

Using an Adapted Case Study Approach to Understand Rural Veteran Experiences in Patient Engagement and Patient-Centered Care Research

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ABSTRACT

How to best engage rural veterans in mental health care is challenging and a topic of public health concern. Rural-dwelling veterans experience greater mental health burden and poorer outcomes than their urban counterparts, making rural veteran engagement in mental health care a public health concern. In this article, we describe how institutional notions of “patient engagement” align with or diverge from rural veteran patient experiences of engagement in mental health care. Using an adapted case study approach developed for our study, we detail the mental health care experiences of three rural-dwelling veteran participants. These case studies illustrate varied forms of mental health care engagement, including use of community resources and self-management activities, that might not be recognized by clinicians as contributing to mental health treatment. Our findings highlight how critical gaps in institutional definitions of care engagement fail to acknowledge veterans’ experiences.

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Introduction

In the United States, 5.2 million veterans (approximately one quarter of all military veterans) reside in rural communities. Rural-dwelling veterans disproportionately experience a larger mental health burden and poorer mental health outcomes than veterans residing in urban and suburban communities.¹ Rural veterans can also face greater geographical, logistical, technological, and financial barriers to accessing health care services.¹⁻³

The Veterans Health Administration (VA) plays a critical role in providing mental health treatment to veterans. The VA serves approximately 3 million rural veterans, representing one third of VA’s total enrolled veteran population.⁴ Adequate mental health treatment has been defined in the VA Uniform Mental Health Services Handbook as attending at least eight sessions of Evidence-Based Psychotherapy (EBP) or receiving at least two months of psychiatric medication coupled with at least four mental health treatment visits within one calendar year.⁵ However, barriers to accessing health care can make it difficult for rural veterans to achieve this institutional metric. For example, research has shown that living more than 25 miles from a VA clinic is a strong predictor of failing to receive adequate mental health treatment.^{6,7} In addition, rurality has been associated with increased drop-out after one to two mental health visits.^{6,7}

Although the phrase “patient engagement” has become central to numerous health care models, including the VA, the concept remains indeterminately defined across varying institutional contexts for the purposes of practice or implementation.⁸ In some cases, patient engagement has been operationalized to characterize treatment initiation, treat-

ment retention, or sometimes both.⁹ In other cases, patient engagement is conceived more broadly as a cognitive, behavioral, emotional, and social construct which fosters self-management.¹⁰ These definitions represent only a few among numerous and diverse definitions of engagement in the health sciences literature.⁸

Even more broadly, patient engagement has been characterized as a component of “patient-centered care”,¹¹ defined by the Institute of Medicine¹² as “care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions”. However, researchers, clinicians, and policy makers still lack an understanding of how patients themselves experience seeking or receiving mental health care, and how these experiences influence help-seeking for mental health concerns in both clinical and non-clinical arenas. Here, we draw from the Agency for Research and Health Care Quality’s (2017)¹³ definition of patient experience as encompassing “the range of interactions that patients have with [a] health care system, including their care from health plans, and from doctors, nurses, and staff in hospitals, physician practices, and other health care facilities”. Understanding how patient experiences of mental health symptoms and help-seeking behaviors depart from institutional definitions of “patient engagement” and “minimally adequate treatment” is important given increased demands placed on clinicians to deliver patient-centered care.¹⁴ In addition, understanding how patient experiences depart from institutional frameworks of engagement is also important given increased expectations for patients with chronic illness to assume greater responsibility for self-management.^{15,16}

In this study we sought to explore rural-dwelling veterans’ experiences of engaging in mental health care using a case study approach adapted for Health Services Research (HSR), defined as a “multidisciplinary field of inquiry, both basic and applied, that examines access to, and the use, costs, quality, delivery, organization, financing, and outcomes of health care services to produce new knowledge about the structure, processes, and effects of health services for individuals and populations”.¹⁷ We utilized an adapted case study approach to conduct a secondary analysis of data from a larger clinical trial study conducted within the VA.^{18,19} The purpose of our analysis was to explore important aspects of patient-reported experiences from the larger study and to examine new research questions that emerged during the larger study’s formative phase. To conduct the analysis reported here, we re-examined our interview data to address two research questions: i) how do individual veteran participants experience engaging in mental health care, and ii) how do veteran experiences of engaging in mental health care align with or depart from institutional definitions of engagement? We illustrate the value of a case study approach adapted to the needs of this secondary analysis through three descriptive qualitative case studies explor-

ing how veteran participants described engaging in mental health care. We then compare how veterans describe experiences of engaging in mental health care with institutional definitions of “patient engagement” and suggest strategies for making the construct of patient engagement and patient-centered care guidelines more responsive to patient experiences.

