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An exploratory study : Hispanic/Latino OEF/OIF U.S. military veterans readjusting post deployment

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ABSTRACT

There are a growing number of service members being deployed and sent to war, heightening the need to explore and address the concerns of U.S. military veterans. Current research on post deployed military veterans is limited by the lack of an equal representation of ethnic minorities in their study populations. This exploratory study attempted to investigate how Hispanic/Latino U.S. military veterans who deployed to Operation Enduring Freedom or Operation Iraqi Freedom, were readjusting to life post deployment.

This study used an online survey consisting of demographic questions and the Post Deployment Readjustment Inventory (Katz, *in press*). A purposive sample of 15 participants, who identified as Hispanic/Latino veterans who deployed to OEF or OIF completed the anonymous survey. Results suggest that overall Hispanic/Latino veterans were adjusting to civilian life with "moderate" difficulty. A particularly problematic area for this study population was Social Readjustment. A central limitation of this exploratory study was the small sample size and as a result it lacks of external validity. However, the fact that Hispanic/Latino veterans were found to have the greatest level of difficulty in the realm of "social readjustment" raises questions for future research about how the trauma of deployment while in the armed forces, is potentially exacerbated by

the societal oppression one faces as an ethnic/racial minority in our culture. This exploratory study will hopefully illuminate the need for future research on Hispanic/Latino veterans in an effort to address all of the biopsychosocial concerns of this vulnerable population.

AN EXPLORATORY STUDY: HISPANIC/LATINO OEF/OIF U.S. MILITARY VETERANS READJUSTING POST DEPLOYMENT

A project based upon an independent investigation,
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TABLE OF CONTENTS

LIST OF TABLES

Table

LIST OF FIGURES

Figures

CHAPTER I

INTRODUCTION

There are a growing number of service members being deployed out of the country and sent to war, heightening the need to explore and address the concerns of U.S. military veterans. To date Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) have required over one million military personnel to be deployed, with nearly half of them experiencing repeat deployments (Department of Defense Task Force on Mental Health, 2007). As the cycle of recruiting, enrolling, and training individuals continues in the military, those that fulfill their requirements and service will be discharged. At such time, military personnel may face a difficult transition into civilian life. By 2006, 2800 voluntary U.S. troops have been killed and thousands more of these troops have been evacuated from combat zones for psychological treatment (MacLean & Elder, 2007). Moreover, with 18,000 American casualties reported from the Iraq war alone, it is estimated that thousands of families and communities are being affected (L. Hoshmand & A. Hoshmand, 2007). Despite their reasons for enlisting, serving and volunteering, once in the armed forces individuals are at risk for loosing stability, safety, health, well-being and a stable social support network due to possible deployments while in a time of war.

Extensive literature is emerging on the needs of military veterans' mental health that is suggesting that deployment makes them a high risk population. Hoge, Auchterlonie and Milliken (2006) report that 19% of soldiers and Marines who return

from Iraq screen positive for posttraumatic stress disorder (PTSD), generalized anxiety or depression. These findings indicate a prevalence nearly twice that observed among soldiers surveyed before deployment (Hoge et al., 2006). These findings suggest that deployment itself has adverse effects on soldiers who are returning back to our communities. Soldiers returning home from OEF/OIF are reporting mental health concerns that may make readjustment to civilian life more difficult for the veteran, their family and our communities. It is critical to examine the mental health of those who have been deployed to OEF/OIF as they may be deployed multiple times. Research by the Department of Defense (DoD) suggests that "psychological concerns are also significantly higher among those with repeated deployments" (Department of Defense Task Force on Mental Health, 2007). Attention to the deployed and returning soldiers is important based on the literature indicating that they may be exhibiting symptoms that may interfere with civilian life.

Research suggests that exposure to combat results in an increased risk of PTSD, major depression, substance abuse, functional impairment in social and employment settings, and the increased use of health care services (Hoge et al., 2006). Given these conditions, and other possible stressors, isolation, anger, anxiety, and stress can ensue, leading to exacerbated symptoms from deployment or new symptoms in readjustment to civilian life. Moreover, those deployed are at a higher risk for losing social support networks and possible exposure to combat and therefore are more at risk for mental health concerns. While our country is at war, U.S. soldiers will continue to be deployed and upon their return, will need to incorporate back to civilian life, their families, communities, employment and intimate relationships. Therefore readjustment to civilian

life is an important life phase that mental health providers and communities need to explore as adverse effects are being exhibited in our ex-military members, our fathers, brothers, sisters and loved ones.

This project seeks to obtain information on stressors/situations during deployment such as, combat, PTSD and Traumatic Brain Injuries (TBI) that may be faced by military veterans who served and were deployed to OEF/OIF. Moreover, this study seeks to explore how such stressors impact a Hispanic/Latino veteran's adjustment to civilian life. Researchers have stated that there is a need for more exploration of the stressors related to a veteran's life, and how they might affect employment, health, intimate relationships, and social readjustment (Hoge, Castro, Messer, McGurk, Coting, & Koffman, 2004; Hoge et al., 2006: Litz, 2007). Furthermore, little is known about the readjustment life of military veterans who identify as Hispanic/Latino. There are a growing number of Hispanic/Latino individuals joining military services, therefore it is critical to understand their specific needs. The overall goal of this study is to examine the role of stressors on the readjustment of Hispanic/Latino military veterans.

The use of Hispanic and Latino terms have been used interchangeably and will be used so in this study so as to be inclusive. In the 1970's "The term "Hispanic" was operationalized as: A person of Mexican, Puerto Rican, Cuban, Central or South America or other Spanish culture or origin, regardless of race" (Hayes-Bautista & Chapa, 1987, p. 64). Hispanic is also sometimes referred to as those who are specifically from Spanish descent. However, the term preferred, more inclusive of national origin is the term Latino.

> The term "Latino", derived from "Latin America," is offered as the term that best reflects both the diverse national origins and the nearly unitary treatment of Latinos in the U.S. The term Latino is operationalized to include all persons of Latin American origin or descent, irrespective of language, race, or culture (Hayes-Bautista & Chapa, 1987, p.61).

