at an agreed-upon time. The participants were recruited by flyers and snowballing sampling or word of mouth from those who chose to participate in the study.

Of the sixteen participants, seven self-identified as White or Caucasian, six as African American or Black, two as Latino or Hispanic, and one as Asian. Thirteen of the providers admitted to having a college degree or higher education. All the participants were at least 35 years of age. The majority (11) of the participants served in the military. The remainder (one) confessed to having connections with the military through family members but never served herself.

The participants are listed below, followed by a brief introduction. They are identified by gender and age after choosing their pseudonym. The pseudonyms selected by the participants were based on the letter of the alphabet they were given.

Table 1

Participant Demographics

Pseudonym	**Age**	**Ethnicity**
Annie	42	Caucasian
Betty	50	Caucasian
Charles	65	African American
Diana	38	Caucasian
Eve	62	African American
Frances	36	Caucasian
George	43	Hispanic
Henry	41	African American

India	43	Caucasian
Jamie	57	African American
Kendrick	56	African American
Lisa	42	African American
Michelle	35	Caucasian
Nathan	37	Caucasian
Olivia	36	Hispanic
Paul	42	Asian

Annie - 42 years old

Annie, Caucasian, is a member of leadership at her place of employment. Anne is married with two daughters, thirteen and six. Her oldest is in her first year of high school and plans to become a doctor. Her youngest child enjoys playing with Pokémon stuffed animals when she is not watching them on television. She has been married for 15 years to a Veteran currently serving in the Army. Annie decided to get involved with the homeless population after taking some classes discussing people experiencing homelessness.

Betty - 50 years old

Betty, Caucasian, is married and has been for 24 years with two adult children, 23 and 26. The older one works in the federal prison system and the younger daughter is in the military. They followed the model of their father, who served in the military for 26 years. She became interested in serving Veterans after meeting homeless Veterans who served with her husband. Betty added there is a huge need to serve those who served this country.

Charles - 65 years old

Charles, an African American, is an ex-homeless Veteran married with no children. He decided to work with the homeless population because of his own experience. Charles retired from the Army after serving 22 years. Charles is the middle of three brothers and chose not to live with family members because of his private issue with drugs. Charles has been working serving homeless Veterans and other people experiencing homelessness for 11 years and enjoys helping those in need and wanting the help. He is grateful to his place of employment for taking a chance on him and allowing him to do what he loves, helping those in need.

Diana - 38 years old

Diana, Caucasian, served as an officer in the Army for 12 years. She is married with three daughters. Her husband is also a Veteran who served in the Army. Diana has a degree in social work and was stationed in various locations in the United States. Diana's father was disabled, and she was the oldest child, so she took care of him the most. After working with her father and others, sparked her interest in the field of social work and assisted her in serving homeless Veterans and others in the local area, especially those with substance use disorders.

Eve - 62 years old

Eve, an African American, is a retired army Veteran, married for 23 years, currently widowed, and has one adult daughter. She shares experiences with those she serves to enhance their relationship. Eve was surprised that she was selected for this job because she admits to never applying for employment with this agency, but here she is six years later, still loving it. She enjoys serving those who served in the military. Eve likes the quiet environment, but sometimes the clients with mental disorders, like PTSD, occasionally flare up and must be

tactfully addressed. Situations like this, where Veterans explored, is where the training comes into play, where we must de-escalate the situation.

Frances - 36 years old

Frances, Caucasian, is a supervisor at facilities that assist homeless Veterans and others experiencing homelessness. She helps those rent challenged by avoiding eviction and other barriers that may contribute to homelessness. Frances understands the benefits of having boundaries and not taking work home and stresses the importance of self-care. She found it valuable to ensure her clients are aware of the resources available to them. She lets the clients voice what their needs are to avoid any assumptions.

George - 43 years old

George, Hispanic, is a retired Air Force senior ranking NCO. After he retired, he knew he wanted to serve more to help those experiencing homelessness. George said, "I understand first-hand the effects of depression and anxiety and their contribution to homelessness." After being discharged, he decided to return to school, complete his degree, and become a case manager, serving people experiencing homelessness. George loves working with his fellow Veterans, serving them by assisting them with housing first.

Henry - 41 years old

Henry, an African American, is the son of a Veteran and is a Veteran himself. He retired from the Air Force as a senior NCO. Henry is married with two daughters. He has been serving homeless Veterans and others since he became a social worker in 2005 after receiving his LMSW. Henry considered starting a private practice but decided against it and will reconsider after retirement. Henry knows being the boss can be challenging, but he loves what he does and can see himself in his practice later in life.

India - 43 years old

India, Caucasian, is a Veteran medically discharged after 14 ½ years. She is married with one 16-year-old daughter. Her husband supports her work, helping people experiencing homelessness, but her mother thinks it is too dangerous since many homeless Veterans she assists have mental disorders. She was familiar with the homeless Veteran population, and the opportunity presented itself to work with them, and she jumped at it. India has worked with homeless Veterans for eight years.

Jamie - 57 years old

Jaime, an African American, is the daughter of a retired Veteran and the wife of a Veteran who served 30 years with the Army. She is the mother of three adult children and works as a supervisor in one of the departments with the VA. She has been providing services to Veterans for over 15 years. Jamie has a strong passion for working with this population and plans to share it with Veterans and others experiencing homelessness. She also assists spouses of deceased Veterans with claims and benefits they have earned.

Kendrick - 56 years old

Kendrick, African American, is a retired Veteran, married to a Veteran, and has two daughters, 12 and 16 years old. He enjoys working with the homeless population and helping them achieve goals. He has worked with Veterans with mental disorders as well as those with substance use disorders. Kendrick has worked with this population for nine years. He regrets a missed opportunity to work with a homeless Veteran with whom he was once deployed.

Lisa - 42 years old

Lisa is an African American, a Veteran, and a mother of an eight-year-old child. Lisa speaks several languages and has worked with homeless Veterans for ten years. She has worked

with several agencies that serve people experiencing homelessness because she believes this is her calling. Lisa is proud to work at her current job because she gets a lot of face-to-face with those experiencing homelessness. She believes helping others is helping herself.

Michelle - 35 years old

Michelle, Caucasian, enjoys her work because of the interaction with the homeless population, including children. She does not have children and loves bringing a smile to their faces. Michelle has worked with people experiencing homelessness for ten years and does not plan to go anywhere. Michelle gives so much of herself in the service of others that it contributed to her burnout. She developed a strategy plan for self-care to assist with avoiding burnout.

Nathan - 37 years old

Nathan is a single Caucasian male social worker who enjoys his work and the people he helps. Nathan has worked as a social worker, serving people experiencing homelessness for about eight years. He has worked with multiple partners to meet the needs of those experiencing homelessness, including Veterans**.** Nathan's desire to serve this population has created a concern for self-care. He later developed a work-life balance and continues to make time for himself away from work. Nathan serves as a supervisor in his place of employment and promotes self-care while promoting the needs of those they serve.

Olivia - 36 years old

Olivia, Hispanic, is a married medically retired Veteran with two kids, and her husband is a retired Veteran. She also added most of her friends are Veterans. Olivia can relate to Veterans with mental disorders because it hits close to home. She aims to serve the homeless population, especially those with mental disorders because all of them do not get the same opportunity for services due to the type of discharge. Olivia chose to help all Veterans regardless of the reason

for being homeless or military discharge. She enjoys seeking out resources if her facility does not have them.

Paul - 42 years old

Paul is Asian and the only clinical psychologist interviewed for this research. He has authored multiple articles on the topic of homeless Veterans. His primary focus is severe mental illness. He has been working with this population since 2002. He is married, and his wife is also a clinical psychologist. He has done direct service with homeless Veterans but is currently working on research.