Methods

Case study research methods are well-known research strategies in qualitative inquiry across disciplines in the social sciences.²⁰⁻²² Case study research can represent both a process of analysis and the product of an analysis²⁰ and there is no single standard format for conducting or reporting case study research.²³ Typically, case study research explores a single case or multiple cases over time, drawing from in-depth data collection involving multiple sources of information (*e.g.*, interview transcripts, observation notes, documents or reports, video or audio recorded materials) to produce a case description and case-based patterns or themes. Individual cases can be seen as units of analysis, and what constitutes a case, or a unit of analysis, is determined within the specific context of a research study and becomes the basis for purposeful sampling.²⁰

Case study research methods are routinely used in health policy evaluation research²⁴ and ethnographic research.²⁵ Numerous traditional methodological and analytical frameworks from the social sciences, including case study research, have been adapted to inform health services implementation efforts.²⁶ To conduct the analysis described in this paper, we adapted the case study approach as we describe in detail below.

Clinical Trial Study

We adapted the case study approach for use as part of a larger clinical trial study (VHA project #12-083). In the formative phase of the larger study, we sought to explore barriers and facilitators to clinician-directed mental health treatment engagement through in-depth individual interviews with 37 veterans enrolled in predominantly rural VA community-based outpatient primary care clinics.^{18,19} All study activities were approved by VA Central Institutional Review Board (IRB approval #13-45).

Participant Recruitment

We recruited veterans who were over age 18, received care at one of the VA outpatient clinic study sites, and were within one year of a positive mental health screen or diagnosis as approved by our VA IRB protocol. We oversampled women and younger veterans (≤ 45 years old), since the VA patient population is comprised of predominantly older (≥ 60 years old) and male (91%) veterans.²⁷ The final sample of participants consisted of 37 veterans, including 27 male and 10 female veterans. Nineteen veterans were

from Louisiana and 18 were from California. Approximately half of all participants (n=18) were over the age of 60 (Table 1).

Preliminary Results of Formative Phase

A team of three qualitative researchers (Koenig, Abraham, Zamora) developed and refined a semi-structured interview guide to elicit individual-level, clinic-level, and community-level barriers and facilitators to clinician-directed mental health treatment engagement. The one-time semi-structured interviews ranged approximately 30-60 minutes in length. Interviews were digitally recorded with participants' permission, professionally transcribed, and uploaded into ATLAS.ti qualitative data analysis software.

Following each interview, the qualitative research team drafted a detailed, post-interview interim case summary.²⁸ The case summaries were used to record descriptive data pertaining to environmental context, relational context, health care experiences, and self-care practices. One researcher (Zamora or Abraham) conducted a quality check of the summaries from their respective region (California or Louisiana) to ensure analytic consistency. These summaries were the basis for the secondary analysis detailed below.

During review of the interview transcripts, the qualitative research team noted that veteran participants described diverse experiences of engagement in mental health care. These experiences of engagement appeared to shift across the study cohort as veterans' needs, preferences, and changes in access to services changed. For example, access to mental health services changed over time due to changes in availability of services (e.g., increased or decreased appointment availability) in their region, or as veterans' preferences changed in favor of community-based resources rather than clinician-directed treatment. This initial finding prompted the lead author to return to the 37 interim case summaries and to review them in order to further explore individual veteran participants experience engaging in mental health care and how veteran experiences of engaging in mental health care align with or depart from institutional definitions of engagement.

Table 1. Participant Demographic Information

		Louisiana (n)	California (n)	TOTAL (n)
Gender	Male	16	11	27
	Female	3	7	10
	Total	19	18	37
Age	18-30	4	3	7
	31-50	4	4	8
	51-70	11	11	22

Procedures for Secondary Analysis

We decided to conduct a secondary analysis to answer the emergent research questions: i) how do individual veteran participants experience engaging in mental health care, and ii) how do veteran experiences of engaging in mental health care align with or depart from institutional definitions of engagement? To conduct this secondary analysis, we selected case study research, framed as “the study of an issue explored through one or more cases within a bounded system (*i.e.*, a setting, a context)”.²³ Individual cases can reveal how multiple factors intersect throughout an individual's life, and thus how conceptualizations of engagement can mean different things at different times for individuals. Additionally, given the goal of making patient voices heard in patient-centered care efforts, preserving entire veteran narratives seemed imperative to our analysis. Thus, in our study, we defined each individual veterans' narrative as a case or as a unit of analysis, then took an inductive approach to systematically comparing the original 37 interim case summaries.

