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## Understanding Female Veterans' Post-Military Community Reintegration as Influenced by Higher Ground Military Program

Anna Johnson

Clemson University, [annaleej96@gmail.com](mailto:annaleej96@gmail.com)

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UNDERSTANDING FEMALE VETERANS' POST-MILITARY COMMUNITY  
REINTEGRATION AS INFLUENCED BY HIGHER GROUND  
MILITARY PROGRAM

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A Thesis  
Presented to  
the Graduate School of  
Clemson University

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In Partial Fulfillment  
of the Requirements for the Degree  
Master of Science  
Parks, Recreation, and Tourism Management  
Recreational Therapy Concentration

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by  
Anna Johnson  
May 2020

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Accepted by:  
Dr. Brent Hawkins, Committee Chair  
Dr. Jasmine Townsend  
Dr. Brandi Crowe

## ABSTRACT

After being granted full military participation in 2015, the population of female veterans is now increasing rapidly (Department of Veteran Affairs, 2017; Strong, Crowe, & Bolton, 2018). Despite this, however, women in the military are commonly overlooked or overshadowed in veteran research (Hawkins & Crowe, 2018a, 2018b; Lundberg et al., 2016). Existing research on this population has recommended an increase in female-specific services to better serve the unique needs of female veterans (Hawkins & Crowe, 2018a, 2018b). In order to provide these services there first needs to be an expansion of research on veterans to include the female voices as it relates to the military experience. This study is part of a larger, multi-methods study in which quantitative and qualitative data were collected to examine the effects of Higher Ground's outdoor recreation camp on the community reintegration process for female veterans. The data presented and analyzed in this thesis is representative of the quantitative data collected through online surveys. The purpose of this study is to provide further evidence for use of recreational therapy and outdoor recreation activities for female veterans. Quantitative results from the study indicate that participation in outdoor recreation camps such as Higher Ground can help ease difficulty of community reintegration in female veterans. Further research needs to be done on female veterans and their experiences reintegrating after attending outdoor recreation programs.

## DEDICATION

This thesis is dedicated to the female veterans who gave their time and effort in participating in my study. Without you, this thesis would not have been possible. Thank you for sharing your experiences with me and for trusting me with your story.

## ACKNOWLEDGMENTS

Firstly I would like to thank my committee chair, Dr. Brent Hawkins, for guiding me through this process and helping me see it through. Thank you to my committee members Dr. Jasmine Townsend and Dr. Brandi Crowe for providing further direction to this study and for their expertise.

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## CHAPTER ONE

### INTRODUCTION

#### **Women's Involvement in the Military**

Women were involved in the military as early as the late 1700's, during the American Revolution, although they were not acknowledged in the same regard as their male counterparts (Holm, 1982; Thomas, 1978). Beginning in the 1900's women were permitted to take on more official roles in the military, such as nurses, which later progressed to other military jobs including military police (Carney et al., 2003). However, because of the Direct Combat Exclusion Rule passed in 1994, women were withheld from participating in direct combat (Vergun, 2013). Although it is clear that despite this, there were women who did engage in direct combat at this time (Street, Vogt, & Dutra, 2009). This occurred as less organized military fighting methods were employed and women were able to circumvent the rule (Street, Vogt, & Dutra, 2009). Approximately 20 years later the rule was lifted and women were officially able to enter military positions they were previously denied entrance (Swick & Moore, 2018). Currently there are approximately 210,600 women in the United States military equating to around 16.3% of all 1.3 million service members (Defense Manpower Data Center, 2018).

Despite now being involved in roles similar to their male colleagues, women in the military have distinctly different experiences (Arnhart et al., 2013; Service Women's Action Network, 2017). Women's involvement in the military is often regarded in a

different light by the public and by other men in the military. It is a common misconception that women who serve only hold roles such as nurses or certain desk jobs, causing some to believe that women have “safer” deployment experiences. This misunderstanding leads to an overall undervaluing of the service that female veterans and service members provide to the military (Service Women’s Action Network, 2017). This can negatively impact the experiences women have both while in the military and upon return from deployment.

Further, the military is a male-dominated industry, meaning women are overwhelmingly a minority. Being part of such a small demographic group in the military can bring about feelings of isolation and misunderstanding. These feelings may continue after service as well, as civilian family and friends are unable to fully grasp the impact military service can have (Strong, Crowe, & Bolton, 2018). Oftentimes women are expected to reintegrate back into the same civilian gender roles they held before their deployment, such as being feminine, emotional, and submissive. On the other hand, the military industry places value in being strong and dominant, the opposite of the aforementioned qualities. Because of this conflict, female veterans may struggle with navigating their military and civilian identities (Strong, Crowe, & Bolton, 2018).

Complications with navigating these experiences and the lack of social support can result in overall difficulty reintegrating into a civilian lifestyle post-deployment (Strong, Crowe, & Bolton, 2018).