Results

This section includes information about the process taken to identify the themes from the participants' interviews and focus groups. This information included several themes and repeated words and phrases during the interviews and focus groups. The themes offered data to support the research questions for the phenomenological study while gathering data from the providers that offered and provided services to homeless Veterans and others experiencing homelessness. The information collected from the providers discussing their perspectives helped to identify themes from interviews and focus groups as they shared their interaction with homeless Veterans and other people experiencing homelessness (Gallardo et al., 2020).

Theme Development

The interviewees repeated words and phrases over and over again throughout the data-gathering process. This process consisted of one-on-one interviews and focus groups with the interviewees. Once I documented the repeated words and phrases, I grouped them based on which of the five focus groups the interviewee was affiliated with and placed them together according to the organization (Moustakas, 1994). Moustakas (1994) called this technique

reduction and elimination. These words and phrases were then connected to a particular theme and validated (Moustakas, 1994).

Major Themes. Three major themes were identified during the analysis from the interviews and focus groups. Some information was expected to be repeated since some participants were from the same organization with similar backgrounds and experiences. The expectation was that the interviewees would share their perspectives on serving Veterans as they assisted with the Veteran's unmet needs. The most dominant theme for unmet needs from the perspective of the provider was not just homelessness but access to resources. This included limited transportation to appointments and an abundance of resources overwhelming homeless Veterans and others experiencing homelessness. The second major theme was the desire to set goals that go hand in hand with getting and maintaining housing. The third theme was discharge status, including other than honorable and dishonorable discharge status and their restrictions.

Theme number one. Access to resources was challenging for many Veterans or others experiencing homelessness for several reasons. First, they have no transportation to appointments that may assist in providing services. Some agencies offered bus passes to those experiencing homelessness, and they either lost them or the passes got stolen, preventing them from going to the desired location. They could always return for another bus pass as some do, and some do not due to possible embarrassment or lack of interest because the pass may get taken away or stolen again. Some of the people experiencing homelessness were discouraged and decided not to make appointments or initiate services to address their unmet needs.

Theme number two. The participants assumed the homeless population had a desire for housing and that many of the people experiencing homelessness do not present themselves with the desire to want housing. As explained by a provider, once they arrived at the facility, goals

were set to assist with getting a home and keeping it. One person experiencing housing turned down her housing opportunity because it was not in a section of town where she wanted her children to attend school. In another situation, the person experiencing homelessness was placed in an apartment later, he moved a female companion in, and she put him out. There was some legal issue to get her out, but he got into another home.

Theme number three. Discharge status was relevant when serving people experiencing homelessness who were Veterans. Some facilities would not serve Veterans discharged under a dishonorable status. They were referred to as one of the few facilities that served those with less than honorable discharges from the military. Some facilities provided services to homeless Veterans who served less than 180 days. SAMMinistries offered services to Veterans in less than 24 hours. Some facilities served all who were experiencing homelessness, while Veterans could have additional benefits, especially those with mental disorders than non-veterans.

Table 2 displays some repeated words and phrases constructed to develop the themes. These repeated words and phrases supported the development of the themes identified. There were emotions expressed by the healthcare providers, as they shared their perspectives on the homeless conditions experienced by Veterans and others living in homeless environments, whether self-imposed or because of some mental disorder diagnosed or not.

Table 2
Repeated Words and Phrases from Analysis

Repeated words/ phrases by Agency	**Researcher developed codes**	**Themes/Subtheme**
Close to Home		
Diverse Backgrounds	DB	Service
Challenges faced by homeless veterans	CFV	Limitations
Political will	PW	Community

Holistic support	HS	Whole Person
Interdisciplinary nature of homelessness	INH	Shelter
SAMMinistries		
Complexity and misconception of homelessness	CMH	Limited Support
Systemic issues and advocacy	SIS	Agencies
Suggestions for improvement	SI	Moving Forward
Mental health and homelessness	MHH	Self-Care
Personal experiences and professional challenges	SOR	Self-Care
American GI Forum		
Holistic support and services	HSS	Whole Person
Navigating resources and support	NRS	Services
Addressing mental health	AMH	Agencies
Personal connections to services	PCS	Self-Care
Haven for Hope		
Understanding needs	UN	Services
Needs of homeless veterans	NV	Services
Different backgrounds	DB	Agencies
Background experiences	BE	Services
Veteran Administration		
Complexity of diagnoses	CD	Service
Challenging work	CW	Job Satisfying
Mental Health and substance abuse treatment	MHSA	Services
Navigating systemic challenges	NSC	Services

Research Question Responses

The purpose of this transcendental phenomenological study was to describe various providers' experiences assisting homeless Veterans with or without mental disorders in San Antonio, Texas. The research questions used in this study allowed the participants to share their experiences and perspectives on providing care or services to homeless Veterans and others experiencing homelessness. As they shared their experiences, several themes were identified and relevant to this phenomenological study. These themes are listed below to provide understanding or insight into the data collected with subthemes repeated by several interviews.

Data collected allowed for the development of themes identified in this study. Theme one focused on access to resources, which was challenging for people experiencing homelessness. Theme one offered relevant data to all three research questions. Theme two led to the lack of desire for housing. This was not the goal for all the homeless Veterans and others experiencing homelessness. Theme three focused on the discharge status of Veterans seeking service from agencies that do not serve all veterans, like those dishonorably discharged. The data below offers more understanding of the themes from the provider's perspective.

Theme one - Access to Resources. This section contains details of the collected data in support of theme one and its relationship to the following research question.

Research question one. *How do healthcare providers describe their experiences helping homeless Veterans in San Antonio, Texas?* Question one was the premiere question because this transcendental phenomenological study focused on the experience and perspective of the providers that serve homeless Veterans and other people experiencing homelessness. This process of collecting data to identify themes started with requesting participants from organizations that served people experiencing homelessness. After participants were identified,

and interviewed, they were assigned a focus group with those deemed eligible based on approved qualifications developed by the researcher to work towards constructing themes and subthemes.

As the theme “access to resources” developed, it became clear that people experiencing homelessness do not have equal access to resources in the city of San Antonio. In Chapter Two, access to resources was identified as one of many barriers, according to Thorndike et al. (2012). Some of the limitations presented by healthcare providers after interacting with homeless Veterans and other homeless individuals were transportation challenges due to loss or stolen bus passes. Transportation was identified in Chapter One as a barrier, according to Conners et al. (2009), and another was not wanting the responsibilities that come with being permanently housed. It is expected people experiencing homelessness want housing. India stated, “There are many that do not want to be held to one place like permanent housing” (Interview with India, December 2023). There was also the challenge of having no permanent address to receive important correspondence, which could affect the motivation or desire for housing of those experiencing homelessness. Some people experiencing homelessness may have additional challenges, which led to the development of the following subthemes limited support, agencies, self-care, and moving forward.

Subtheme number one. The first subtheme was limited support, and it was evident from the lack of interest in being housed. Many of those experiencing homelessness did not want to deal with the routine or strict structure that was followed while serving on active duty. So, they were comfortable moving from place to place whenever they wanted. Not staying in a place long enough created an environment where the services were limited because they could not be located and had no permanent address to provide correspondence. Diana asked, “How can we

provide services if we can't locate them?" (Interview with Diana, January 2024), creating an issue limiting follow-up from health providers and agencies.