Throughout the inductive process of case review, the lead author conducted “open coding”²⁹ of the interim case summaries, a type of coding that Charmaz²⁹ describes as examining qualitative data by breaking data into parts that enables analysts to examine and compare segments for similarities and differences. The goal in open coding is to “remain open to all possible theoretical directions suggested by interpreting the data”.²⁹ During open coding of the case summaries, the lead author identified several factors which shaped how veterans managed and conceived of mental health care. This resulted in the development of an original set of inductive codes, defined as: i) Transition Experiences from Military to Civilian Life - the transition period between initial separation from the military and re-entering civilian life, often marked by personal challenges such as reconnecting with family or entering the civilian workforce; ii) Turning Point Experiences^a - an experience, event, or awareness that prompts changes to the direction of a trajectory over the long term such as life events, positive or negative mental health treatment experiences, or changes in mental health symptom severity;³⁰ iii) Trusted Persons - individuals who hold the trust of and play essential roles in a veteran's mental health care engagement, including family members, institutional professionals such as social workers, or fellow veterans; and iv) Self-Management Activities - any non-clinician-directed activity or modality that an individual engages in to support their well-being, such as gardening or hiking, or community activities such as attending church.

The lead author discussed these codes with the larger qualitative research team, which reviewed the case sum-

^a Our use of “turning point” is drawn from its conceptualization in the *Lifecourse Approach*.³⁰



Figure 1. Secondary Analysis Process.

maries to validate all proposed codes, code definitions, and their application to the data as being able to capture key aspects of veterans' experiences across a diverse set of participant experiences. Importantly, this inductive coding process helped to determine key domains relevant for gaining insight into potential divergences between veterans' experiences and institutional definitions of patient engagement. These codes guided the formation of a framework for exploring veterans' descriptions of the diverse forms of mental health care in which they engaged and for developing the template for presenting the three veterans' case studies in this paper.

Purposeful Sampling for Adapted Case Study Approach

The development of the inductive codes informed the purposeful sampling process used to select the three in-depth cases described in the sections below (Figure 1). To purposefully sample individual cases for further analysis,^{23,28} the first author drew from the example of widely-used sampling typologies in case study research such as the folk-urban continuum in sociology²⁰ and the neuroses-to-psychoses continuum in psychology²⁰ to construct the continuum of "actively participating in clinician-directed treatment" to "no engagement in mental health treatment" that provided the parameters for sampling. The three veteran cases presented in this paper represent one of the following points along a continuum of mental health care engagement observed among the larger sample of study participants, including: i) engaging in self-directed informal mental health care, ii) opting for both clinician-directed treatment and self-management activities, and iii) complete disengagement from clinician-directed mental health treatment.

Our objective in developing the case studies was to achieve depth and complexity rather than representativeness or statistical generalizability.^{28,31} Thus, the cases were generated as illustrative coordinates along the continuum, versus as a complete set of categories.²⁰ The cases illustrate how each veteran's conceptualization of engagement in care unfolded in different ways.

After purposively selecting three cases, the lead author returned to the interview transcripts to ensure that each

case contained sufficient richness of detail to illustrate different experiences of mental health care engagement and to explore the primary research questions of how rural-dwelling veterans might experience and seek mental health care. Throughout this stage, the lead author used the inductive codes first as a guide to selecting passages from the interview transcripts and then to organize the presentation of data. Throughout case review and data analysis, at each step, the lead author reviewed the original interview transcripts in addition to the interim case summaries to ensure the quotations were correctly contextualized. Lastly, veteran participants were given pseudonyms to protect their identities.

Ultimately, the goal of developing the cases was to illustrate veterans' experiences of engaging in mental health care by describing how they sought help, or didn't, across various settings. This approach offers unique insights into how individual veterans' contexts helped shape their experiences of engagement. More broadly, we aimed to explore how veterans addressed diverse constraints to accessing mental health treatment, such as geographical and bureaucratic barriers, among others, to prompt a wider-ranging inquiry into how patient engagement and patient-centered care guidelines in clinical settings might become more responsive to patient experiences.

Results

In the sections that follow, we used the inductive codes as a template for structuring the three cases of Nicholas, Samuel, and George (pseudonyms) to examine how each veteran's experience of engagement in mental health care both aligns with and diverges from the VA's institutional definitions of patient engagement.

Nicholas: Engaging in Self-Directed Informal Mental Health Care

Background. Nicholas is a 27-year-old Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) Army veteran who is native to the West Coast. During his time in the military, Nicholas served as an Infantryman and was deployed to the Middle

East. After returning home from the military, he lived and attended college in a town in a rural region of California.