## **Community Reintegration**

Their return home post-deployment is a process commonly referred to as community reintegration (CR). CR is defined as a return to life participation after a period of separation from regular life activities (Crocker, Powell-Cope, Brown, & Besterman-Dahan, 2014). In reference to the veteran population, this participation includes activities related to: socialization, work, education, spirituality, civic engagement, self-care, spousal and parental relationships, leisure, domestic life, and economic life (Resnik, Bradford, Glynn, Jette, Hernandez, & Wills, 2012).

The rate of success in these life factors combined determines overall success of CR. CR can also be impacted by the gender of that veteran. The path back to civilian life after deployment may be paved with difficulties for many veterans, but additional challenges exist for many female veterans. When compared with their male counterparts, female veterans are more likely to experience military sexual trauma (MST), and are more often diagnosed with post-traumatic stress disorder (PTSD), depression, and anxiety (Street, Vogt, & Dutra, 2009). As these experiences can greatly impact the CR process for female veterans, therapeutic techniques such as outdoor recreation activities are becoming popular amongst this population.

## **Defining Outdoor Recreation**

The use of outdoor recreation as strengths-based interventions can be influential in bringing about additional sources of social support, increased mood, feelings of autonomy, and decreased PTSD symptoms, (Caddick, Smith, & Phoenix, 2014, Lundberg et al., 2011).

Recreational Therapy practices can employ the use of outdoor recreation activities such as adaptive sports, adventure therapy, and other types of nature-based interventions. These interventions are used to achieve individualized therapeutic goals and objectives for the purpose of improving physical, mental, cognitive, and emotional functioning (Lundberg et al., 2011).

Practitioners may use outdoor recreation interventions to enhance the identified strengths of participants, rather than attempting to remedy potential weaknesses (Hawkins, Townsend, & Garst, 2016). Outdoor recreation programs have the potential to be especially beneficial to the veteran population. In the current literature, however, there is a lack of female veteran representation. This study, which seeks to address this deficiency, was conducted in partnership with Higher Ground (HG), an organization providing outdoor recreation camps for individuals with disabilities, including veterans.

### **Higher Ground**

Offering programs in Sun Valley, Idaho, Los Angeles, California, and the state of New York, the mission of HG is to “...use recreation, therapy, and continuing support to give people of all abilities a better life [and to]... bridge the gap between disability and belonging” (Higher Ground, n.d., p. 1). HG provides programming for two main populations: individuals with disabilities and veterans. Higher Ground Military Program (HGMP) is unique in that they provide a variety of camps for veterans, allowing them to attend as couples, families, or singles with a supporter. HGMP also offers female-specific camps. Throughout this paper, female veterans and service members at HGMP will be

referred to as *participants*, and the individuals they attended the camp with will be referred to as *supporters*.

### **Justification for the Study**

The purpose of this study is to increase female veteran visibility within military research, specifically in the field of Recreational Therapy. In the current literature, female veterans' experiences are often excluded or overshadowed by the voices of their male counterparts (Demers, 2011; Hawkins & Crowe, 2018b). This lack of female representation does a disservice to the population as it contributes to their being misunderstood and underserved. Without adequate research, evidence-based practices for female veterans are limited, which is also a barrier to the practitioners who serve them (Hawkins & Crowe, 2018a, 2018b; Lundberg et al., 2016).

Programs and organizations that serve veterans should pay close attention to the needs of their female veteran participants. There are times in which programming should be more intentional in addressing female-specific needs. While women and men may encounter similar experiences while in the military, women may also face additional challenges such as being stigmatized, and experiencing military sexual trauma (MST) or other forms of gender violence (Hawkins & Crowe, 2018b; Lundberg et al., 2016). As indicated in some of the current literature, the Department of Veterans Health Administration (VHA) is ill equipped to address the additional barriers women face (Hawkins & Crowe, 2018a, 2018b). That being said, organizations such as HG acknowledge this deficit in programming and are one of the few organizations to offer

programs open to and designed for female veterans only. This study seeks to identify how HGMP influences community reintegration for female veterans.

### **Research Question**

*Overarching Research Question (RQ):* How does outdoor recreation programming at HGMP impact CR, military identity, and social support of female veterans who have acquired a combat-related disability?

*RQ 1:* How does participation in HGMP impact CR in female veterans?

### **Definition of Terms Used**

Community Reintegration: The process of returning back to regular life activities after a period of separation from those activities (Crocker et al., 2014).

Outdoor Recreation: Recreation that takes place in outdoor settings.

Service Member: Someone who is currently in the military.

Social Support: Help from friends or family. There are four types of social support: emotional, informational, instrumental, or appraisal (Seeman, 2008; Thoits, 2011; Warren, 2005).

Stigma: Discriminating against someone because of differences (Crocker & Major, 1989).

Veteran: Someone who was previously in the military, but has discharged or retired.