Agencies. This subtheme was identified based on agencies that attempted to follow up with those who requested services at some point. Unfortunately, they were no longer at the provided location, and the person experiencing homelessness would say no and not accept housing. As this research was being conducted, I had the opportunity to observe someone who was not a Veteran and was not homeless requesting assistance. He stated, "I have a home and have been out of work for three months, I need a job." He met with the agency career officer and came out with a job referral. Eve said, "Once their services were turned down because the property was not in the school district the mother wanted" (Interview with Eve, January 2024). I would not have expected someone with kids to turn down housing for any reason. It is challenging enough when you cannot reach a person you are attempting to offer services to due to restrictions like no phone, no resident or address, and when a person experiencing homelessness refuses shelter, it creates frustration or burnout, creating self-care concerns.

Self-Care. Self-care was important when serving others. It was important to take care of yourself before you can take care of others. One example of this was when flying on an airline. The attendants first encourage each customer to put on their oxygen mask before assisting someone else with their mask in case of an emergency. According to Miller and Owens (2020), in Chapter One self-care is so critical the National Association of Social Workers created a policy called the *Professional Self-Care and Social Work*. Betty said, "She just kind of pulls back, otherwise she would be a wreck" (Interview with Betty, November 2023). By taking care of oneself it becomes a little easier to move forward to taking care of others, continuing to provide care for the homeless population they serve.

Moving Forward. Moving forward can be challenging when the provider has issues that create conflict for themselves and the person needing services. Moving forward from past hurts and pains should offer guidance to the person suffering and may require therapy. When proper care is not received, a provider may not be suited to care for others (Crewell & Poth, 2018). Some of the providers were hesitant to recommend therapy because they were concerned about treatment. Therapist notes do not reflect what the health care provider shared, so the people experiencing homelessness may feel unheard also. India said, “She knows people in the homeless population that refuse to talk with therapists because they say I’m not crazy” (Interview with India, February 2024). This may limit the possibility of getting housed if they desire housing.

Theme two - Lack of Desire for Housing. The section will discuss barriers identified by several subthemes from providers or agencies including service, holistic approach, community, limitations, and shelter.

***Research question two*.** *How do healthcare providers describe the challenges or barriers related to serving homeless Veterans?* These subthemes described contributing factors and identified barriers, challenges, and unmet needs while providing services from an agency or provider's perspective. This study identified specific concerns that all people experiencing homelessness were not just seeking housing but serving the whole person concept, meaning they required services that were tailor-made to serve their unmet needs.

Services. The services provided by most agencies were vast and plentiful. This was a barrier and part of the issue, according to Paul, who stated, “There are thousands of different services, and sometimes this can be overwhelming to homeless Veterans and others experiencing homelessness” (Interview with Paul, January 2024). This created what can be perceived as the

water hose effect, creating challenges or information overload when it is all provided to you all at once. Paul added, “This would cause them to throw their hands up because it’s almost too much” (Interview with Paul, January 2024). The information provided here may be more helpful if offered in a less challenging or devastating manner more catered to the individual, but treating the whole person, or taking on a holistic approach.

Holistic Approach. This approach required getting to know the person’s unmet needs and listening to them as they identified and voiced needs, including mental health, food, employment, and legal advice. Christian churches promoted a holistic approach to their congregations (Stephens, 2011). Paul said, “In the history of homelessness, there has been a lot of homeless services provided by religious organizations” (Focus group with Paul, January 2024). There was not a cookie-cutter approach when serving those experiencing homelessness. So, the objective must be to serve the whole person. Many interviewees voiced concerns about communities not accepting the homeless or offering affordable housing in their neighborhoods. Betty said, “There are many community partners, but the homeless are not welcome in the community” (interview with Betty, November 2023).

The funding was available for those seeking housing or to be placed, removing the stigma. Due to a lack of support, the funding vouchers not distributed created barriers to getting housing. Annie said, “Even though the vouchers are received, there is no increase in staff support to get them in the hands of the homeless” (Interview with Annie, November 2023). Once the vouchers are received, they are distributed to those in need seeking housing to gain access to the community to become a new resident versus a person experiencing homelessness.

Community Involvement. A vital piece of addressing homelessness was community involvement. The lack of involvement or support generated barriers or challenges for people

experiencing homelessness. Frances said, “More involvement is needed, and let’s get community buy-in to support the holistic approach and in their chance for success” (Focus group with Frances, February 2024). The community partners were actively involved in the PIT, which means point in time. This was where agencies went out and counted the homeless population throughout the city. This event assisted with future funding and identified communities that may require more services. The event also helped with putting eyes on those with mental issues who may seek services or treatment. But even with this process of locating, counting, and offering services, there were still barriers and limitations.

Limitations to Providing Services. Providers run into limitations when conducting a PIT count. The interference from the authorities strongly encouraged the people experiencing homelessness to move or relocate before the PIT count. Eve said, “The PIT count can be an eye-opening experience because of what you see on the streets” (Focus group with Eve, February 2024). It stated that police would have the homeless people or homeless camps relocate before the PIT count. It was confirmed by Eve. Eve said, “The police would go out there and tell the people to leave, and this made them unable to be accounted for during the PIT count” (Focus group with Eve, February 2024). This action generated a less accurate number and affected future funding, limiting the services provided to people experiencing homelessness. This barrier or limitation may have a lasting effect on the funding needed.

Shelter For People Experiencing Homelessness. Paudyal et al. (2017) stated that shelter improvement increases health status. I thought shelter would be a high priority for all people experiencing homelessness. Eve said, “Services were rejected because the school was not in the part of town this person experiencing homelessness wanted her kids to attend” (Interview with Eve, November 2023). It was surprising to hear when the option was to be housed or be

homeless. Eve added, “Nobody wants to be homeless, but during the PIT count, I realized that statement was incorrect because some people want to live off the grid” (Focus group with Eve, February 2024). This was the desire of many despite having money or their discharge status from the military.

Theme three - Discharge Status and Service Eligibility. This section will address the discharge status and the benefits that are related to each discharge category from the provider’s perspective.

***Research question three*.** How do healthcare providers describe the most effective strategies used to assist homeless Veterans in meeting their needs?

Job Satisfying Serving All. Job satisfaction was achieved after identifying the most effective strategy to assist the person who needed help in front of them and making a positive impact. Henry said, “Making a positive impact on those he serves keeps him coming back” (Focus group with Herny, February 2024). Paul added, “As a clinical psychologist working with homeless Veterans was very impactful in offering better services” (Interview with Paul, January 2024). The most effective strategy was to first locate those experiencing homelessness who wanted help and shared with them what they are eligible for based on the discharge category. Some agencies will not offer services to Veterans dishonorably discharged. Olivia said, “Haven will take anybody once they prove they were in the military, no matter their discharge status” (Interview with Olivia, December 2023).

Dishonorably discharged homeless Veterans can receive some services but not many. Lisa said, “Bad conduct and dishonorable discharged Veterans are ineligible for many benefits received by those honorably discharged” (Interview with Lisa, December 2023). Some agencies served anyone despite their discharge status. Jaime said, “There have been situations where

dishonorable discharges may not receive burial benefits in some cases, it may depend on how long you served" (Interview with Jaime, November 2023). Veterans who received a dishonorable discharge may even face employment limitations. Some applications inquired about military service and type of discharge, which could be a contributing factor towards homelessness for many Veterans. Jaime suggested, "Send military members to reserve status servicing as a reservist allows them the opportunity to redeem themselves instead of discharging with a strike against them, by giving them a dishonorable discharge" (Interview with Jaime, November 2023). This action could result in a positive effect on Veterans experiencing homelessness in the future.