Transition experiences from military to civilian life. In the year after Nicholas first separated from the military, he embarked on an extended backpacking and camping trip with his dog along the Pacific coast. He converted his truck into a camper, spent much of his time alone, and preferred this way of life even for a period of time after enrolling in classes at a university in the region. Nicholas found transitioning from military life back to life as a civilian challenging. He noted that many of his relationships suffered during this period, as illustrated in the following quotation:

Pretty much all of my relationships were destroyed. Whether it be my girlfriend or my friends or my family. It was just they didn't know what to do. They didn't know how to reach out. I don't want to blame them for that, but they didn't know what to do about it.

Thus, his relationships suffered as a result of friends and family not knowing how to support or help him during this transitional period. Nevertheless, instead of seeking help for his mental health concerns, Nicholas waited to seek treatment. He described some of the reasons for his hesitation in the following passage: "It was distrust, I guess... I didn't trust that they could actually help me. I didn't know the services they offered and I didn't know if I could trust them to treat me rather than lock me up". In short, both a lack of knowledge regarding the resources available to him and a lack of trust in the possible outcomes of reaching out for help were barriers to initiating mental health treatment for Nicholas.

Turning Point. Although he had already been experiencing nightmares and managing his symptoms on his own, he also increasingly began experiencing flashbacks and intrusive memories while awake. He stated:

I was having a lot of problems. I was hallucinating, hearing things. I didn't even need the medication. It was without being on it... Memories were being recalled at invasive times. It was just invasive memories and sometimes they'd be set off by triggers; either smells or certain stuff would trigger them. That's when I knew I was having a big-time issue.

Initially, to manage these experiences, Nicolas began drinking heavily and eventually received a DUI. This critical juncture prompted him to seek clinician-directed mental health treatment for the first time.

Nicholas recounted the state of internal crisis he was experiencing when he finally arrived at a clinic to seek help, stating: "I ended up going in and I remember even the first day when they checked me I must have looked super calm on the outside but when they checked my vi-

tals they were just off the charts. My pulse rate must've been well over 100". Unfortunately, Nicholas' initial mental health treatment experience was not positive, as he was prescribed medications that made him feel disoriented and "like a robot". He recalled that as a result he became reluctant to re-engage in clinician-directed mental health treatment, stating:

I used to see a mental health professional, but I haven't done that in a while... I kind of avoid it. I'll just admit it. I avoid it... the last thing I want is to be prescribed medication at this point because I've already tried doing that several times and it just doesn't make me feel right.

Hence, negative early clinical experiences ultimately led Nicholas to become averse to taking psychiatric medications, and reluctant to place his trust in clinician-directed mental health treatment.

Trusted Person. Despite Nicholas' negative early mental health treatment experiences, he recognized a need for ongoing support for Posttraumatic Stress Disorder (PTSD). To meet his needs, he chose to opt out of clinician-directed mental health treatment and instead initiated an informal care relationship with a trusted person at the university he attended. Nicholas described this trusted person and their relationship as follows:

There's a lady on our [university] campus that runs the Veteran's Office. She has a degree in psychology, but she's also a social worker... She's like my own, personal shrink, I guess you would say. I come in and I vent, and she says within the past couple of years she sees I've been mellowing out compared to when I first arrived.

Although Nicolas' trusted person had a background in mental health treatment, she did not formally act as a mental health provider or deliver evidence-based treatment in a clinical setting. Thus, by choosing to engage with a trusted person rather than a clinician, Nicholas redefined how and where he would engage in mental health care on his own terms. He further described his relationship with this trusted person in the following way:

It's informal and that's kind of what I like. I like to be able to walk in. The whole appointment process for mental health stuff, like getting an appointment, walk in, and sometimes I'm not comfortable. I'm trying to figure out the person I talked to and the thing is... if [a veteran doesn't] really feel like they know the person then you don't really trust the person.

Here, Nicholas described various constraints he encountered to engaging in clinician-directed mental health treat-

ment (e.g., the formal process of scheduling appointments, building trust with a clinician) as factors that contributed to his reluctance to re-engage in treatment. Having had prior negative experiences, Nicholas found a way to establish an alternative form of care.

Self-management. Nicholas also discussed engaging in self-management activities to manage his mental health in his everyday life. He routinely engaged with nature in the region in which he lived through mountain biking, trail running with his dog, hiking, and camping. In particular, he noted receiving a DUI as what prompted him to start mountain biking more, stating: “One of the big things that I ended up doing was, well, part of it was brought on because I got a DUI. I ended up mountain biking a lot more”. He also highlighted liking to “work with his hands” and described spending time working on cars. In addition, Nicholas described traveling to get tattoo work done by an artist with whom he shared a close relationship, and characterized getting tattooed by this artist as a part of his healing. These activities represented additional aspects of what Nicholas considered to be engaging in mental health care, even though these activities would not typically be recognized by health care providers as mental health treatment.