## CHAPTER TWO

### LITERATURE REVIEW

#### **Introduction**

Although the population of female veterans and female service members is expanding rapidly (Department of Veteran Affairs, 2017; Strong, Crowe, & Bolton, 2018), the organizations serving them fall short of meeting their needs (Arnhart et al., 2013; Service Women's Action Network, 2017). Compounding with the issue of unmet needs are additional issues related to negative public perceptions of women, specifically women in the military. The combination of these barriers results in female veterans experiencing increased difficulty in their CR process (Arnhart et al., 2013). This literature review intends to examine the intersection of female post-military experiences, lack of services, and CR difficulty.

#### **Female Veterans and Female Specific Experiences**

The challenge of integrating social identities is one faced by both male and female veterans alike. In the reintegration process veterans must grapple with the conflicting roles of being a former service member, a civilian, a parent, spouse, and other roles they may take on at their jobs or in their communities (Burkhart & Hogan, 2015). For women this role integration includes the extra challenge of pressure to conform to other gender roles related to being a woman, such as conforming to standards of femininity, a role often discouraged by the military (Demers, 2013; Hawkins & Crowe, 2018a). Attempts to

reintegrate are hindered by this conflict between traditionally feminine roles the hyper-masculine military values (Demers, 2013).

Further, if a female veteran chooses not to step into these feminine roles, they may be mistreated by other civilians who stigmatize them for those differences (Demers, 2013).

### **Perceptions of Women in the Military**

Due to role conflict, female veterans are often forced to withstand stigmatization. These negative perceptions can come from anyone, whether it be male colleagues, military supervisors, or civilian strangers. In the current literature, female veterans routinely report that they are subjected to stigmatization due to their involvement in the military (Boldry, Wood, & Kashy, 2001; Hawkins & Crowe, 2018a, 2018b; Koblinsky, Schroeder, & Leslie, 2016; Service Women's Action Network, 2017). According to some studies, men in the military perceive women as being deficient in particularly masculine traits, including competitiveness, independence, and being good decision-makers (Arnhart et al., 2013; Boldry, Wood, & Kashy, 2001).

These judgments may come from misunderstanding women's military experience. Common myths about female military service members include the belief that women are not involved in combat, that they only participate in desk jobs or as nurses, and that experiencing MST is expected (Boldry, Wood, & Kashy, 2001; Hawkins & Crowe, 2018a, 2018b; Service Women's Action Network, 2017). Civilian and military subscription to these myths results in women having to overcome additional barriers to their CR process.

## **Gender Based Services**

As outlined in previous sections, female veterans' experiences in the military are different from that of their male counterparts and therefore, they face unique challenges to CR. For this reason, offering gender-specific programming to female veterans should be of utmost importance to organizations that serve veterans.

### *Lack of Adequate Services*

Despite being a quickly developing population within the military, female participation rates in services provided by the VHA and other third-party veteran programs is consistently low (Hawkins & Crowe, 2018a, 2018b; Koblinsky, Schroeder, & Leslie, 2016; Lundberg et al., 2016; Service Women's Action Network, 2017). As identified by previous studies, this under- utilization of services is a result of such programs and organizations being largely male- dominated (Hawkins & Crowe, 2018a, 2018b; Koblinsky, Schroeder, & Leslie, 2016; Lundberg et al., 2016; Suris et al., 2007). Although this is a reflection of the military being a traditionally male-dominated industry, it is important that these organizations still address the needs specific to female veterans. Female veterans report feeling marginalized and misunderstood by the VHA and similar organizations (Hawkins & Crowe, 2018a). Healthcare providers and other practitioners serving veterans may believe in negative myths and have unrealistic perceptions of a woman's role in the military, causing them to feel uncomfortable receiving services at these locations (Hawkins & Crowe, 2018a, 2018b; Koblinsky, Schroeder, & Leslie, 2016; Service Women's Action Network, 2017). It is for this reason there is an urgent need for female-specific spaces within military services.

### *Female Specific Programming*

A need for female-specific spaces has been declared by female military service members and veterans alike. The Service Women's Action Network conducted a large survey in which they found that 97% of females in the military, retired or otherwise, wish for there to be female-specific organizations for veterans (2017). Gender-specific spaces are crucial in that they provide a safe space for women to express their feelings related to their female veteran identity and bond over shared experiences. Such spaces allow participants to analyze their experiences and may help them come to terms with any trauma they may have faced (Hawkins & Crowe, 2018a).

In addition to barriers due to gender discrimination, female veterans are also at a higher risk of mental illnesses such as depression and anxiety. The Service Women's Action Network also identified that experiencing gender violence such as MST and sexual harassment, was a large factor in negatively impacting the mental health of female veterans (Service Women's Action Network, 2018). In order to combat these negative effects, veteran organizations should include trauma-informed programming. A way to do so is to provide peer-support through female-specific programs, as social support is a buffer to certain symptoms of mental illness (Koblinsky, Schroeder, & Leslie, 2016; Service Women's Action Network, 2017). However, combined gender programs can still have positive effects on female veterans. Programs that include both male and female veterans can strengthen the relationship between the two populations and increase the visibility of women in the military (Hawkins & Crowe, 2018a).