Even though Latino is the preferred term used there are still institutions such as the military and the U.S. census that continue to use the term Hispanic to describe those of Latino origin. Both terms will be included in this study for recruitment and literature searches.

As the Hispanic/Latino population is growing, so is their representation in military service. The Department of Defense Population Report stated that in 2007, the total number of Hispanic non-prior service active accessions amounted to a total of 13.47% (M. Segal & D. Segal, 2007). Furthermore, the U.S. census estimates that the Hispanic/Latino population currently represents a total of 15 % of the U.S. population (U.S. Census Bureau, 2008). This is important to note because Hispanic/Latino an ethnic minority may have different experiences that affect their transition back to civilian life compared to other ethnic groups.

Kulka, Schlenger, Fairbank, Hough, Jordan, Marmar and Weiss (1990) found that there were ethnic differences in how Vietnam veterans were adjusting to civilian life. This study noted that African-American and Hispanic Vietnam veterans tended to report more mental health and life adjustment problems compared to European American veterans. Research has found higher levels of PTSD symptoms among Vietnam Hispanic military veterans as opposed to European American military veterans (Ortega & Rosenheck, 2000). An emerging, yet consistent finding is that PTSD is being

disproportionately reported in people of color, placing them at a higher risk for more life adjustment difficulties (Kulka et al., 1990).

In the next section, literature on combat trauma is reviewed and the effects of deployment on the following areas of life: Health, Career, Social Adjustment, Intimate Relationships, Deployment Concerns, and PTSD Symptoms. This literature review is followed by an examination and discussion of the specific aims of the present study.

CHAPTER II

LITERATURE REVIEW

Over 1.6 million service members have been deployed to Iraq and Afghanistan (Miles, 2005). Currently, eight years later, the U.S. continues to engage in both Afghanistan and Iraq with few plans to end the mobilization of troops. Military veterans are an important group of individuals to examine, as they are asked to potentially sacrifice their lives for the safety of our country, such a task makes them a necessary yet very vulnerable population. The U.S. Department of Defense has called the mental health community and providers to action, as research has found that barriers to care, substance misuse, and poor physical and mental health outcomes are a few health issues that exist in returned veterans and communities (Hoge, Castro, Messer, McGurk, Cotting, & Koffman, 2004). As the cycle of recruiting, enrolling, and training individuals continues in the military, those that fulfill their requirements and service will be discharged, at such time, military personnel may face a difficult transition into civilian life. More information regarding their needs post military life and deployment is important so that interventions can be created to enhance well-being in all areas of the veteran's civilian life.

Trauma Theory: Understanding Readjustment

Soldiers are in deployment settings with mild to severe deployment stressors. Some of the severest stressors they are exposed to are combat, engaging in military life and often deadly struggles with the enemy. The impact of combat on military populations

is related to the traumatic effects that combat has on an individual. In order to understand the importance of readjustment post deployment it is important to define trauma as it relates to combat and other experiences to deployment that are potentially stressful and traumatic.

Trauma has been defined by many authors, researchers and clinicians, as overwhelming an ordinary system of care that gives people a lack of sense of control, connection and meaning in the world (Herman, 1992). “Trauma is an event or experience that involves the imposition of severe (or traumatic) stressors” (Basham, 2008, p.414). According to the Diagnostic Statistical Manual of Mental Disorders, IV-TR, trauma is defined by fulfilling the criteria for Post Traumatic Stress Disorder (PTSD).

> A traumatic event is when both of the following are present: (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury; (2) the person’s response involved intense fear helplessness or horror (American Psychiatric Association, 2000, p. 463).

The effects of trauma on an individual are paramount, as it may impact several areas of his or her life at once. Trauma can affect an individuals’ social functioning, as well as, their mental and physical health. The current research on combat veterans is leading the development of knowledge about traumatic disorders (Herman, 1992). PTSD is a diagnosis that is often found in military veterans. Most research on post deployment adjustment has emphasized the experience of combat as traumatic. However, recent research has examined deployment itself, without the experience of combat, as a traumatic stressor (Litz, 2007).

PTSD is characterized by three major elements: hyper arousal (e.g. getting startled and easily agitated), avoidance (e.g. isolation, numbing, detachment and

emotional blunting) and re-experiencing of the traumatic experiences (e.g. nightmares, flashbacks, sensory and visual memories of the event) (Van der Kolk, 2003, p. 171). All of these symptoms interfere with daily life because they interfere with the ability to initiate and sustain social relations. Individuals experiencing reoccurring thoughts of deployment may have a difficult time feeling safe when they are revisiting the source of their stressful experiences. Individuals experiencing hyper arousal may encounter social difficulties in relationships and employment, in addition to other facets of life.

Trauma can cause feelings of intense fear, helplessness, loss of control, and the threat of annihilation (Herman, 1992). Such feelings as a result of deployment, can strongly impact later adjustment to civilian life. The threat of annihilation or fear of injury may be presumed to be a severe deployment stressor, as soldiers are in a combat setting in a foreign country with the perpetual fear of injury that may evoke a stress response. Combat itself may be a severe form of deployment stress, as it has been linked to detrimental health outcomes. Deployed soldiers who are now veterans face unique stressors. These unique stressors make readjustment to civilian life post deployment to OEF or OIF a life threatening and stressful situation, creating a traumatic response.

Areas of Readjustment Post Deployment

Overall, the literature on trauma has demonstrated a consistent link between combat and readjustment difficulties among U.S. Military veterans post deployment. Recent research emphasizes that "a new generation of veterans may be at risk for life course disturbances implicated by exposure to war-zone stressors and adversities" (Litz, 2007, p. 217). War-zone stressors can include, fire fights, being ambushed, handling dead remains, Improvised Explosive Devices (IED's), witnessing physical injury, hearing

about buddies getting shot, wounded or killed, being ambushed, and ground combat (Litz, 2007). As the number of military personnel increases, as well as, their chances of deployment, stressors, and repeat deployment, the likelihood of developing mental and physical health issues increases. Next will be a review of PTSD in relation to the veteran population.