Case Conclusion. Nicholas’ description of his own efforts to define engagement in care on his own terms illustrates his experience navigating the constraints he encountered while seeking mental health treatment. For this veteran, mental health ultimately took place outside of clinical settings, shifting the setting of care from settings where clinicians and established institutional processes held greater authority to settings where he possessed greater autonomy for making decisions about how he wanted to engage in mental health care. For Nicholas, engaging in mental health care meant engaging in self-directed informal mental health care. However, many of the community and self-directed activities he engaged in remained largely unrecognized by formal health care providers and thus were likely not captured in his VA electronic medical record, highlighting a gap between an institutional definition of engagement in mental health care and a veteran’s experience of engagement in mental health care.

Samuel: Opting for Both Clinician-Directed Treatment and Self-Management Activities

Background. Samuel is a 52-year-old career Navy and Gulf War Veteran who is native to the state of Louisiana. Samuel served as an Air Crewman for the majority of his career in the Navy, and spent over 7 years serving overseas in the Middle East and in Europe. Since retiring from the military after completing 20 years of service, he worked in civilian jobs until he was laid off. He eventually decided to return to school with his wife’s encouragement.

Transition from military to civilian life. Over the 20 years that Samuel spent in the military, he recalled mental health as a topic that people often didn’t discuss for fear

of losing security clearances and other privileges, fear of losing access to certain jobs, and even fear of being medically or dishonorably discharged. He described these concerns in following quotation:

You really can’t talk about stuff like that once you’re in the military because you don’t want to get no bad discharge or anything like that. So, you got to keep things regulated...If I didn’t say anything I’d be protecting myself... I wanted to do my 20 years [of military service]. I didn’t want to jeopardize that, you know?

Here, Samuel described how while being an active service member, mental health status was something that should be concealed, which he referred to as “keeping things regulated”. He further noted how this long-ingrained attitude became a habit which he carried over into his post-military life. He stated that it took him several years after retiring from the military to mention his mental health concerns to his VA primary care provider.

Soon after Samuel retired from the military and returned to Louisiana, the region was hit with Hurricane Katrina in 2005, a historic natural disaster for the region. Hurricane Katrina destroyed countless family homes across the Gulf Coast, including Samuel and his wife’s home and his sister’s home in a nearby town, stating that his own home “got hit with 32 feet of water”. In contemplating what finally led him to seek mental health care, Samuel described uncertainty about the root of his anger issues, depression, anxiety, and drinking, stating:

I mean, just as far as the anger issues and stuff like that, not being motivated sometimes... I don’t know, I was in a few mishaps [in the military] and stuff... [T]his was in the 90s that I was involved with [the response for] that building that got blown up in [city]. Couple issues. [I was involved in a] couple of plane crashes. I’ve seen a couple of my friends killed... I guess it could be a combination of stuff. Even probably... coming back home. Going through Katrina and stuff... I was right here in my home here [when that happened].

Samuel therefore attributed his mental health concerns to a combination of factors, including experiences while serving in the military and experiencing a major natural disaster after he returned home, highlighting the inextricability of social, historical, and structural factors in his experiences of health.

Turning Point. Samuel reached a critical juncture when his mental health issues began to affect everything in his life, especially his relationship with his wife. It was at this point that both Samuel’s wife and his father, a fellow veteran, encouraged him to discuss mental health care with his primary care provider. In the excerpt below,

Samuel recounted his initial experience discussing his mental health concerns with his primary care provider:

I was talking to my doctor. Explaining to him how I feel sometimes and losing interest in things. I really get angry a lot, too, you know? For whatever; I don't even know what it would be for. Then, just kind of having sometimes no control over myself. Having trouble getting it together...everything was affecting my relationship with my wife and my home and even stuff when I had a job.

In this segment, Samuel recalled having felt out of control, as well as having been unable to pinpoint the source of these experiences. He also reflected upon how these factors negatively impacted his life during his visit with his primary care provider.

After this visit, Samuel's primary care provider referred him to a mental health provider. Following this, Samuel began a series of counseling sessions at his local clinic and tried different medications with guidance from his new mental health provider. In the passage below, Samuel described this experience:

[I started talking to the mental health provider] to try to find out what was going on with me and to see if they could come to some type of a resolution or an answer—why do I get so angry all the time? Then, after that, once I got on the meds and everything even keeled out I felt like, “Well, I don't really need to go back to talk to nobody no more”.

After a period of trial and error, Samuel and his mental health provider found a medication that helped keep him at an “even keel”. Having successfully accessed multiple forms of clinician-directed mental health treatment, Samuel made the decision to only maintain the form of treatment that aligned with his personal preferences: prescription medication.