Summary

Chapter 4 focused on the experiences of healthcare providers working with homeless Veterans and other people experiencing homelessness in San Antonio, Texas. This researcher gathered data and created multiple themes focusing on the three. One was "Access to Resources." There were sixteen interviewees from five different agencies and four focus groups in San Antonio, Texas. The leading research question explored how healthcare providers described their experiences assisting homeless veterans, shedding light on the challenges and barriers encountered in providing care and support.

The transcendental phenomenological study was to explore the experiences of providers assisting homeless Veterans in San Antonio, Texas, identifying the limitations and challenges of serving the homeless population. The researcher found several themes developed from the data collected through interviews and focus groups with healthcare providers and agency workers. The interviews and focus group data were transcribed and offered to the participants to confirm correctness. The above actions assisted with developing the following themes.

Theme 1: Access to Resources highlighted the significant barriers homeless Veterans faced in accessing needed services. Providers stated that transportation issues, such as lost or stolen bus passes and unwillingness to accept permanent housing due to a desire to relocate whenever they wanted to, being independent, and lacking any responsibilities. These were barriers for many homeless Veterans and other people experiencing homelessness. These identified subthemes limited support, agency challenges, the importance of self-care for providers, and the need for forward movement provided service to those wanting it despite the many barriers.

Theme 2: Lack of Desire for Housing showed that not all homeless Veterans sought to be housed, challenging the assumption that housing was a goal for this population. This theme contained difficulties in providing services when individuals declined housing based on personal choice or location challenges, such as school district locations. It also touched on other barriers like community involvement, the lack of a holistic approach to care, and agency limitations, including those reflected during the Point in Time (PIT) count, which affected funding and future services. The PIT count accessed the location to provide better service to those not accounted for or who have chosen not to seek services.

Theme 3: Discharge Status and Service Eligibility addressed how Veterans' discharge statuses impacted their eligibility for services as homeless Veterans. This theme identified the most effective strategies for assisting homeless Veterans and focused on the importance of tailoring services to homeless Veterans' needs based on discharge status. Providers expressed a commitment to serving all Veterans experiencing homelessness, regardless of discharge status, but recorded barriers often limited the availability of services to those with dishonorable

discharges. Veterans with this type of discharge can receive services but are limited to those with an honorable discharge.

Overall, the study highlighted the critical need for a distinction understanding of the barriers to services provided for homeless Veterans, advocating for a more tailored, holistic approach to care that considers the circumstances and preferences of everyone. It also highlighted the importance of addressing providers or agency challenges, such as those related to discharge status and community support, to improve access to resources and support for homeless Veterans. This study allowed healthcare providers and agencies to share their perspectives, contributing to a positive way of providing care and addressing unmet needs.

Chapter Five: Conclusion

Overview

The purpose of this transcendental phenomenological study was to describe various healthcare providers' experiences interacting with homeless Veterans and other people experiencing homelessness in San Antonio, Texas. The problem statement identified unmet needs and the lack of services from a healthcare provider's perspective, sharing their stories and life experiences serving people experiencing homelessness. This study aimed to identify the unmet needs of homeless Veterans in San Antonio, Texas, from the healthcare provider's perspective and the services provided to assist in meeting the needs of homeless Veterans. The research questions used to guide this study are listed below:

1. How do healthcare providers describe their experiences helping homeless Veterans in San Antonio, Texas?
2. How do healthcare providers describe the challenges or barriers related to serving homeless Veterans?
3. How do healthcare providers describe the most effective strategies used to assist homeless Veterans in meeting their needs?

Chapter 5 begins with an overview of the study followed by the purpose of this transcendental phenomenological study. The objective of the study was to gather data from providers who have served homeless Veterans and other people experiencing homelessness in San Antonio, Texas and providers shared their perspectives on serving the homeless population. A discussion of the findings was followed by the implications of the data collected for the study. Once the implication of the study was provided, an explanation of the delimitations and limitations, and then recommendations for future studies.

Summary of Findings

An analysis of the data collected from the healthcare providers resulted in three themes and four subthemes. Theme one was the premiere theme of access to resources, which identified barriers that limited the homeless population's access to agencies that were able to offer needed assistance to homeless Veterans and other people experiencing homelessness. Some of the challenges identified resulted in four subthemes. Theme one's subthemes were (a) limited support, (b) agencies, (c) lack of self-care, (d) and moving forward.

The information gathered contributed to all three research questions. Theme two, lack of desire for housing, highlighted challenges and barriers that aided in the knowledge of why some people experiencing homelessness were not automatically accepting housing. In the development of theme two, the following subthemes were identified (a) services, (b) holistic approach, (c) community involvement, (d) limitations to providing services, and shelter for people experiencing homelessness.

Data collected in theme three overlapped with those of theme one and theme two. Theme three highlighted two subthemes, job satisfaction and discharge status. These subthemes addressed research question three, strategies that assisted providers in doing their best while guiding Veterans with restrictions to an agency to meet their needs. This promoted job satisfaction, according to some providers, and kept them returning to work, day after day, even when expecting some type of challenge when it came to serving Veterans. Job satisfaction was identified as one of the most effective strategies for preparing themselves to serve the homeless population. This strategy encouraged providers to learn about resources and limitations that may limit or restrict services. One of those restrictions was discharge status or category. Homeless Veterans with a dishonorable discharge did not receive the same services as Veterans with an

honorable discharge because of their lack of eligibility. They may receive services from some agencies but not from all.

Discussion

The theoretical framework for this transcendental phenomenological study aimed to focus on the experiences of healthcare providers as they attempted to identify the unmet needs of homeless Veterans and others experiencing homelessness in San Antonio, Texas, with or without mental disorders. This study was guided by the perception that all homeless Veterans wanted their unmet needs met and housed. Previous research focused on women only, developing treatment plans from past cases where the providers were not trained to serve the homeless Veteran population (Finley et al., 2018). Women were the primary focus because they were among the fastest-growing population of people experiencing homelessness (Salem et al., 2017). This phenomenon extended to families including children. Many were homeless by choice and others by unexpected circumstances beyond their control, creating multiple unmet needs. Fleury et al. (2021), stated several needs go unmet because it is a continuous cycle, when one need gets met, another one takes its place. This section included the findings of this study and how they related to the theoretical framework and empirical framework.

Theoretical Framework Relationship to the Study

It would be hard to imagine a person experiencing homelessness to turn down or reject housing for any reason. The research identified homeless individuals who refused housing for what they considered to be reasonable to them. One mother experiencing homelessness refused housing because the school she wanted her kids to attend was not in that particular neighborhood. Another person experiencing homelessness refused housing because he wanted to move around from place to place whenever he wanted to. The initial hypothesis was rejected

because every homeless person did not want to be housed or wanted the regiment that comes with certain responsibilities such as paying monthly bills.

There may be situations where someone suffering from some type of mental disorder may not have the mental capacity to know what is to their benefit. Some mental disorders may manifest themselves differently (Dell et al., 2020). PTSD may contribute to homelessness and depression in several ways, leading to substance use or substance abuse (Stanley & Joiner, 2020). This study confirmed that a lot of people experiencing homelessness suffer from some type of mental disorder. Eve said, “The clients we deal with most of them have some form of mental issues” (Focus group with Eve, February 2024). Previous research supported this position but more from the perspective of the homeless person and with limited data from the provider's perspective.

Empirical Framework Relationship to the Study

As this research moved forward, it was clear that the passion shared by all the interviewees working with this population was genuine. Most of the literature focused on the contributing factors to homelessness and mental disorders affecting the unmet needs of homeless Veterans in San Antonio, Texas. The unmet needs of homeless Veterans and other people experiencing homelessness cover a wide range from dental to legal concerns (Zur & Jones, 2014). Veterans experiencing homelessness were distinct groups, having different unmet needs, and required knowledgeable healthcare providers, multiple resources, and support to combat homelessness (Tsai et al., 2021).