Post Traumatic Stress Disorder

PTSD is the most common psychological condition found in military veterans. Recently research has found that at least 15% of veterans had met screening criteria for major depression, PTSD, or alcohol misuse post-deployment (Hoge, Terhakopian, Castro, Messer, & Engel, 2007). However, it has only been in the last 30 years that the medical society has acknowledged the existence of PTSD (Herman, 1992). "In 1980 for the first time, the characteristic syndrome of psychological trauma became a "real" diagnosis. In that year the American Psychiatric Association included in its official manual of mental disorders a new category, called *post-traumatic stress disorder"* (PTSD) (Herman, 1992, p. 28). Before this diagnosis, brave soldiers who came home from WWII were seen as weak or hysterical. U.S. military veterans returned home with symptoms of startled responses, hyper vigilance, nightmares, anger, and conditions labeled as "Shell shock" or "Battle Fatigue" (Herman, 1992).

In response to a U.S. congress mandate in 1983, that required further research on PTSD and other postwar psychological problems, the National Vietnam Veterans' Readjustment Study (NVVRS) was conducted. This multi method study on the well-being of Vietnam Veterans, suggests that military soldiers can be harmed psychologically by the actions and events that take place in combat (Kulka et al., 1990). Findings in the

study indicate that approximately 830,000 male and female Vietnam combat veterans (26%) had symptoms and related functional impairment associated with PTSD (Kulka et al., 1990). Additionally, Vietnam Veterans reported psychological problems including anxiety, depression and alcohol abuse, with Hispanic Vietnam veterans reporting more mental health and life adjustment problems compared to European American veterans.

Dohrenwend, Turner, Turse, Lewis-Fernandez and Yager (2008) sought to investigate why Hispanic/Latino Vietnam veterans were reporting higher rates of PTSD and discovered that a younger age of entry into military service may explain their mental health outcomes. Furthermore, lower levels of education and test scores were linked to a PTSD diagnosis. Lewis-Fernandez, Turner, Marshall, Turse, Neria, and Dohrenwend (2008) also sought to explain why Hispanic/Latino veterans reported higher levels of PTSD. Through the use of the (NVVRS) study, they found that higher reports of PTSD symptoms were not in fact due to cultural expressivity style, which had been mentioned by a previous study, but the genesis of this phenomena still remained unclear. Only a few studies have tried to understand and explain why Hispanic/Latino veterans are reporting higher incidences of a PTSD diagnosis. These findings accentuate the need to uncover protective factors that can attenuate the impact of war on the physical health and emotional well-being of Hispanic/Latino veterans.

It is important to note that PTSD can be examined as both a stressor and an outcome of stress. PTSD has been consistently linked to adjustment issues, such as, psychological health problems, poor health outcomes and less satisfaction in intimate relationships, (Nelson Goff, Crow, Reisbig & Hamilton, 2007; Orcutt, L. King, & D. King, 2003). Additionally, PTSD has been described as an outcome of deployment (Hoge

et al., 2004) and experiencing combat, therefore, elaboration of the role of PTSD on levels of adjustments will be further explained in other adjustment areas (Taft, Stern, L. King & D. King, 1999; Herman, 1992).

Deployment

Understanding the effects of deployment on mental health concerns has mobilized political attention to trauma, combat stress and finally to the PTSD diagnosis. Our military veterans are being deployed multiple times, and are facing long-term deployment settings with severe war stressors. Deployment is an important and routine component of military life for service members. However, deployment to a combat zone is an extremely stressful experience (Hoge et al., 2007; Killgore, Stetz, Castro, & Hoge, 2006; Litz & Orsillo, 2004). Deployment has a direct impact on individuals, families, and communities, such impacts may come in the form of stressors that are connected with a deployment setting and can directly impact the individual. For example, combat stress is one of many stressors that soldiers may face during a war zone setting. Current statistics indicate *that* fatal wounds, death and serious injuries for soldiers in combat settings significantly impact the deployed soldier (Hoge et al., 2007).

While there are many other deployment stressors that soldiers experience, such as, harsh environmental conditions, disease, and military sexual trauma, this paper will focus on the role of deployment, combat trauma and stress. Deployed soldiers may suffer from combat related trauma and more specifically combat stress. Combat has been linked to psychological and physical health problems and expected service usage by post-deployed military veterans. These effects of combat highlight the need to examine how deployment

settings work as a stressor, to assist mental health care providers and government agencies (Department of Defense Task Force on Mental Health, 2007).

Hoge and colleagues (2004) examined three groups of soldiers and Marines who returned from deployment to Iraq and Afghanistan. Soldiers were screened for various kinds of mental and physical outcomes, and reported on an extensive list of pre and post deployment stressors. Results suggest that a high percentage of combat stressors exist among the three groups of military soldiers and Marines surveyed, specifically, soldiers reported experiencing incoming artillery, rocket, or mortar fire, saw dead bodies or human remains, or knew someone seriously injured or killed. Interestingly there is a heightened level of stress in Iraq compared to Afghanistan, that is 89% percent of Army soldiers serving in Iraq reported being attacked or ambushed versus 58% of soldiers in Afghanistan. These statistics imply that soldiers may have higher levels of exposure to traumatic events and stressors depending on the deployment setting. Findings also suggest that soldiers have higher levels of exposure to combat trauma stressors in both OEF and OIF deployment settings.

Research has found a direct link between exposure to stress and psychological well-being. In relation to actual deployment and combat stress, Adler, Wright, Bliese, & Eckford (2008) reported that 55.3% (n=203) of their sample participants reported an A2 PTSD DSMIV criteria event. Participants in this sample had experienced a deployment related traumatic event that threatened personal injury such as being shot at, ambushed, injured as well as having friends die or be seriously injured, watching others die or be seriously injured, and/or dealing with human remains, moreover, this impacted mental health and well-being. These realities suggest that a deployment setting is a stressful

event no matter if actually involved in direct combat. Witnessing, acting on or hearing about others being injured, are deployment stressors that can negatively affect a soldier's physical and mental health. This demonstrates that deployment itself can be detrimental.