Trusted Person. Samuel also had a trusted person who was critical in his decision to seek clinician-directed mental health treatment: his wife. Not only did she encourage him to talk to his primary care provider about mental health care, but she supported him in re-engaging with their church community. Samuel described how going to church with his wife benefitted his health, stating: “I just recently started going back to church with my wife. That's been making me feel a lot better too, you know? Calmed me down some, put things in perspective and order”. Samuel also described how going back to church was not something he would have initiated on his own, stating: “I never would've took the initiative and went [to church] on my own... If my wife was going then she would ask if I wanted to go... I never did it on my own”. This illustrates the crucial role that Samuel's wife played in his engagement in care both in the clinic and in their community, highlighting

the impact that the support of a trusted person can make in encouraging multiple forms of care across various settings.

Self-management. In addition to attending church, Samuel cited playing guitar as an important self-management activity. He described how playing guitar “calms me down, and I got it lying next to my bed right now”. Samuel recalled that what led him to play guitar was his initial desire to socialize with other veterans through organizations such as the Veterans of Foreign Wars (VFW), stating: “[Being with] people that I served with, too, you know? Same time, same experiences and stuff like that. Sure. That'd be a big help”. He soon realized, however, that much of the socialization at those organizations revolved around drinking, as he described in the following quotation:

If you go down to [the VFW] all that's going to do is lead to drinking, so I stay away from that drinking stuff... Like when I first retired after the military, I went to a couple American Legions out here and...I just lost interest in it...I didn't want to be around all that mess.

Having weighed the benefits of socializing with other veterans at the VFW against the cost of putting himself at risk of drinking, Samuel opted to play the guitar to manage his mental health, stating: “I did have a problem with drinking before but I got to leave all that stuff alone. Yeah, I manage, I just play guitar”. The examples presented here illustrate how Samuel navigated the risks and constraints present in some community settings (*i.e.*, VFW) but not in others (*i.e.*, church). Through a period of trial and error similar to that experienced with a mental health provider, he ultimately chose to engage in care through a combination of clinician-directed treatment and self-management activities that aligned with his own preferences for mental health care.

Case Conclusion. Samuel successfully engaged in mental health treatment at his local clinic, and his ongoing engagement through prescription medications fits the VA institutional metric of engagement. He also engaged in alternative activities in other settings, such as attending church and playing guitar, as part of his broader notion of engagement in care. For Samuel, engagement in mental health care took shape as opting for both clinician-directed treatment and self-management activities. Like Nicholas, however, Samuel's engagement in mental health care included activities that would not typically be captured by his health care institution's definitions of mental health care engagement. This, again, highlights the limits to which approaches or modalities of care are ultimately recognized as contributing to mental health treatment and which are not.

George: Complete Disengagement from Clinician-Directed Mental Health Treatment

Background. George is a 67-year-old Vietnam-era veteran who has lived “in the hills” in rural California for

over 20 years. After having resided on an isolated parcel of land with a partner for many years, he now lives alone and opts to rarely leave, preferring solitude to others' company much of the time.

Transition from military to civilian life. During our interview, George did not discuss the branch in the military in which he served in or military occupational specialty (MOS). Rather, he described challenges related to transitioning back to civilian life after military service upon first returning from war as a young man. In contrast with Nicholas and Samuel who at least in part attributed their mental health concerns with military service experiences, George emphasized coming home from his deployment in Vietnam as his major traumatic experience related to military service. He reflected on this period, stating:

"I'm lucky if I didn't end up in the hills, I would end up in prison... I didn't do well when I came there... Yeah, coming back was traumatic. And I lucked out. I mean, I'm in the hills... I spent 15 years homeless, so any place is really a good place in time".

In this quotation, George described how the experience of transitioning back to civilian life after being discharged from the military was "traumatic". Further illustrating the political climate of the era in which he served, George continued:

"We weren't wanted. The country didn't want us; no one wanted us". He felt fortunate to have ultimately ended up in "the hills" because life on his homestead offered him an alternative to the challenge of successfully re-entering civilian life.

Turning Point. George's first attempt to seek help from the VA as a young veteran was prompted by challenges he faced transitioning back to civilian life. However, he was ultimately unable to access VA care services despite his efforts and described feeling as though the VA had given him the "run around". This made him "walk away" from the VA and clinician-directed mental health treatment – at least temporarily.