This research enhanced earlier research because of the approach to gaining knowledge from a more current healthcare provider workforce. The resources have changed, offering more resources to homeless Veterans and others experiencing homelessness to assist them with getting

housed. There have been changes to help Veterans over the years, with overwhelming resources to guide those who wanted housing. Local agencies have provided employment opportunities with their agency or made a referral to increase their chances for employment and housing. This assistance was similar to an invitation offered by CHF, increasing the development of services to address unmet needs (Campbell et al., 2015). This study uniquely highlighted the services available for this population to assist with minimizing barriers and limitations, including financial, educational, and healthcare (Thorndike et al., 2022) while guiding homeless Veterans and other people experiencing homelessness. The homeless population in San Antonio, Texas, continued to have unmet needs, but now there are lots of resources available with SACRD.org to access needed services.

Implications

The theoretical and empirical implications for this transcendental phenomenological study identified the unmet needs of homeless Veterans from the healthcare provider's perspective. It was valuable to obtain knowledge from the experience gained while serving homeless Veterans and other people experiencing homelessness. In some situations, providers allowed their personal lives to be dominated by their work, which created challenges and barriers away from work. The result could manifest boundary concerns and possibly emotional issues for the providers getting exhausted because of stress (Franklin & Fong, 2011) from working harder for those experiencing homelessness than they do for themselves. Homelessness for a Veteran was defined as having ever found it necessary, during or after military service, to sleep for any length of time in a shelter, on the streets, or in another non-residential setting because of having no other place to stay Ackerman et al. (2020).

A large amount of the research focused on serving homeless Veterans and some of the behaviors that lead to homelessness, like personal safety, family conflict, or behavior concerns (Hyde, 2005). As the research was on its way, there was a clear desire to serve the homeless population sacrificially. It was clear the providers performed as their brother's keepers, and we are to be accountable for ourselves and others (Romans 14:12, NASB). This researcher observed providers were not spending time with family because they chose to stay at work and oversee intense issues like confirming beds were available for a particular night. Many providers were military-affiliated and understood the phrase No man left behind. They practiced and lived this motto, as observed by their commitment to serving not just the people experiencing homelessness but all who sought their help.

Delimitations and Limitations

Delimitations refer to the boundaries set by the researcher on the scope of a research study. These boundaries were intentionally chosen to define where the study will and will not go (Creswell & Creswell, 2017). The decision to use a phenomenological design was selected because it was the best fit for this study. This study also emphasized the experience of the participants (Creswell & Poth, 2018) and the knowledge gained from serving homeless Veterans and other people experiencing homelessness. Delimitations for this study were restricted by the age of the participants to be at least 25 years of age, to contribute to this study and work as a healthcare provider serving homeless Veterans for 5 years.

Delimitations

The purpose of this transcendental phenomenological study was to describe various providers' experiences assisting homeless Veterans with or without mental disorders in San Antonio, Texas. The research allowed me to restrict the research to a specific city with a high

population of potential participants. The participants were encouraged to have at least five years of experience serving the homeless population and working in San Antonio to participate in this transcendental phenomenological study (Creswell & Poth, 2018), with at least 25 years of age. The rationale for this was the participants would gain a vast amount of knowledge based on working with Veterans experiencing homelessness.

Limitations

The limitations of this study reflected providers who worked in only five selected agencies willing to participate. One of the selected agencies had challenges with availability and was able to participate in the focus group portion of the study. The sample of providers serving Veterans experiencing homelessness was minor compared to the substantial number of providers in the San Antonio area. Interviewing more participants may have rendered a similar outcome, but incorporating more providers may offer a more significant reach for data collecting. This could assist in providing additional services or cross-service, limiting possible frustrations from providers, and allowing them to share one another's burdens while offering services.

This action is supported by a biblical worldview. According to the word of God, Galatians 6:2 (New American Standard Bible) tells believers, "We are to bear one another burdens." This scripture means assisting others is the least we can do to help them address unmet needs. After meeting their needs, they can assist others and share what God did for them since there is no partiality with God (Romans 2:11).

Recommendations for Future Research

The transcendental phenomenological method was ideal for this study because the data was collected from the providers and based on their experiences (Creswell & Poth, 2018). San Antonio is the second largest city in Texas after Houston but with a large military population.

The population of military members is so large that the city is known as Military City USA. In future research, there should be a larger sample of providers serving the homeless Veteran population throughout the city. I would recommend a phenomenological study, gaining knowledge from the experiences of those providing care to the homeless population.

A future study should extend the interviewing to more providers citywide that are serving homeless Veterans and non-veterans experiencing homelessness. It encouraged that all risks be considered and improved. A future study may benefit from mixing the agencies instead of having a focus group with members from the same agencies. Future researchers should incorporate some of the other agencies, promoting a possible increase in knowledge and services provided. It will also be beneficial to confirm all participants are available and willing to participate throughout the entire process, contributing to the growth of this field of research. Future research should also investigate case studies to identify ways to motivate those experiencing homelessness towards seeking services.

Summary

The purpose of this transcendental phenomenological study was to describe various healthcare providers' experiences interacting with homeless Veterans in San Antonio, Texas. After addressing the research questions, question one was the leading question to gain knowledge from the provider's perspective. The results from the study identified three major themes. Theme one was access to resources, theme two was lack of desire for housing, and theme three was discharge status and service eligibility. Once the interviews and focus groups were concluded, the data collected was used to gain data and develop four subthemes (a) limited support, (b) agencies, (c) lack of self-care, and (d) moving forward in theme one. Theme two consisted of four subthemes (a) services, (b) holistic approach, (c) community involvement, and

(d) limitation to providing services. Many of the subthemes overlapped throughout all three research questions. Research question three had one subtheme, job satisfying serving all, and identified various discharge categories and the benefits or restrictions that accompanied them as they related to the homeless Veterans population.

The homeless Veterans population may or may not always be around requiring services, including housing. There will never be one cookie-cutter approach to addressing unmet needs and other concerns. A case study would have been a possible method to use, requiring multiple cases to study, and taking place over some time, with in-depth data gathered and several sources of information (Creswell & Poth, 2018). A phenomenological approach was best to extract information from providers and Veterans experiencing homelessness. This information helped construct themes and subthemes for all three research questions.

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APPENDIX

APPENDIX A: INTERVIEW QUESTIONS

This list of questions will be asked during the one-on-one interviews with participants. Questions may require clarification questions result in further questions.

1. What interesting fact(s) can tell me about your interaction with homeless Veterans? (Icebreaker)
2. What led you to become interested in serving homeless Veterans?
3. What is it like serving homeless Veterans with mental disorders? What keeps you coming back to continue this work?
4. How do you take care of yourself, avoiding burnout?
5. What is it like providing supportive services to homeless Veterans and their families?
6. Describe your experience guiding or referring homeless Veterans to other support services.
7. What is it like for you to find assistance or support for homeless Veterans?
8. What organizations have you reached out to on behalf of a homeless Veteran?
9. Describe some of the challenges you may have experienced with accessing needed resources for homeless Veterans with mental disorders.
10. What agency or organization was the most helpful in addressing the Veteran's unmet needs?

APPENDIX B: OTHER DATA COLLECTION PROCEDURES

Focus Groups Questions

- How would you describe your experience serving homeless Veterans?
- Share your experience with homeless Veterans diagnosed with mental disorders.
- How did you assist them with their concerns?