Both female specific programs and mixed gender veteran programs can create an environment that allows for the facilitation of successful CR, as the facilitation of social support and connections with other veterans allow for shared understanding.

### **Conceptualizing Community Reintegration**

The process of returning home from the military, either post-deployment or following discharge is one of great significance. Community reintegration, sometimes referred to as community integration or CR, is the process of returning to normal participation after a significant life change, such as a traumatic injury (Crocker et al., 2014). Although there are many aspects of life used to conceptualize CR, the definition this study most closely follows is that set by Crocker and colleagues (2014). Crocker and colleagues (2014) define CR as “...a return to participation in life roles following discharge from an institution where one was separated from normal community living and then returns to life in a community” (p. xi). Thus, this concept applies to service members being discharged from military service, returning home from deployment, or after receiving medical care. Acknowledging the unique circumstances and situations of each veteran can aid in identifying facilitators and barriers to CR.

### **Facilitators and Barriers to Community Reintegration**

Research literature has identified and described many facilitators and barriers to CR post- military service. Some of the most commonly reported barriers faced by veterans upon their return home include mental health conditions such as anxiety, depression, PTSD, and substance abuse (Resnik et al., 2012). Also, many veterans may return having endured physical injuries including traumatic brain injury (TBI),

amputations, or spinal cord injury (SCI); all of which can impact their ability to successfully reintegrate (Crocker et al., 2014; Hawkins, McGuire, Linder, & Britt, 2015a; 2015b). These factors may limit their ability to complete certain tasks and activities of daily living (ADLs), to form and maintain relationships, and fulfill life roles (e.g. motherly or fatherly duties, employment) (Demers, 2011; Hawkins & Crowe, 2018b; Hawkins, McGuire, Linder, & Britt, 2015a; 2015b; Lundberg et al., 2016). These factors may be further hindered by other environmental influences, such as the inaccessibility of building infrastructure, transportation, and healthcare services (Hawkins, McGuire, Linder, & Britt, 2015a). Ultimately these limitations and barriers can culminate and be detrimental to the Veteran's perceived self- efficacy, which can keep them from overcoming those barriers, and thus, successfully reintegrating (Hawkins, McGuire, Linder, & Britt, 2015a).

Conversely, facilitators to CR are often simply the opposite of the barriers. For instance, a lack of social support is a barrier to CR, whereas strong social support acts as a facilitator (Hawkins & Crowe, 2018b; Hawkins, McGuire, Linder, & Britt, 2015b). Strong social support may also serve as a buffer to other CR barriers, such as PTSD (Pietrzak, Johnson, Goldstein, Malley, Rivers, & Southwick, 2010). Other facilitators to successful CR include perceived self- efficacy, protective personal beliefs (e.g. motivation), and access to community-based programs and other recreational opportunities (Hawkins and Crowe, 2018a, 2018b; Hawkins, McGuire, Linder, & Britt, 2015a; 2015b; Lundberg et al. 2016).

## **Use of Outdoor Recreation for Veterans**

As stated in Chapter One, outdoor recreation activities can be beneficial for the veteran population. For the purposes of this study, outdoor recreation was defined as recreation that takes place in an outdoor setting. Common types of outdoor recreation include those such as camps, adventure recreation, and adaptive sports, among others. Current research analyzing the effects of recreation in general, have found recreation to be useful in the facilitation of therapeutic outcomes (Hawkins, Townsend, & Garst, 2016; Lundberg et al., 2016). This occurs as recreation is considered what is called an opportunity structure, meaning it has the power to bring about therapeutic and transformative outcomes (Lundberg et al., 2016). Specifically, outdoor recreation provides opportunity structures through the combination of environmental and social contexts (Lundberg et al., 2016). This is effective in facilitating the ease of CR.

Adaptive sports and recreation programs increase positive mood states and therefore, consistent participation in such programs can bring about mood stability and increase overall quality of life (Lundberg, Bennett, & Smith, 2011). Outdoor recreation enables mood stability by providing an outlet for stress (Lundberg et al., 2016). Veterans participating in outdoor recreation and adaptive sports programs have indicated that these activities provide a distraction from other daily stressors. Furthermore, when mood stability is achieved, mental health is improved (Lundberg et al., 2016). Combating symptoms of mental health impairments such as PTSD, depression, and anxiety is critical in bringing about ease of CR as these symptoms can hinder the process (Lundberg, Bennett, & Smith, 2011).

Further, when used for therapeutic purposes, outdoor recreation often employs a strengths-based approach. Practitioners using this method emphasize participant skills, rather than focus on remedying deficits (Hawkins, Townsend, & Garst, 2016). When used with the veteran population, outdoor recreation can simulate feelings of excitement in overcoming challenging tasks, a concept common in military culture (Caddick, Smith, & Phoenix, 2014; Hawkins, Townsend, & Garst, 2016). Veterans may find comfort in the familiarity of these feelings, which can facilitate elements of reintegration (Caddick, Smith, & Phoenix, 2014; Hawkins, Townsend, & Garst, 2016).