Deployment Concerns

A new area of research is the topic of deployment concerns. Deployment concerns can be defined as thoughts or worries, physical or environmental stressors, exposure to traumatic events, combat, trauma and personal stressors. Soldiers who experience such effects may develop psychological or health problems in civilian life. Concerns relating to deployment are important to consider as they may greatly affect readjustment to civilian life (Litz & Orsillo, 2004; Hoge et al., 2004). There is a need to explore if ruminating thoughts and thoughts of unfinished business regarding deployment may negatively affect veterans in their readjustment to civilian life (Katz, *in press*). Further exploration is needed to determine if thoughts, worries and concerns for deployed soldiers of OEF/OIF military veterans are negatively affecting the veteran's adjustment to civilian life.

Social Adjustment

The structure and nature of the U.S. armed forces may cause the loss of social support systems and networks of loved ones. Hoshmand and Hoshmand (2007) report that deployment cycles are estimated at 30% to 50%, which disrupt family life and community belonging by removing families from the support system of extended families and hometown communities. The impact of such a lifestyle has been studied extensively as "The impact of these separations on both the active duty member and the family members left at home become paramount issues for the military healthcare system" (D.

Lombard & T. Lombard, 1997, p. 79). As individuals deploy into combat, trainings, and duties overseas, their personal relationships may become strained. The importance of military members and their family is important to note as health care systems have to incorporate family members into treatment to address ruptured support systems.

Social adjustment is impaired when the veteran's ability to relate and feel connected to family, friends and community is adversely affected. Interpersonal functioning may be impaired in returning from Afghanistan and Iraq. Most maladaptive social impairment has been explained by combat trauma as marital problems, substance use, depression, anxiety, and PTSD diagnosis (Kulka et al., 1990; Taft et al, 1999; Killgore et al., 2006; Hoge, McGurk, Thomas, Cox, Engel, & Castro, 2008), however, there are some studies that show that post deployment stress alone, affects the soldier (Hoge et. al., 2004; Killgore et al., 2006). Hoge and colleagues (2004), found that pre deployed soldiers reported less psychological conditions than at post deployment. The authors found significantly higher reporting of psychological distress such as depression, anxiety, and PTSD symptoms was indeed attributed to deployment to OEF and OIF.

Military veterans post deployment are facing difficulties and potentially dealing with combat stress without a PTSD diagnosis, but also with subthresholds of PTSD symptamotology (Jakupcak et al., 2007). There are very few studies that specifically discuss the social impairment and experiences in social adjustment among the Hispanic/Latino OEF/OIF military veteran population (Kulka et al., 1990). Studies on combat military veterans provide a small foundation to expand and explore social adjustment in Hispanic/Latino military veterans. Kulka and colleagues (1990) noted specific differences among Hispanic/Latino Vietnam Veterans in interpersonal

functioning as compared to White combat veterans. Hispanic/Latino military combat veterans exhibited higher levels of readjustment difficulties such as higher rates of PTSD, psychological health problems, employment concerns and substance use. Researchers found that the veteran's level of adjustment was associated with physical and mental health problems, as well as, limitations in occupational and interpersonal functioning. These findings suggest that combat veterans experience impairments in both work and personal relationships, which are linked to negative well-being.

Current studies of OEF/OIF combat veterans explore the relationship of PTSD to poor interpersonal functioning. In a recent study by Jakupcak et al. (2007), researchers found that Iraq and Afghanistan treatment-seeking war veterans with PTSD and subthreshold symptoms of PTSD, also reported experiencing anger, hostility, and aggression. Among a sample of Iraq and Afghanistan war combat veterans, which were mostly male (97%) and White (71%), the authors sought to explore interpersonal functioning. Results suggest that anger, aggression, and hostility are seen within the first few years after returning from combat duty even after adjusting for combat and problem drinking. Researchers found that those diagnosed with PTSD and with a subthreshold of PTSD symptoms both reported higher percentages of acts of aggression (e.g., threatening physical violence), and impaired interpersonal functioning (Jakupcak et al., 2007). These findings indicate that interpersonal functional impairment exists among soldiers post deployment, such impairments may interfere with social readjustment. It is important to note that the study aforementioned did not include medical factors such as a diagnosis of traumatic brain injury that may also impact a veteran's experience of anger or aggression. Moreover, this study consisted of predominantly White male participants who were

treatment-seeking. The demographic limitations of this study's sample make it difficult to generalize the findings to ethnic minority or female soldiers.

The maladaptive patterns of social functions associated with combat-related PTSD are numerous. Research has found that combat-related PTSD is linked to interpersonal violence, social anxiety, avoidance, marital/family discord and occupational impairment (Frueh, Turner, Beidel & Cahill, 2001). However, it is important to note that social functioning is difficult to measure and address. Frueh and colleagues (2001), suggest that a multi-method approach in a comprehensive assessment should be included while determining social functioning and impairment in combat veterans with PTSD. Frueh and colleagues, (2001) sought to infer that the development of social functioning among combat veterans is imperative as there are many assumptions based on symptom severity, behaviors and chronicity. Researchers addressed the complexity of assessing for symptom severity to determine PTSD versus social functional impairment.

In regards to assessment and screening, Milliken, Auchterlonie & Hoge (2007) conducted a study on active and National Guard and Reserve soldiers and reviewed the soldiers' response to the Post Deployment Health Assessment (PDHA) and then three to six months later reviewed the Post Deployment Health Re-Assessment (PDHRA). This was a longitudinal descriptive study of a cohort of 88,235 U.S. military soldiers who returned from Iraq and who completed the PDHA and the PDHRA. Researchers found that initial screenings soon after post deployment may lead to an underestimated mental health problem. PDHRA results found more significant mental health problems at later screenings. Findings suggest that early screening may lead to underestimated mental health concerns that are later found in veterans post deployment at least six months after

deployment. Specifically, 3.5% of soldiers reported interpersonal conflicts in the PDHA assessment while at three to six months later in the PDHRA they reported a 14% difficulty in interpersonal conflicts. An increased percent of relationship problems for veterans was noted at a later screening assessment indicating that soldiers are having more difficulties post deployment as time passes. This finding suggests that difficulty with social adjustment is happening at least six month to one-year post deployment. While Milliken and colleagues 2007 contribute to our understanding of timing of measurement, it is important to note that participants in their study were active component soldiers who may have different experiences than those discharged out of active duty with a veteran status. Additionally, no information regarding ethnicity was explained, limiting our understanding of interpersonal relationships among ethnic minority soldiers.