Interviews

- Interviews will be recorded and transcribed verbatim.
- Participants are going to share their thoughts during the interview process once it begins, and the researcher will verify the continuous involvement of the participant every 15 minutes with guided interaction until completion.
- The researchers will communicate with the participants about their experiences during the interview.
- The researcher will document the participant's behavior and any follow-up required on the participant's behalf at the end of the session.

APPENDIX C: CONSENT FORM FOR PARTICIANTS

Consent

Title of the Project: A Transcendental Phenomenological Study: Identifying the Unmet Needs of Homeless Veterans with or without Mental Disorders from a Healthcare Providers Perspective
Principal Investigator: Thomas Scott, Doctoral Candidate., School of Behavioral Sciences, 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 employed as a healthcare provider, be at least 25 years of age, and have five years of experience serving homeless Veterans.

Taking part in this research project is voluntary. Please take time to read this entire form and ask questions before deciding whether to participant in this research.

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

The purpose of this transcendental phenomenological study is to describe various healthcare provider's experiences interacting with homeless veterans in San Antonio, Texas. In addition, this study attempts to identify the needs shared by healthcare providers that serve homeless Veterans diagnosed with or without mental illness.

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:

1. The first task is an interview. This interview will take approximately 1 hour and will be conducted either in person or virtually and be audio and video-recorded.
2. The second task is a focus group, which will take approximately 60 – 90 minutes. The focus group will also be conducted either in-person or online and will be audio and video-recorded.
3. Lastly, I will ask you to review the transcriptions to check for accuracy or confirm agreement.

How could you or others benefit from this study?

Participants should not expect to receive a direct benefit from taking part in this study.

Benefits to society include increased knowledge of the public with interactions of the healthcare providers with homeless Veterans in the local area.

What risks might you experience from being in this study?

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

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[s] will have access to the records.

- Participant responses will be kept confidential by replacing names with 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 members of the focus group may share what was discussed with people outside of the group.
- Data will be stored on a password-locked computer. After five years, all electronic records will be deleted, and all hardcopy records will be shredded.
- Recordings will be stored on a password-locked computer for five years and then deleted. The researcher will have access to these recordings.

How will you be compensated for being part of the study?

Participants at each facility will receive a number after completing the procedures, which includes the interview and focus group. A copy of the number will be placed in a drawing for an opportunity to win a $50 dollar Amazon gift card if their number is selected. One person at each facility will win the gift card.

Is study participation voluntary?

Participation in this study is voluntary. Your decision on whether to participate will not affect your current or future relations with Liberty University, Haven for Hope, South Alamo Regional Alliance for the Homeless, San Antonio Metropolitan Ministries, American GI Forum, and Audie Murphy Veteran Administration Medical Center. If you decide to participate, you are free to not answer any question or 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 contact 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. 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 Thomas Scott. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact him at phone number [redacted] and/or email [redacted]. You may also contact the researcher's faculty sponsor, Dr. Thomas Vail, 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 IRB. Our physical address is

Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA, 24515; our phone number is 434-592-5530, and our email address is irb@liberty.edu.

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner 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 agree 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 of the records. If you have any questions about the study after you sign this document, you can contact the study team 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 and video-record me as part of my participation in this study.

_____
Printed Subject Name

_____
Signature & Date

APPENDIX D: INFORMED CONSENT – FOCUS GROUP

Principal Researcher: Thomas Scott
Phone: 210-837-4363

Purpose
This study investigates the healthcare providers' experiences serving homeless Veterans in San Antonio, Texas. As part of this study, you will be asked to participate in a focus group and answer semi-structured and open-ended questions. This study will take approximately 60 -90 minutes.

Participants' Rights
I understand that my responses will be kept in the strictest of confidence and will be available only to the researcher. No one will be able to identify me when the results are reported, and my name will not appear anywhere in the written report. Please do not share other people's identities or responses from the focus group with others to maintain the anonymity of the participants outside of the focus group. I also understand that I may skip any questions or tasks that I do not wish to answer or complete. I understand that the consent form will be kept separate from the data records to ensure confidentiality. I may choose not to participate or withdraw at any time during the study without penalty. I agree to have my verbal responses recorded and transcribed for further analysis with the understanding that my responses will not be linked to me personally in any way. After the transcription is completed, the recordings will be destroyed.

I understand that upon entering and completing, I will be given a full explanation of the study. If I am uncomfortable with any part of this study, I may contact Dr. Thomas Vail, Committee Chairperson at Liberty University in Lynchburg Virginia at [redacted]

I understand that I am participating in a study of my own free will.

Consent to Participate
I acknowledge that I am at least 25 years of age or older and that I understand my rights as a research participant as outlined above. I acknowledge that my participation is fully voluntary.

Print Name: _____

Signature: _____ Date: _____

APPENDIX E: IRB APPROVAL REQUEST LETTER

What is the name of the study and who is doing the study?

The name of the study is a transcendental phenomenological study: Identifying the unmet needs of homeless Veterans with or without mental disorders from a healthcare provider's perspective. The person doing this transcendental phenomenological study is Thomas Scott.

Why is Thomas Scott doing this study?

Thomas Scott wants to know how to assist in identifying and getting the needs of homeless Veterans with mental disorders met and available resources that may be needed.

Why am I being asked to be in this study?

Participants are being asked to be in this study because of their experience serving homeless Veterans.

If I decide to be in the study, what will happen and how long will it take?

If you decide to be in this study, you will be asked some questions in an in-person interview format and you will be observed. This will take approximately 1 hour.

Do I have to be in this study?

No, you do not have to be in this study. If you want to be in this study, then tell the researcher. If you do not want to, it is OK to say no. The researcher will not be angry. You can say yes now and change your mind later. It is up to you.

What if I have a question?

You can ask questions any time, now or in the future. You can talk to the researcher. If you do not understand something, please ask the researcher to explain it to you again.

Signing your name below means that you want to participate in this study.

_____

Signature Date

Thomas Scott

[redacted]

Dr. Thomas Vail

[redacted]

Liberty University Institutional Review Board

1971 University Blvd, Green Hall 2845, Lynchburg, VA 24515

irb@liberty.edu

APPENDIX: IRB APPROVAL

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

October 25, 2023

Thomas Scott
Thomas Vail

Re: IRB Exemption - IRB-FY23-24-395 A Transcendental Phenomenological Study: Identifying the Unmet Needs of Homeless Veterans With or Without Mental Disorders From a Healthcare Providers Perspective

Dear Thomas Scott, Thomas Vail,

The Liberty University Institutional Review Board (IRB) has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study to be exempt from further IRB review. This means you may begin your research with the data safeguarding methods mentioned in your approved application, and no further IRB oversight is required.

Your study falls under the following exemption category, which identifies specific situations in which human participants research is exempt from the policy set forth in 45 CFR 46:104(d):

Category 2.(iii). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:
The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §46.111(a)(7).

For a PDF of your exemption letter, click on your study number in the My Studies card on your Cayuse dashboard. Next, click the Submissions bar beside the Study Details bar on the Study details page. Finally, click Initial under Submission Type and choose the Letters tab toward the bottom of the Submission Details page. Your information sheet and final versions of your study documents can also be found on the same page under the Attachments tab.

Please note that this exemption only applies to your current research application, and any modifications to your protocol must be reported to the Liberty University IRB for verification of continued exemption status. You may report these changes by completing a modification submission through your Cayuse IRB account.

If you have any questions about this exemption or need assistance in determining whether possible modifications to your protocol would change your exemption status, please email us at irb@liberty.edu.