### **Summary**

The literature examined here provides evidence that the female veteran population is consistently under-resourced by veteran organizations and overlooked in research. The barriers this population faces in regards to lack of resources, stigmatization, role navigation, and mental health conditions impede upon their ability to successfully reintegrate (Burkhart & Hogan, 2015; Resnik et al., 2012). In order to combat the effect of these barriers, recreational therapists can use outdoor recreation to help meet the needs of female veterans.

## CHAPTER THREE

### METHODS

#### **Study Design**

This study utilized a retrospective multi-methods design, utilizing the collection of both quantitative and qualitative data to examine the impact of HGMP on female veterans' post- deployment experiences, specifically CR, military identity, and social support. Quantitative data was collected using an online survey and qualitative data was collected through phone interviews. The aim of this individual thesis is to understand how HGMP participation affects female veterans CR. Therefore, for the purposes of this thesis, only the quantitative data on CR will be reported.

#### **Study Setting**

HGMP offers outdoor recreation programming for combat and non-combat veterans. HGMP hosts week-long camps for veterans throughout the year. Each camp consists of small groups of six to eight participants. Depending on the camp, participants may attend with their spouse, family, or close friend (Gillette, n.d.). HGMP groups participants based on their common attributes such as marital status or injury type, in order to create a bond between participants based on their commonalities (Gillette, n.d.). HGMP hosts camps in three locations in the United States, Sun Valley, Idaho; Los Angeles, California; and within New York. Camp programming is based on the season and rotates throughout the year. Summer programs include outdoor activities such as fly fishing, white water rafting, and other water sports. Fall and winter programs consist of

snow sports such as skiing. Camp activities are led by a team of Certified Therapeutic Recreation Specialists (CTRS's) and volunteers (Gillette, n.d.). Overarching Program goals of HGMP include increasing confidence, developing relationships with other participants, and raising awareness of recreation activities, among others (Gillette, n.d.).

In addition to the seasonal themes, HGMP also structures camps around daily themes. Each day at camp is dedicated to achieving a planned therapeutic outcome. Examples of daily objectives include building relationships with other participants, using recreation for emotional and physical well-being, improving existing relationships, and regaining a sense of self-worth (Gillette, n.d.). Participants are reminded of these themes and desired goals at various points throughout the day in order to increase their effectiveness.

This organization was picked for the study because of their focus on long-term rehabilitation of veterans. HGMP is dedicated to ensuring their participants have proper resources and support even after they leave camp, as exhibited by their intentionality in achieving daily and programmatic goals. One outcome that HGMP emphasizes is that of facilitating bonds between participants. These relationships begin developing upon arrival at camp and are strengthened throughout the week. The aim behind facilitating these connections is to create lasting relationships that participants can continue to grow outside of camp (Gillette, n.d.). This has a direct impact on CR, as socialization is one of the defining factors of the concept (Resnik et al., 2012). Social support is also a facilitator to CR and a buffer against barriers such as PTSD (Koblinsky, Schroeder, & Leslie, 2016; Pietrzak et al., 2010; Service Women's Action Network, 2017). Further, HGMP also

provides participants with informational and financial resources after completing camp. Staff creates individualized reintegration plans for each participant including resources for continuing recreational involvement within their communities. The financial resources are then to be used towards participation in those recreational activities. Additionally, HGMP follows-up with participants up to three years after they leave camp in order to continue to support them.

### **Participant Selection**

Study participants were selected using a non-probability sampling method from HGMP. Participants from the HGMP were eligible for the study if they were female-identifying veterans who participated in a camp between the timeframe of June 2017 and June 2019. Supporters of participants who attended the camp were also included if they were female veterans as well. The study was initially only open to participants from January 2018 to June 2019, but due to low response rate, the timeframe was widened. Also, HGMP only accepts participants into their camps if they have experienced a combat-related injury or disability, such as PTSD, TBI, or MST, among others. Participants who met the eligibility criteria from all three Higher Ground locations were included. The survey was distributed to 87 eligible participants. Directors at Higher Ground sent eligible study participants a link to the online survey via email. The email sent to participants included introductory information about the study written by the research team and the survey itself included a detailed consent form.

Initial target sample size for the survey was only 12 participants. A total of 37 participants opened the survey and 19 completed it. However, due to an error inputting

the Military to Civilian Questionnaire (M2C-Q) survey, two participants had to be removed. This brought the total number of survey participants to 17.

### **Procedures and Instrumentation**

Approval from the Clemson University Institutional Review Board was obtained prior to data collection. Quantitative data was collected through an online Qualtrics survey. The survey contained questions on demographic information (e.g. disability rating, military rank, camp location, program type, diagnosis), and three standardized assessments on military identity, social support, and CR. CR was measured using the M2C-Q (Appendix A).