The ability to be socially adjusted implies acceptance, interaction, and a sense of belonging within a relationship, family and community. Deployment in a war setting impacts a soldier's interpersonal functioning in their being and in turn impacts their interactions in intimate relationships. The importance of social adjustment is crucial for physical and mental health. More importantly research is needed in determining if Hispanic/Latino military veterans are having much more social adjustment difficulty post deployment. Hispanic/Latino military veterans may endorse traditional cultural values of *familismo* or *familism*, which imply strong family networks and family obligations (Cauce & Domenech-Rodriquez, 2002).

A descriptor of the family system in the Mexican community is the concept of *familismo* or *familism*, a notion that includes family closeness, familial obligation,

familial support, and strong ties to cultural traditions (Cauce & Domenech-Rodriguez, 2002). These values may assist Hispanic/Latino military veterans in the post deployment adjustment, by providing a strong support system. On the other hand, it may be that these values hinder adjustment and well-being, because Hispanic/Latino military veterans may not want to burden the family system, and therefore, do not seek their support. More importantly, there are cultural and ethnic differences among Latino groups. Given the lack of research on the Latino population, it is unclear how the interpersonal relationships of Hispanic/Latino military veterans will be impacted.

Implications to social adjustment suggest that social functional impairments lead to poor health outcomes. One important health outcome that has been linked to poor social adjustment is suicide. Recent studies on suicide among veteran populations have stated that there is a higher risk for veterans to commit suicide than individuals in the general community (Brenner, Gutierrez, Cornette, Betthauser, Bahraini, & Staves, 2008). There are no clear updated statistics that include military veterans, most statistics are on active duty soldiers. Statistics from military websites and studies are difficult to accurately assess and access. However, a recent qualitative study explored the vulnerability and high risk of suicide for combat veterans.

Brenner and colleagues (2008) interviewed 16 combat veterans to explore if Joiner's interpersonal-psychological theory of attempted and completed suicide could be applied to this population. Researchers found that military veterans were more at risk due to increased tolerance for pain, numbing, and experience to witnessing combat, physical injury or death, such experiences habituated soldiers to pain, sense of burdensomeness and a lack of belongingness. Along with an increased amount of tolerance to pain and

fear, there is a sense of burdensome to the social support network, that is, veterans did not want to burden their friends and families. Individuals in this study were twice as likely to die by suicide when compared with non-veteran males. This finding prompted exploration regarding Joiner's theory on combat veterans.

> Joiner's theory, states that suicides are attempted and completed in individuals who are an unbearable burden on their family, friends, and/or society (burdensomeness); their efforts at establishing and maintaining social connections have repeatedly been thwarted or have failed (failed belongingness); and through multiple experiences they have acquired the ability to engage in suicidal behavior. When all three elements are present, suicidal behavior with lethal intent is likely and imminent. (Brenner et al., 2008, p. 212).

This finding is important, as military veterans who are not adjusting socially, and have an interpersonal impairment, may experience a lack of a sense of belonging and experience themselves an unbearable burden. Combat and deployment stressors may affect a veterans' ability to tolerate pain and fear, creating a very low threshold of tolerance as a result of sensitization. Social adjustment can in fact be problematic for mental health, physical well-being, and possible survival therefore, it is important to examine not only the circumstances in which interpersonal impairment can occur (e.g. combat) but also alternative sources of support which can assist in social adjustment post deployment. It is important to explore if there are differences among Hispanic/Latino ethnicities in relation to values or strengths that may already be in place for a veteran to receive support from cultural traditions that may ameliorate feelings of burdensomeness and not belonging. However, it may also be argued that certain differences among Hispanic/Latino ethnicities may possibly exacerbate feelings of burdensome and belonging and therefore place Hispanic/Latino veterans at an increased risk for worse health outcomes.

There are many concerns regarding the lack of literature specifically addressing the Hispanic/Latino population. There is a need to address the strengths and vulnerabilities that might place Hispanic/Latino veterans at possibly a higher risk to adverse health outcomes. The importance of family for the Hispanic/Latino community may be either a source of strength or as a source of vulnerability.

Health

The Armed Forces consistently highlights the positive impact of joining the military, such as a greater opportunity for those who are economically disadvantaged, positive growth and maturity, coping with adversity, and a broader perspective on life (Maguen, Vogt, L. King, D. King, & Litz, 2006). Yet the effects of combat are rarely discussed and have been linked to marital problems, anxiety, depression, Post Traumatic Stress Disorder (PTSD), and low quality of life satisfaction (Maguen et al., 2006; MacLean & Elder, 2007; Hunt & Robbins, 2001; Hoge et al., 2004). It is important to note that both the positive and negative effects of military life on the individual vary depending on the health of the individual (MacLean & Elder, 2007).

In a deployment setting soldiers are at risk for war stressors and combat, which can greatly affect an individual's mental and physical health. War stressors that directly affect the soldier during deployment are possible due to the deployed country, diseases and adverse environmental conditions (Department of Defense Task Force on Mental Health, 2007; Litz & Orsillo, 2004). However, in a post deployment setting, combat stress and a PTSD diagnosis are possible experiences faced by military veterans. Military veterans who were in a combat zone may have experienced such conditions that can

affect medical health post deployment. This section focuses on health outcomes that may be attributed to deployment setting, combat stress and finally on a PTSD diagnosis.

As mentioned, deployment and combat may have adverse effects on physical and psychological health (DoD Mental Health Task Report, 2007; Kulka et al., 1990; Hoge et al., 2004). Not only does deployment tend to affect psychological health (Hoge et al., 2004) but it is also related to physical health (Trump, 2006). It is important to note the differences between deployment stressors, combat stress and an actual PTSD diagnosis. This section will focus on physical and medical health. However, it is important to note that most research has already established that PTSD is connected to adverse physical and medical health outcomes (Taft et al., 1999; Kulka et al., 1990; Hoge et al., 2004; Killgore et al., 2006; Milliken et al. 2007).