Over the 40 years that followed his initial attempt to access the VA, George continued to try to access VA mental health services during multiple life crises. Each time, George said he could not get the care he wanted or needed despite his efforts and described feeling as though the VA had turned its back on him and his Vietnam-era comrades. Eventually, George's compounding feeling of betrayal constituted a turning point in his attitude toward seeking clinical care. Even after successfully enrolling in VA benefits and initiating primary care at a VA clinic decades later in his 60s, George was reluctant to seek clinician-directed mental health treatment, stating:

I'm not interested in talking to anybody anymore. I was interested when I was losing my family. I was interested when I was homeless. I was interested when I was having all these problems, and I didn't know how to cope. Now I'm not interested. There's other people that need it.

In this quotation, George described how he lost interest in trying to engage in clinician-directed mental health treatment after having failed to do so time and time again. George acknowledged that access to mental health treatment in the VA is better now than it was when he first returned from Vietnam, but still chose not to pursue it. In his opinion, there are other veterans who need access to treatment more than he does now. George further reflected on what he characterized as a generational shift in access, stating: "That's what's changing a lot for these new guys coming home. I'm glad to see it. They deserve it".

Trusted Person. Several years prior to our interview, George met a woman who worked for his county's Social Services at an outreach event in a nearby town. This social worker helped him document his military service-related PTSD and qualify for VA benefits. In contrast to health care providers he had encountered during prior attempts to access VA services, George characterized the social worker as "straightforward...and she didn't break my trust". He continued to meet with her for a period of time during which she helped him establish primary care at a nearby VA clinic. However, as a result of prior experiences with the VA and the perception that he could no longer benefit from mental health treatment, George elected to remain completely disengaged from clinician-directed mental health treatment. Instead, continued to manage his mental health concerns on his own, entirely outside of clinical settings.

Self-management. George preferred his own self-directed mental health care regimen, which included activities he considered to be restorative such as working the land on his homestead. He described this in detail during the interview:

We [George and his former partner] got, like, seven different kinds of apple trees, pears, peaches, plums, 100 lavender plants inside the yard. Man, there's walls of lilacs. We got a front pond with fish in it, with a fountain that drops down into a lower one... and then goes to a weeping willow... We've created a paradise.

In this quotation, George described how the result of the restorative work of "working the land" was the creation of the "paradise" that he calls home. He claimed that working the land "keeps me busy and wears me out. It's amazing how much it restores the soul. You know, I don't know how to explain it. It's real". Here, George illustrated how the land both offered him an alternative to the typical

civilian life within which he struggled to reintegrate and an alternative approach to managing his mental health.

Another aspect of what George considered a part of his self-directed care was isolation from others. He lived alone at his home, which he rarely left. He felt uncomfortable being around people who lived in towns and cities and enjoyed the solitude, life outdoors, and living “six miles off the pavement” in a “different reality”. He described this in the following excerpt:

“I might not leave here maybe once or twice a month. I don’t deal well with people. There’s no radio and television here. I can go weeks and never even talk to anybody—which is fine with me, because what I’m looking at is unbelievable”.

In addition to working the land and solitude, George also noted occasionally playing cards at casinos and in tournaments with a friend who is a fellow veteran, and he believed that these social activities also contributed to his mental well-being. Having noted the contrast between his preference for isolation and going to casinos, he commented: “I feel totally comfortable in a casino [with] the amount of security that’s in a casino... Even though I got long hair, and a beard, and stuff, I always make friends with security”. Thus, although completely disengaged from clinician-directed mental health treatment, George nevertheless considered himself engaged in his own forms of self-directed mental health care.

Case Conclusion. George’s description of his efforts to engage in mental health care illustrates how a veteran who was unable to access mental health treatment at various critical points throughout his life found alternative ways in non-clinical settings where he did have access. In doing so, George was able to get his care needs met despite almost complete disengagement from clinician-directed mental health treatment. For this veteran, engagement in care took place through some activities that would be endorsed by clinicians (e.g., gardening) and others that would not typically be endorsed by clinicians (e.g., going to casinos with friends). Even after a pathway to mental health treatment became available to him later in life, he elected to engage in care through his own home and social relationships. George’s story reminds us that individuals persist in their own self-management strategies despite repeatedly encountering social and institutional barriers to engagement in formal mental health treatment.

Discussion

How to best engage rural veterans in mental health care is challenging and a topic of public health concern.^{1,2} Currently, a critical limitation to adequately addressing this issue is how the concept of patient engagement has been defined by researchers, clinicians, and policy makers. In this paper, we used a case study approach adapted

for HSR to explore how three rural veterans described experiences of engaging in mental health care, and how their definitions aligned with and departed from VA institutional definitions of engagement. In each of the case studies, participants self-managed symptoms and responded to different challenges by engaging in activities that would not typically be considered mental health treatment, such as playing guitar, working the land, trail running, and engaging in community-based activities such as attending church.