The M2C-Q is a 16-item assessment used to determine post-deployment difficulty with CR in combat veterans (Sayer et al., 2011). M2C-Q questions were constructed based on literature regarding physical and psychosocial functioning, measures of CR used with individuals with disabilities, and qualitative data and descriptions from veterans (Sayer et al., 2011). In developing the M2C-Q, Sayer and colleagues sought to assess CR by measuring difficulty in functioning in the home, at the workplace, in the community, and in personal relationships (Sayer et al., 2011).

Using the M2C-Q, participants were asked to rank their agreement with a statement regarding their post-deployment CR experiences on a Likert scale ranging from 0 = no difficulty to 4 = extreme difficulty. Scores on all 16 items were added and divided by the total number of completed items to reveal average scores. Higher scores indicated greater difficulty with CR (Sayer et al., 2011). Because this was a retrospective study, participants completed two identical, side-by-side versions of the M2C-Q. The first was a

pre-test designed to assess their level of difficulty in CR prior to attending HGMP. The second was a post-test to assess level of difficulty in CR after attending HGMP. Both surveys were completed at the same time, one directly after the other, and required participants to reflect upon their experiences after the military but before attending HGMP and after the military after participating in HGMP. A retrospective design was used to decrease the risk of response-shift bias as it increases the probability of authentic responses (Sibthorp, Paisley, Gookin, & Ward, 2007). Additionally, because the concept of CR is one that develops over time and thus, could not be adequately assessed immediately after participation in HGMP, a retrospective design was deemed most appropriate.

The M2C-Q was tested for construct validity by comparing results with scores on a community readjustment scale and mental health screening measures. It was found to have moderate construct validity between .49 and .58. Further, the M2C-Q has moderate internal consistency, ranging from .48 to .78 (Sayer et al., 2011).

### **Data Analysis**

Twenty-five participants responded to the survey, however, six cases were excluded from analysis due to their not completing the survey. Two additional cases were removed from the data set due to an error with the M2C-Q. Upon opening the survey to participants, there was an error in the M2C-Q post-HGMP survey. The post-HGMP survey was missing the column containing the option to answer “extreme difficulty” in relation to CR. The survey had been open for approximately one week when this error was realized. Only five participants had completed the full survey including the M2C-Q

at that point and of those five, only two had answered items on the post-HGMP survey at the highest available level (*a lot of difficulty*).

These participants were thus removed from the data. Because the other three participants had only answered up to a 2 on the scale (*some difficulty*), it was assumed that they would not have answered at a 4 (*extreme difficulty*) if it had been an available option. It was for this reason the other three participants were left in the data and included in the data analysis.

Participant demographic information was collected, however limited. Questions about demographics on the Qualtrics survey were mainly related to military experiences, such as military rank, and number of deployments. Other questions were asked about the HGMP the participant attended (e.g date and location of camp), and previous experience with similar outdoor recreation programs. Percentages of demographic responses were calculated using SPSS, measures of central tendency were not used.

All data were analyzed using the Statistical Package for the Social Sciences (SPSS) version 26.0. Internal consistency of the M2C-Q was tested using Cronbach's alpha. The Cronbach's alpha indicated a high level of internal consistency for the M2C-Q (Cronbach's alpha = .91). The data was inspected for normality through visual analysis and the Shapiro-Wilk test. The data was found to be relatively normal ( $p > .05$ ), but due to the small sample size, the data was analyzed using nonparametric tests. Specifically, the Wilcoxon signed rank test was chosen as it is the nonparametric equivalent of the dependent t-test and allows for examination of pre and post HGMP attendance impacts on CR (Laerd Statistics, 2015). The data met all three assumptions for using a Wilcoxon

signed-rank test. Because the M2C-Q uses a Likert scale, it met the first assumption for ordinal dependent variables. Next, the data came from two related groups in that pre and post-HGMP surveys were collected from the same group (Laerd Statistics, 2015). After the test was run, it was visually inspected and found to meet the third assumption of the test for symmetry.

Some surveys contained individual missing items in the M2C-Q. Three participants left items blank in both the pre and post surveys of the M2C-Q. One participant left three items unanswered in the pre-HGMP survey, and four items unanswered in the post-HGMP survey. Another left one item unanswered in the pre-HGMP survey, and three in the post-HGMP survey. For these two participants mean replacement was used when calculating overall scores and for data analysis procedures. The third participant who left items blank did so because they did not apply to her experiences. This was confirmed as the survey was completed over the phone with the participant where she gave confirmation. Therefore, mean replacement was not used for this participant's unanswered items. For the M2C-Q, the Wilcoxon signed-rank test was analyzed twice, the first time with mean replacing and the second time without. Similar results were achieved for both; however, the analysis containing the mean replaced values was used and reported on in this study.

## CHAPTER FOUR

### RESULTS

After cleaning the data, there were a total of 17 participant surveys that were analyzed. Following data cleaning, 88.24% (n=15) of participants who completed the survey had attended the Sun Valley HGMP, 52.94% (n=9) were at a VA disability rating of 100%, 94.12% (n=16) were diagnosed with PTSD, and 82.35% (n=14) experienced depression. A summary of demographic results can be found in Table 1.