Researchers report a strong relationship between combat trauma and poor physical and mental health outcomes (Kulka et al., 1990; Taft et al., 1999; Hoge et al., 2004; Killgore et al., 2006; Hoge et al., 2007). Specifically, individuals with a PTSD diagnosis have higher poor self-rated health outcomes and somatic complaints than those who do not have a PTSD diagnosis (Killgore et al., 2006). For example most studies on Vietnam veterans found higher rates of PTSD, major depression, anxiety and substance use (Hoge et al., 2007).

Additionally, research has found that Hispanic military veterans report higher substance abuse problems and PTSD than their Caucasian counterparts (Kulka et al., 1990). With multiple and lengthy deployments to OEF/OIF, attention to military veteran health is needed. Hoge and colleagues (2004) have found that at least 17% of returning OIF and 11% OEF soldiers and Marines post deployment met criteria for major

depression, generalized anxiety, and PTSD. Also, noteworthy is that barriers to care were significantly alarming, that is, veterans with mental health disorders were twice as likely to express concern for possible stigmatization which impacted their utilization of seeking mental health services (Hoge et al., 2004).

There are important implications as most studies link combat stress to an actual PTSD diagnosis and therefore poorer health outcomes (Taft et al., 1999; Hoge et al., 2007). However, most studies linking combat stress with physical health outcomes are also stressing the need to decipher soldiers experiencing combat stress from those diagnosed with a PTSD diagnosis. A PTSD diagnosis is connected to deployment combat exposure and therefore to poorer physical health (Taft et al., 1999; Hoge et al., 2007; Hoge et al., 2008). It is unclear how PTSD without combat exposure may be related to health outcomes post deployment, or how combat exposure without PTSD is related to such outcomes.

Hoge and colleagues (2007) obtained self-report surveys from 2,863 soldiers one year after their return from combat duty in Iraq. Seventeen percent of participants met criteria for PTSD. Moreover, those diagnosed with PTSD were linked to lower general health and more, sick call visits, missed workdays, physical symptoms and high somatic symptom severity. These results demonstrated that those individuals diagnosed with PTSD reported health as being poor or fair, for example, specific health conditions include: (1) 74.9% reported feeling tired or having little energy, (2) 71.1% reported trouble falling or staying asleep or sleeping too much, (3) 50.2% reported pain in arms, legs or joints and (4) 45.9% reported nausea, gas or indigestion, constipation, loose bowels or diarrhea. Also, 23.6% of soldiers with a PTSD diagnosis reported having

pounding or racing heart as compared to those not diagnosed with PTSD (3.7%) (Hoge et al., 2007). However, it is important to note that this was a cross-sectional self-report design limiting casual inferences, and that the sample was not randomly selected and excluded soldiers who did not come back from deployment due to medical separations. Similar to other research on military populations there was no mention of race or ethnicity in the findings or in the study's methodology, limiting our understanding of diverse populations.

There is an extensive amount of literature linking health service utilization and trauma. More specifically PTSD and health care service utilization are indirectly connected to poor health outcomes (Elhai, Kashdan, Snyder, North, Heaney & Frueh, 2007). This indicates that behavior and actual health versus utilization should be considered. For example, research needs to focus on assessing health outcomes such as the type of medical illness the veteran is seeking care for, the veterans symptom severity versus actual service utilization. Service utilization may also indicate that patients may be seeking to obtain compensation versus only seeking health services. Veterans have the option of applying for service related injuries, and if eligible may be compensated. Many exams, interviews, and procedures are done to determine eligibility. Most exams are completed by medical and mental health providers therefore seeking services may not only be for direct health services. Physical health symptoms may not correlate with service visits. Knowing what service patients seek out and for what symptoms is needed to further assess if PTSD is in fact related to health care utilization.

It is important to understand health challenges that Hispanic/Latino deployed OIF/OEF soldiers face when returning back to their communities. Trump (2006) studied

post deployment military personnel who went to Europe and Southwest Asia and found that post deployment self –rated health (SRH) status was linked to subsequent hospitalization, separation and ambulatory care visits. This study suggests that deployment itself has an impact on health. However, no mention regarding Hispanic veterans was noted.

Poor neuropsychological outcomes following deployment to OIF/OEF has also been linked to war zone stressors. Vasterling, Proctor, Amoroso, Kane, Heeren & White, (2009) report that negative health consequence of war zone deployment are possible and may compromise neuropsychological functioning. In their study of combat veterans deployed to OIF/OEF they found small declines in the ability to sustain attention, focus, learn and remember new information resulting from war-zone participation, such impairments may influence an individual's ability to maintain employment. Cognitive and brain trauma is a rising concern among returned OIF/OEF military veterans.

A signature medical wound for the current conflicts in Iraq and Afghanistan is a Traumatic Brain Injury (TBI) (Hoge et al., 2008). Protective gear has assisted soldiers in returning with less fatal injuries, yet they still exhibit head, neck, brain trauma and psychological injuries. Improvised Explosive Devices (IED) have been commonly experienced in OEF/OIF warfare, increasing the possibility for serious injury, specifically head injuries. Blasts from the explosion tend to cause mild, moderate and severe head injuries or concussions. TBI has been linked to cognitive impairments and physical health problems. It is suspected that at least 18% of military soldiers are reporting symptoms of irritability, memory problems, headaches, and difficulty concentrating which may be connected to mild TBI's (Hoge et al., 2008).

Health is an important variable to investigate in all military veterans, however it is important to note the role of ethnicity. Very few studies specifically interview or survey Hispanic/Latino military veterans post OEF/OIF deployments. It is not clear if deployed military veterans who identify as Latino/Hispanic may have more or less health concerns or functional impairments. There is a small amount of literature specifically aimed at Hispanic/Latino military veterans health concerns, which has reported that they are at a higher risk for health concerns when compared to their European American counterparts (Kulka et al., 1990; Ortega & Rosenheck, 2000). Studies that mention the Hispanic/Latino population usually lump Hispanic/Latino's into only one category, without identifying specific ethnic or cultural identity

Career

Individuals coming of age have many life options. Three to pursue are: higher education, the work force, or serving in the armed forces (MacLean & Elder, 2007). The Armed Forces, an All Volunteer Force since 1973, is one of many life options for U.S. citizens. There are some non-citizens who are eligible for military service, however it is specifically and dependent upon certain eligibilities, stipulations and whether or not the country is at peace or war era (Schulte, 2007).