Sincerely,
G. Michele Baker, PhD, CIP
Administrative Chair
Research Ethics Office

APPENDIX G: RESEARCH PERMISSION REQUEST

19 August 2023

Audie L. Murphy Veteran Administration Medical Center
7400 Merton Minter,
San Antonio, TX 78229
210.617.5300
Attention: John W. Boerstler, Chief Veterans Experience Officer

Subject: Permission to Conduct Research at Audie L. Murphy Veteran Administration Medical Center

Dear John W. Boerstler,

My name is Thomas Scott, and I am a Doctor of Education (Ed.D.), Pastoral Counseling and Community Care student at Liberty University, Lynchburg, Virginia (Online) program. The research to be conducted for my dissertation involves the experiences of care or services provided to homeless Veterans from the healthcare provider's perspective. This will allow the participants to share lessons learned and how they may approve or grow to the benefit of those under their care at Audie L. Murphy Veteran Administration Medical Center in San Antonio, Texas. This project will be completed under the supervision of Dr. Thomas Vail Ph.D., Adjunct Professor, Liberty University.

I wish to seek your consent to conduct an applied research study that will include 3-5 healthcare providers from this facility. The interview will consist of two data collection methods: focus groups, semi-structured interviews, and possibly documents obtained from the Internet.

Upon completing the study, a copy of the completed interview will be provided to the participant for their review and corrections needed. This report will not be presented to anyone outside of Liberty University's education department and the participants you select to participate. Ethical considerations will be followed with the intention to serve those they interact with better and learn from any limitations or generate new ways to serve. If you require any further information, please contact me at your earliest convenience at [redacted].

Sincerely,

///SIGNED///
Thomas L. Scott, Liberty University
Doctor of Education (Ed.D.) Candidate
[redacted]

APPENDIX H: RESEARCH PERMISSION REQUEST

19 August 2023

Haven for Hope
1 Haven for Hope Way,
San Antonio, TX 78207
210.220.2100
Attention: Kim Jefferies, President and CEO

Subject: Permission to Conduct Research at Haven for Hope

Dear Kim Jefferies,

My name is Thomas Scott, and I am a Doctor of Education (Ed.D.), Pastoral Counseling and Community Care student at Liberty University, Lynchburg, Virginia (Online) program. The research to be conducted for my dissertation involves the experiences of care or services provided to homeless Veterans from the provider's perspective. This will allow the participants to share lessons learned and how they may approve or grow to the benefit of those under their care at Haven for Hope in San Antonio, Texas. This project will be completed under the supervision of Dr. Thomas Vail Ph.D., Adjunct Professor, Liberty University.

I wish to seek your consent to conduct an applied research study that will include 3-5 healthcare providers from this facility. The interview will consist of two data collection methods: focus groups, semi-structured interviews, and possibly documents obtained from the Internet.

Upon completing the study, a copy of the completed interview will be provided to the participant for their review and corrections needed. This report will not be presented to anyone outside of Liberty University's education department and the participants you select to participate. Ethical considerations will be followed with the intention to serve those they interact with better and learn from any limitations or generate new ways to serve. If you require any further information, please contact me at your earliest convenience at [redacted].

Sincerely,

///SIGNED///
Thomas L. Scott, Liberty University
Doctor of Education (Ed.D.) Candidate
[redacted]
[redacted]

APPENDIX I: RESEARCH PERMISSION REQUEST

19 August 2023

South Alamo Regional Alliance for the Homeless (SARAH)
4100 E Piedras Dr # 105,
San Antonio, TX 78228
210.876.0720
Attention: Katie Vela, Executive Director

Subject: Permission to Conduct Research at South Alamo Regional Alliance for the Homeless (SARAH)

Dear Katie Vela,

My name is Thomas Scott, and I am a Doctor of Education (Ed.D.), Pastoral Counseling and Community Care student at Liberty University, Lynchburg, Virginia (Online) program. The research to be conducted for my dissertation involves the experiences of care or services provided to homeless Veterans from the provider's perspective. This will allow the participants to share lessons learned and how they may approve or grow to the benefit of those under their care at SAMMinitries in San Antonio, Texas. This project will be completed under the supervision of Dr. Thomas Vail Ph.D., Adjunct Professor, Liberty University.

I wish to seek your consent to conduct an applied research study that will include 3-5 healthcare providers from this facility. The interview will consist of two data collection methods: focus groups, semi-structured interviews, and possibly documents obtained from the Internet.

Upon completing the study, a copy of the completed interview will be provided to the participant for their review and corrections needed. This report will not be presented to anyone outside of Liberty University's education department and the participants you select to participate. Ethical considerations will be followed with the intention to serve those they interact with better and learn from any limitations or generate new ways to serve. If you require any further information, please contact me at your earliest convenience at [redacted].

Sincerely,

///SIGNED///
Thomas L. Scott, Liberty University
Doctor of Education (Ed.D.) Candidate
[redacted]
[redacted]

APPENDIX J: RESEARCH PERMISSION REQUEST

19 August 2023

American GI Forum
611 South Frio
San Antonio, TX 78205
210.223.4088
Attention: Sergio Dickerson, CEO

Subject: Permission to Conduct Research at American GI Forum

Dear Sergio Dickerson,

My name is Thomas Scott, and I am a Doctor of Education (Ed.D.), Pastoral Counseling and Community Care student at Liberty University, Lynchburg, Virginia (Online) program. The research to be conducted for my dissertation involves the experiences of care or services provided to homeless Veterans from the provider's perspective. This will allow the participants to share lessons learned and how they may approve or grow to the benefit of those under their care at American GI Forum in San Antonio, Texas. This project will be completed under the supervision of Dr. Thomas Vail Ph.D., Adjunct Professor, Liberty University.

I wish to seek your consent to conduct an applied research study that will include 3-5 healthcare providers from this facility. The interview will consist of two data collection methods: focus groups, semi-structured interviews, and possibly documents obtained from the Internet.

Upon completing the study, a copy of the completed interview will be provided to the participant for their review and corrections needed. This report will not be presented to anyone outside of Liberty University's education department and the participants you select to participate. Ethical considerations will be followed with the intention to serve those they interact with better and learn from any limitations or generate new ways to serve. If you require any further information, please contact me at your earliest convenience at [redacted].

Sincerely,

///SIGNED///
Thomas L. Scott, Liberty University
Doctor of Education (Ed.D.) Candidate
[redacted]

APPENDIX K: RESEARCH PERMISSION REQUEST

19 August 2023

SAMMinistries
1919 Northwest Loop 410 #100,
San Antonio, TX 78213
210.340.0302
Attention: Nikisha J. Baker, President, and CEO

Subject: Permission to Conduct Research at SAMMinistries

Dear Nikisha J. Baker,

My name is Thomas Scott, and I am a Doctor of Education (Ed.D.), Pastoral Counseling and Community Care student at Liberty University, Lynchburg, Virginia (Online) program. The research to be conducted for my dissertation involves the experiences of care or services provided to homeless Veterans from the provider's perspective. This will allow the participants to share lessons learned and how they may approve or grow to the benefit of those under their care at SAMMinitries in San Antonio, Texas. This project will be completed under the supervision of Dr. Thomas Vail Ph.D., Adjunct Professor, Liberty University.

I wish to seek your consent to conduct an applied research study that will include 3-5 healthcare providers from this facility. The interview will consist of two data collection methods: focus groups, semi-structured interviews, and possibly documents obtained from the Internet.

Upon completing the study, a copy of the completed interview will be provided to the participant for their review and corrections needed. This report will not be presented to anyone outside of Liberty University's education department and the participants you select to participate. Ethical considerations will be followed with the intention to serve those they interact with better and learn from any limitations or generate new ways to serve. If you require any further information, please contact me at your earliest convenience at [redacted].