Table 1: Demographics Statistics

<b>Demographics-</b>		
<b>Disability Rating</b>	60% = 1 70% = 2 90% = 3 100% = 9 Not answered/ Not applicable = 2	
<b>Military Rank</b>	E3 = 1 E4 = 7 Other = 2	E5 = 4 E6 = 2 W3 = 1
<b>Higher Ground Camp Location</b>	Sun Valley = 15 New York = 2	
<b>Higher Ground Camp Year</b>	June 2017 = 3 August 2017 = 1 October 2017 = 2 September 2017 = 2 January 2018 = 1	July 2018 = 2 August 2018 = 4 December 2018 = 1 May 2019 = 1
<b>Diagnosis</b>	PTSD = 16 Brain Injury = 3 Spinal Cord Injury = 1 GAD = 11 Hearing Impairment = 2	Depression = 14 Borderline Personality Disorder = 1 Chronic Pain = 1 Eating Disorder = 1

Average scores on the measure were calculated at pretest and again at posttest. Looking only at the raw scores, out of 17 total participants, 16 experienced an increase in ease of CR after attending HGMP as compared to their pre-HGMP scores. One participant scored the same on both pre and post surveys, indicating their level of difficulty in CR neither increased nor decreased pre to post-HGMP.

The Wilcoxon signed-rank test indicated that post-HGMP difficulty of CR was statistically significantly lower than pre-HGMP ( $Z=-3.519$ ,  $p < .05$ ). The Pre-HGMP M2C-Q mean score was 2.601, while post-HGMP M2C-Q mean score was 1.709, indicating participants had greater ease of CR after attending HGMP. For this reason, the null hypothesis is rejected.

The M2C-Q does not have any subscales that allow for further breakdown of scoring. Large effect sizes were observed ( $r=.85$ ) (Cohen, 1988).

## CHAPTER FIVE

### DISCUSSION

The purpose of this study was to determine how attendance at HGMP impacted female veterans, specifically as it relates to their CR. Based on the findings of this study, participants were positively impacted by their attendance. Female veteran participants attributed attendance at HGMP with a positive impact on their CR. Nearly all survey participants reported a decrease in level of difficulty in CR after participating in HGMP.

An analysis of previous studies indicated that outdoor recreation programs such as HGMP have the potential to bring about certain therapeutic outcomes in veterans and improve their CR process (Caddick, Smith, & Phoenix, 2014; Lundberg, Bennett, & Smith, 2011; Lundberg et al., 2016). There are a number of reasons participation in HGMP could have brought about this result within this population. Specifically, HGMP's focus on cultivating relationships between participants may perhaps have been most influential. HGMP's small program size coupled with participants' commonality with one another serves to facilitate a bond between them in the hopes that they will continue to rely on each other even after leaving the camp (Gillette, n.d.). The aspect of having peer social support is one that is often mentioned in literature about CR in veterans, as social support is a facilitator to CR and buffers against barriers to CR such as PTSD (Koblinsky, Schroeder, & Leslie, 2016; Pietrzak et al., 2010; Service Women's Action Network, 2017).

HGMP also provides ongoing financial and informational resources for their participants, helping them with their CR even after camp has completed (Gillette, n.d.).

This helps to ensure outcomes achieved at camp remain intact upon return home. While at camp participants are introduced to new recreational activities and are encouraged to use them as facilitators for improving both mental and physical health, meaning it is imperative participants have opportunities to continue to engage in similar activities in their own communities. Previous literature has identified the ability of recreation to provide opportunity structures. Such an opportunity structure is created by fostering the development of social support and personal autonomy during recreation participation (Lundberg et al., 2016). HGMP effectively utilizes recreation opportunity structures by intentionally grouping participants according to their similarities and allowing them to bond over their shared experiences as female veterans, while simultaneously engaging in physical tasks. Additionally, participants have freedom to engage in the activities they wish to; staff does not force participants into any activity for sake of sticking to a schedule. The relaxing of program structure allows participants to strengthen their autonomy and explore which recreational activities are most therapeutic to them. The combination of these factors can help ease the difficulty of CR.

The current body of literature regarding female veterans' post-military experiences is especially limited, resulting in the services they are offered being inadequate and not suitable to fit their needs (Koblinsky, Schroeder, & Leslie, 2016; Lundberg et al., 2016; Suris et al., 2007; Service Women's Action Network, 2017). The lack of research with this population is ultimately harmful to them as their resulting unmet needs is ultimately a hindrance to CR. Conversely, access to recreational opportunities, such as HGMP, has been reported to be a facilitator of CR in veterans

(Hawkins and Crowe, 2018a, 2018b; Hawkins, McGuire, Linder, & Britt, 2015a; 2015b; Lundberg et al. 2016). The findings from this study contribute to this growing body of research, further suggesting that recreational programs can be a facilitator of CR for female veterans. This study provides additional evidence for this concept. Nearly all survey participants reported a decrease in difficulty of CR after attending HGMP, further indicating that strengths-based outdoor recreation programs can facilitate CR for female veterans. However, additional research is still needed in order to solidify this hypothesis and contribute to evidence-based practices.