Currently the U.S. has a reserve force without conscription in effect since the end of the war in Vietnam (MacLean & Elder, 2007). Due to its volunteer nature, members of the armed forces are women and men who have chosen the profession because of patriotism, honor, or for advancement in higher education or socioeconomic status (MacLean & Elder, 2007). Most individuals in military service often obtain skills that are essential for military life and culture. However, once discharged and no longer part of

military life, those skills that one obtained and exercised daily may not be transferable to civilian communities and employment settings (Clemens & Milsom, 2008).

The importance of career and employment is a crucial part of life for civilians as well as discharged enlisted soldiers (Clemens & Milsom, 2008). As enlisted members are being discharged the need for career and employment is a priority. Deployment has caused social networks to be broken or fractured which may make it difficult for soldiers to have a strong support network causing readjustment difficulties to employment settings (Litz & Orsillo, 2004). This is important to consider as military veterans might have difficulties obtaining employment which can lead to unemployment and other life stressors, mental health issues, family problems, decreased self-esteem and self-efficacy, and economic hardships.

Deployment and deployment stressors such as combat trauma, or combat stress have affected the OEF/OIF military veteran population's employment needs. An important factor regarding employment in a military veteran is his/her deployment to OEF or OIF. Deployment to both settings make it so that there is a higher risk for difficulties not only due to time of military life but also due to possible deployment stressors, combat trauma, stress responses and PTSD symptoms and diagnosis. Litz and Orsillo (2004) noted the importance of assessing the needs of the post deployed and discharged soldier as there may exist a need to discuss the transition to civilian life and the possibility of exploring a new career, education and life goals.

In 2004, fewer than 4% of enlisted service members held a four year college degree and enlisted members made up 84% of the U.S. military's active duty personnel (Clemens & Milsom, 2008). As education is a factor in obtaining a higher paying

employment there is a need to provide occupational services to returning military veterans.

Kulka and colleagues (1990) noted that Black and Hispanic veterans exhibited higher levels of occupational difficulties and unemployment, compared to their European American counterparts. Theater combat on ethnic minority veterans seems to place them at higher risk for employment difficulties. White/other and Hispanic males were more likely to be working than Black Vietnam theatre veterans (Kulka et al., 1990). Also, Vietnam theater female and male, veterans with PTSD, reported higher levels of occupational insecurity. Overall, male Vietnam veterans with PTSD were both less educated and more likely to be unemployed (Kulka et al., 1990). These findings suggest that unemployment is more likely to occur if PTSD is present. Recent studies (Hoge et al., 2004; Hoge et al., 2007) note the increasing psychological difficulties post deployment in OEF/OIF veterans, however, more studies should explore the role of deployment to OEF/OIF and career readjustment.

Intimate Relationships

As soldiers return to civilian life the government is no longer responsible for the structure of their lives, schedules, room and board, discipline, deployment and training. Moreover, this adjustment phase may not only affect the individuals leaving the military, but also the families and communities they return to. Solomon (1988) found that many soldiers had difficulty reintegrating into their families. Author states that guilty feelings, emotional withdrawal, and elevated levels of aggression in the returning veteran may make it difficult to reintegrate into the family. Therefore, it is critical to examine how intimate relationships are affected by deployment.

Research is needed to explore the effects of exposure to war trauma on soldiers, their partners and couple relationships (Nelson Goff et al., 2007). Researchers suggest that trauma should not be considered an individual experience. A deploying soldier suffers from a temporary rupture in their social support network, family and intimate relationships. The conflict in Vietnam surged much research on intimate relationships and interpersonal problems among returning veterans. In a study by Roberts, Penk, Gearing, Robinowitz, Dolan, and Patterson (1982), researchers discuss the role of PTSD in combat veterans, non PTSD combat veterans and non-combat veterans to examine the impact on intimate relationship and family adjustment. Roberts and colleagues (1982) surveyed 274 male Vietnam-era veterans who were seeking treatment at a drug or alcohol dependence treatment program. One of the measures used was the Horowitz Inventory and intimacy that measured, aggression, compliance, independence and sociability. Researchers found that those with a PTSD diagnosis in fact scored higher on interpersonal difficulties, specifically veterans reported more problems in intimacy and sociability than the other veterans in other groups. Researchers also suggest a need to explore the finding of hostility. Veterans with PTSD symptoms and those combat veterans without a PTSD diagnosis, both reported hostility equally. The PTSD group also had more maladjustment on interpersonal functions, however an interesting finding was that although problems in intimacy and sociability were associated with PTSD, the relationship between PTSD and maladjustment in family functioning was not supported. This finding is important to note as researchers suggest that problems of intimacy may only be related to spouses, partners or lovers and may have no affect in overall family maladjustment. A limitation to this study was that the sample was seeking treatment for substance abuse. Researchers

explain that PTSD symptoms may be attributed or compounded by drug or alcohol dependence, in turn, drug or alcohol dependence may explain the problems in intimacy.

A more recent study regarding the impact of combat trauma on intimate relationship satisfaction is a study by Nelson Goff and colleagues (2007). Nelson Goff and colleagues (2007) sought to explore the impact of combat traumatic stress on relationship satisfaction of OIF/OEF deployed soldiers and their spouses/partners. Researchers interviewed 45 couples and found that high levels of individual trauma symptoms in the soldier, such as sexual problems, dissociation, and sleep disturbances greatly predicted lower marital/relationship satisfaction for the individual and his or her spouse (Nelson Goff et al., 2007). A Limitation to this study was that soldiers were active duty, and highly educated military officers and thus not very representative of a broad Army population.