Sincerely,

///SIGNED///
Thomas L. Scott, Liberty University
Doctor of Education (Ed.D.) Candidate
[redacted]
[redacted]

APPENDIX L: PARTICIPANT RECRUITMENT EMAIL

Subject: Recruitment Email to Conduct Research at American GI Forum

Dear Potential Research Participant,

As a doctoral candidate in the School of Behavior Science at Liberty University, I am conducting research on the needs of homeless Veterans from the provider's perspective.in San Antonio, Texas, as part of the requirements for a doctoral degree. The purpose of my research is to gain knowledge from multiple healthcare providers and better understand their perspectives on care provided to the homeless and themselves. This research will identify the challenges for the homeless and for the healthcare provider during their interactions. I am writing to invite you to join my study.

Participants must be currently employed as a healthcare provider with five or more years of experience serving homeless veterans and be 25 years of age or older. Participants will be asked to participate in an interview and a focus group, both of which will be either in person or virtual. While names and other identifying information will be collected, their involvement will be confidential, and names will be replaced with pseudonyms. The interviews and focus groups will be audio and video-recorded and transcribed. The interviews will take approximately one hour and focus groups an estimated 60 to 90 minutes to complete. The participants will be asked to review their transcriptions to check for accuracy or confirm agreement.

To participate, please contact me directly by email at [redacted] to schedule an interview. I will screen you to confirm your qualifications, and if you meet my participant criteria, I will work with you to schedule a time for an interview and focus group.

A consent document will be provided for you in person at the time of the interview. The consent document contains additional information about my research. If you choose to participate, you will need to sign the consent form and return it to me at the time of the interview.

Participants at each facility will receive a number after completing the procedures, which includes the interview and focus group. A copy of the number will be placed in a drawing for an opportunity to win a $50 dollar Amazon gift card if their number is selected. One person at each facility will win the gift card.

Sincerely,

///SIGNED///
Thomas L. Scott, Liberty University
Doctor of Education (Ed.D.) Candidate
[redacted]

APPENDIX M: PARTICIPANT RECRUITMENT EMAIL

Subject: Recruitment Email to Conduct Research at SARAH

Dear Potential Research Participant,

As a doctoral candidate in the School of Behavior Science at Liberty University, I am conducting research on the needs of homeless Veterans from the provider's perspective.in San Antonio, Texas, as part of the requirements for a doctoral degree. The purpose of my research is to gain knowledge from multiple healthcare providers and better understand their perspectives on care provided to the homeless and themselves. This research will identify the challenges for the homeless and for the healthcare provider during their interactions. I am writing to invite you to join my study.

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To participate, please contact me directly by email at [redacted] to schedule an interview. I will screen you to confirm your qualifications, and if you meet my participant criteria, I will work with you to schedule a time for an interview and focus group.

A consent document will be provided for you in person at the time of the interview. The consent document contains additional information about my research. If you choose to participate, you will need to sign the consent form and return it to me at the time of the interview.

Participants at each facility will receive a number after completing the procedures, which includes the interview and focus group. A copy of the number will be placed in a drawing for an opportunity to win a $50 dollar Amazon gift card if their number is selected. One person at each facility will win the gift card.

Sincerely,

///SIGNED///
Thomas L. Scott, Liberty University
Doctor of Education (Ed.D.) Candidate
[redacted]

APPENDIX N: PARTICIPANT RECRUITMENT EMAIL

Subject: Recruitment Email to Conduct Research at Haven for Hope

Dear Potential Research Participant,

As a doctoral candidate in the School of Behavior Science at Liberty University, I am conducting research on the needs of homeless Veterans from the provider's perspective.in San Antonio, Texas, as part of the requirements for a doctoral degree. The purpose of my research is to gain knowledge from multiple healthcare providers and better understand their perspectives on care provided to the homeless and themselves. This research will identify the challenges for the homeless and for the healthcare provider during their interactions. I am writing to invite you to join my study.

Participants must be currently employed as a healthcare provider with five or more years of experience serving homeless veterans and be 25 years of age or older. Participants will be asked to participate in an interview and a focus group, both of which will be either in person or virtual. While names and other identifying information will be collected, their involvement will be confidential, and names will be replaced with pseudonyms. The interviews and focus groups will be audio and video-recorded and transcribed. The interviews will take approximately one hour and focus groups an estimated 60 to 90 minutes to complete. The participants will be asked to review their transcriptions to check for accuracy or confirm agreement.

To participate, please contact me directly by email at [redacted] to schedule an interview. I will screen you to confirm your qualifications, and if you meet my participant criteria, I will work with you to schedule a time for an interview and focus group.

A consent document will be provided for you in person at the time of the interview. The consent document contains additional information about my research. If you choose to participate, you will need to sign the consent form and return it to me at the time of the interview.

Participants at each facility will receive a number after completing the procedures, which includes the interview and focus group. A copy of the number will be placed in a drawing for an opportunity to win a $50 dollar Amazon gift card if their number is selected. One person at each facility will win the gift card.

Sincerely,

///SIGNED///
Thomas L. Scott, Liberty University
Doctor of Education (Ed.D.) Candidate
[redacted]

APPENDIX O: PARTICIPANT RECRUITMENT EMAIL

Subject: Recruitment Email to Conduct Research at SAMMinistries

Dear Potential Research Participant,

As a doctoral candidate in the School of Behavior Science at Liberty University, I am conducting research on the needs of homeless Veterans from the provider's perspective.in San Antonio, Texas, as part of the requirements for a doctoral degree. The purpose of my research is to gain knowledge from multiple healthcare providers and better understand their perspectives on care provided to the homeless and themselves. This research will identify the challenges for the homeless and for the healthcare provider during their interactions. I am writing to invite you to join my study.

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To participate, please contact me directly by email at [redacted] to schedule an interview. I will screen you to confirm your qualifications, and if you meet my participant criteria, I will work with you to schedule a time for an interview and focus group.

A consent document will be provided for you in person at the time of the interview. The consent document contains additional information about my research. If you choose to participate, you will need to sign the consent form and return it to me at the time of the interview.

Participants at each facility will receive a number after completing the procedures, which includes the interview and focus group. A copy of the number will be placed in a drawing for an opportunity to win a $50 dollar Amazon gift card if their number is selected. One person at each facility will win the gift card.

Sincerely,

///SIGNED///
Thomas L. Scott, Liberty University
Doctor of Education (Ed.D.) Candidate
[redacted]

APPENDIX P: PARTICIPANT RECRUITMENT EMAIL

Subject: Recruitment Email to Conduct Research at Audie L. Murphy Veteran Administration Medical Center

Dear Potential Research Participant,

As a doctoral candidate in the School of Behavior Science at Liberty University, I am conducting research on the needs of homeless Veterans from the provider's perspective.in San Antonio, Texas, as part of the requirements for a doctoral degree. The purpose of my research is to gain knowledge from multiple healthcare providers and better understand their perspectives on care provided to the homeless and themselves. This research will identify the challenges for the homeless and for the healthcare provider during their interactions. I am writing to invite you to join my study.

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To participate, please contact me directly by email at [redacted] to schedule an interview. I will screen you to confirm your qualifications, and if you meet my participant criteria, I will work with you to schedule a time for an interview and focus group.

A consent document will be provided for you in person at the time of the interview. The consent document contains additional information about my research. If you choose to participate, you will need to sign the consent form and return it to me at the time of the interview.

Participants at each facility will receive a number after completing the procedures, which includes the interview and focus group. A copy of the number will be placed in a drawing for an opportunity to win a $50 dollar Amazon gift card if their number is selected. One person at each facility will win the gift card.

Sincerely,

///SIGNED///
Thomas L. Scott, Liberty University
Doctor of Education (Ed.D.) Candidate
[redacted]