### **Recommendations for Practice and Research**

It is recommended that practitioners already serving the population of female veterans consider including outdoor recreation interventions in their practice. This study found that outdoor recreation and nature-based programs such as HGMP have the potential to bring about positive outcomes for female veterans relating to their ability to successfully reintegrate. The CR process is a difficult one for all veterans, so the organizations serving them should provide practices that will facilitate the ease of this process. HGMP's unique combination of outdoor recreation activities, trauma-informed programming, and facilitation of peer support may have been instrumental in easing the CR process. Similar programs serving veterans, specifically female veterans, should look to HGMP as a model for designing and implementing their services.

Additional consideration into the needs of female veterans should be included in future research. With the number of women entering the military in both combat and non-combat roles increasing rapidly, the population of female veterans will continue to grow

as well. As the population grows there will be a need for more services for the group. Therefore, those doing research concerning veterans should be aware of the ways in which gender can impact military experience and the barriers that come with being a woman who serves. This research is critical as it will give insight into the unique needs of female service members and provide evidence for best practices.

### **Limitations**

Due to the retrospective nature of the study, one limitation is the issue of accurate recall (Sibthorp, Paisley, Gookin, & Ward, 2007). This is because there is a difference in time between participation in HGMP and survey participation. This time difference also varies between each study participant.

Another limitation is the issue of a small sample size. As discussed in the literature review, there is an issue of lack of programming for female veterans and under-utilization of existing programs by female veterans as caused by feeling unwelcome in many veteran spaces. This results in an overall small sample size for the study. Because of this, the results from this study are not able to be generalized across the entire female veteran population.

There were also issues with the data collection methods. Three surveys contained missing data in individual items on both the pre and posttest M2C-Q. Although mean replacement was used for these participants, it is unclear whether or not these items were left blank because they did not directly apply to the participant, or if it was merely a mistake. Further, there was the issue of the posttest M2C-Q missing the last column. This

mistake was corrected immediately upon realizing it and participants were removed from data analysis accordingly.

## **Conclusions**

This study sought to examine if there was a relationship between HGMP attendance and ease of CR for female veterans. The study found that participants indicated a reduction in difficulty with CR after they attended HGMP. The results of this study add to a growing body of literature on the CR of female veterans and the use of outdoor recreation activities to facilitate that process. Inclusion of recreation-based interventions into services for female veterans is suggested along with a call for more research on its effects.

APPENDIX

Military to Civilian Questionnaire (M2C-Q)

The following items intend to assess the level of ease or difficulty you have had in successfully reintegrating back into your community. Each item is scored on a Likert scale ranging from 0-no difficulty to 4-extreme difficulty. For each item you will provide two answers: the first relating to your experiences prior to attending Higher Ground and the second relating to your experiences after attending Higher Ground.

Please rate your level of difficulty...	Pre HGMP	Post HGMP
<b>Dealing with people you do not know well (such as acquaintances or strangers)?</b>	0 1 2 3 4	0 1 2 3 4
<b>Making new friends?</b>	0 1 2 3 4	0 1 2 3 4
<b>Keeping up friendships with people who have no military experience?</b>	0 1 2 3 4	0 1 2 3 4
<b>Keeping up friendships with people who have military experiences (including friends who are active duty or veterans)?</b>	0 1 2 3 4	0 1 2 3 4
<b>Getting along with relatives (such as siblings, parents, grandparents, in-laws and children not living at home)?</b>	0 1 2 3 4	0 1 2 3 4
<b>Getting along with your spouse or partner (such as communicating, doing things together, enjoying his or her company)?</b>	0 1 2 3 4	0 1 2 3 4
<b>Getting along with your child or children (such as communicating, doing things together, enjoying his or her company)?</b>	0 1 2 3 4	0 1 2 3 4
<b>Finding or keeping a job (paid or nonpaid or self-employment)?</b>	0 1 2 3 4	0 1 2 3 4
<b>Doing what you need to do for work or school?</b>	0 1 2 3 4	0 1 2 3 4

Please rate your level of difficulty...	Pre HGMP	Post HGMP
Taking care of you chores at home (such as housework, yard work, cooking, cleaning, shopping, errands)?	0 1 2 3 4	0 1 2 3 4
Taking care of your health (such as exercising, sleeping, bathing, eating well, taking medications as needed)?	0 1 2 3 4	0 1 2 3 4
Enjoying or making good use of free time?	0 1 2 3 4	0 1 2 3 4
Taking part in community events or celebrations (for example, festivals, PTA meetings, religious or other activities)?	0 1 2 3 4	0 1 2 3 4
Feeling like you belong in “civilian” society?	0 1 2 3 4	0 1 2 3 4
Confiding or sharing personal thoughts and feelings?	0 1 2 3 4	0 1 2 3 4
Finding meaning or purpose in life?	0 1 2 3 4	0 1 2 3 4

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