Given the barriers that rural-dwelling veterans face in engaging in mental health treatment, it is imperative for VA and individual clinicians to understand the constraints and preferences that might affect veterans’ decision-making around help-seeking for mental health concerns. Factors that can impact individual veterans’ agency, access to, and engagement in different forms of care described by Nicholas, Samuel, and George include: the harms that veterans have experienced both during and after service, particularly after engaging in combat; the role of trusted persons; challenging transition experiences from military to civilian life; experiences of stigma against seeking mental health treatment, both during and after service; well-documented bureaucratic and institutional barriers veterans have faced seeking VA health care services; the broader political climate of the era in which a veteran served; and sharply varying degrees of available resources across rural-urban divides throughout the U.S. These broader social and structural contexts are also well-described throughout the health sciences literature^{2,32,33} and are crucial for health services providers to acknowledge given increased expectations for patients with chronic illness to assume greater responsibility for self-management.

As VA strives to improve patient engagement and patient-centered care, bridging knowledge and practice between institutional definitions and guidelines with veterans’ lived experiences can inform new patient-centered mental health interventions and outcomes. Acknowledging and honoring veterans’ experiences of engagement in mental health care will not only help bridge knowledge gaps in this area but will also improve clinicians’ and health care institutions’ ability to care for individual veterans.

In 2012, the VA Office of Patient-Centered Care and Cultural Transformation was established to work with veterans, VA leadership, health care providers and staff to bring about a cultural transformation away from a strictly biomedical model to include a more “personalized, proactive, patient-driven” approach. This more patient-centered approach has been implemented through the national rollout of the VA Whole Health program which began in 2017. Though not specific to mental health, these Whole Health programs encourage patients and providers to collaborate to establish health goals aligned with what matters most to patients.³⁴ As such, re-conceptualizing a broader range of self-management activities as contributing to mental health treatment and recording these activ-

ities in the VA electronic medical record can be an important first step in aligning patient experiences and institutional definitions of mental health treatment, as well as encouraging engagement in care overall. Future studies will need to assess mental health outcomes associated with engagement in more personalized care approaches.

Methodological and Analytic Approach

The methodological and analytic approach outlined in this paper has both limitations and unique strengths. Secondary analysis of qualitative data is typically conducted for the purposes of examining new questions which are closely related to or extend the primary study questions, validating or expanding findings from the original data.³⁵ Tate and Happ³⁵ outline an approach to conducting “exemplar” secondary analysis which accounts for practical advantage, data adequacy, passage of time, researcher relationships to primary study, informed consent of participants, and rigor of analytic approach. Our secondary analysis met the criteria for “exemplar” secondary analysis in terms of: i) facilitating exploration of important aspects of patient-reported experiences from the primary study, ii) reducing participant burden for vulnerable patients by relying on existing data, iii) maximizing the utility of participants’ time investment and expertise, iv) allowing minimal passage of time between data collection and analysis (secondary analysis was conducted as the primary study was ongoing), v) integrating the qualitative research team in both the secondary analysis and the primary study, vi) recording an audit trail of methodology notes and analytic memos, and vii) holding regular meetings to establish credibility and dependability of findings. Thus, although the analysis presented in the paper was not the original aim of the larger clinical study, our adapted case study approach rigorously and systematically produced rich data and results.

Our use of an adapted case study approach responds to typical constraints in HSR settings, namely, that researchers aren’t always able to conduct intensive, longitudinal or immersive research with participants. The adaptation of more traditional qualitative research methods in HSR, such as ethnographic research, has been influenced by the importance of generating findings in formats and within time frames when they can be used to inform improvements in care.²⁶ In this study, we used an adapted case study approach because we had access to one-time, semi-structured interview data within the context of the formative phase of a larger clinical study. In contrast to more traditional case study research methods, we showed that researchers can re-purpose the narratively rich data from existing data sources to gain new insights about the target population that may lead to other important findings. These findings offer potential implications for both policy and care delivery, as well as support the development and implementation of an intervention.

Since there is no current standard for reporting case

study research, our adapted case study approach offers a flexible guide or format that could be applied by other researchers. Our adapted case study approach used an inductive coding process to guide our analysis, an approach that is unconventional for more traditional case study research and one that lends a unique strength to our study. Other researchers working in HSR settings can similarly produce an analytic template generated from a coding scheme that emerged from inductive coding of pre-existing data to structure the development of case studies.

Finally, given the goal of making patient voices heard in patient-centered care efforts, in this paper we show how case study methods are uniquely suited to ensure that patients’ voices are heard in patient-centered research, contributing not only to the literature on qualitative research methodology but also to the growing bodies of literature on patient engagement and patient-centered care.

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