Trauma exposure and PTSD symptoms may also have an effect on the individual by increasing his or her risk of engaging in intimate partner violence (Orcutt et al., 2003). Intimate partner violence is a significant social problem and it is shown as being present in the veteran population (Orcutt et al., 2003). Orcutt and colleagues (2003) found that trauma exposure and subsequent PTSD symptom severity is important to the perpetration of intimate partner violence. Their study researched a subsample of Kulka and colleagues (1990) study on Vietnam veterans (NVVRS).

While there is emerging literature on interpersonal violence among intimate relationships and combat veterans for those diagnosed with PTSD, further studies need to explore the effects of combat trauma on family and intimate relationship satisfaction. It is important to consider the effects of deployment on soldiers and intimate relationships

because not all combat trauma may lead to PTSD yet most literature focuses on PTSD symptoms and interpersonal relationship difficulties. It is important to explore relationships between deployment and overall family and intimate relationships adjustment post deployment to prevent interpersonal and marital conflict. An open question remains in the literature as to how Hispanic/Latino veterans may be adjusting to intimate relationships, as there might be specific challenges to the Hispanic and Latino population.

The Current Study

The purpose of this exploratory study is to conduct an investigation of the post deployment difficulty level of readjustment to civilian life faced by returning military veterans who identify as Hispanic/Latino and who served in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). The project has two main goals, one is to examine if military veterans who identify as Hispanics/Latinos, are having slight, moderate or considerable levels of difficulty in their readjustment to civilian life post deployment. The goal is to assess if the Latino population is experiencing a considerable level of difficulty in adjusting to life post deployment, with the use of the Post Deployment Readjustment Inventory (Appendix F). Previous research on Hispanics/Latinos military veterans suggests that they may experience worse outcomes than veterans of European Descent.

As part of understanding levels of readjustment, this study explores what areas of readjustment are more problematic for Hispanic/Latino U.S. military veterans. The level of difficulty in readjusting to life, post-deployment, will be examined using the following categories: Health, social adjustment, PTSD, concerns regarding deployment and intimate

relationships. Research on military veterans in general has found that the transition to civilian life can create numerous challenges for returning soldiers. Consistent findings link deployment and combat to poor health outcomes, interpersonal problems, psychological difficulties, intimate relationship satisfaction and violence. However, how Hispanic/Latino veterans are affected in these areas still remains an open question that needs to be addressed.

The second goal of this study was to explore the relationship between levels of adjustment and an individual's demographic characteristics. Experiencing stressors, such as, combat, PTSD, or TBI, has been linked to later adjustment issues for military veterans (Hoge et al., 2008). Moreover, how military veterans cope with such issues post deployment also has an impact on readjustment, therefore, it is critical to examine how individuals with such characteristics adjust to civilian life. These questions will be examined through an exploratory and quantitative study using survey data on a sample of Hispanic/Latino U.S. military veterans readjusting to civilian life post deployment to OEF/OIF.

CHAPTER III

METHODOLOGY

Sample

This study surveyed Hispanic/Latino U.S. military veterans who deployed at some point during their service to Operation Enduring Freedom and or Operation Iraqi Freedom. In order to determine eligibility participants were asked to answer five "yes" or "no" questions in an online screener. The five questions asked were the following: 1. Are you 18 years old or older? 2. Have you ever served and been a member in the U.S. military service? 3. Are you currently an active member of the U.S. military? 4. Did you or your unit ever deploy to Operation Enduring Freedom (OEF) or Operation Iraqi Freedom (OIF)? 5. Do you identify as Hispanic or Latino?

A total of 34 participants completed the online screener,19 were ineligible given the screener requirements. As stated, participants self screened via an online study screener (Appendix A) and those who did not meet the above mentioned criteria were excluded from the sample. Nine participants were excluded because they were currently in active duty and thus not considered to be military veterans. Four were military veterans but did not deploy to OEF/OIF and two did not serve in the U.S. military at all. A total of four participants were eligible to continue to the survey but did not complete any portion of the survey. Only 15 qualified and continued on to complete the survey questionnaire.

The final sample of participants for this study was a total of 15 self-identified military veterans from the U.S. armed forces. Sample participants came from diverse

areas of service such as Army (n=5), Marines (n=6), or Navy (n=4). Sample participants reported serving in military service between the years of 1994 and 2009.

All participants had to self identify racially/ethnically as Hispanic or Latino. Participants were then asked to specify Latin ethnic identity by specifying origin: 1. Mexican 2. Mexican-American/Chicano 3. Puerto Rican 4. Cuban 5. Central American and 6. South American. The majority of participants, 73%, identified as Mexican and Mexican-American/Chicano (n=11). Only one participant identified as Puerto Rican. Moreover, 20% of participants reported identifying ethnically from Central and South America (n=3), including Venezuela and El Salvador.

This study consisted of 93% male participants (n=14) and one female participant. Participants were at least 18 years old or older at the time of the survey and ranged in age from 24 to 35 years old (M=28.27, SD=3.305). The majority of the participants identified as living in California (n=10), while others reported living in New York (n=1), North Carolina (n=1), Ohio (n=1), Virginia (n=1), and Argentina (n=1). In order to complete the survey, participants had to have access to a public, work or personal computer, read English, and have access to the Internet.

Procedure

Due to the lack of literature on the Hispanic/Latino military veteran population this study used a quantitative exploratory method with a non-probability sample. Recruiting for this study was difficult and therefore a purposive sampling method was used. Recruiting may have been difficult due to the sample being a vulnerable and hard to reach population. It appears that the following reasons may have contributed to the lack of sample participants: (1) The lack of incentive, (2) The limited amount of recruitment

time, (3) The requirement that participants had to have access to a computer and the internet and (4) VA Health agencies were not used as recruitment sites. Government agencies such as the VA Health Centers could not be used in this study's recruitment methods, because VA agencies required lengthy Internal Review Board procedures. These reasons may have impacted the sample size to be small.

In order to ensure the confidentiality and anonymity of participants, this study was accessed online via a URL address provided by www.surveymonkey.com. Participants were recruited online, through search engines and social networking pages. Online public social networks included facebook.com, myspace.com and craigslist.com. An online flyer (Appendix B) was created and posted in discussion boards on facebook.com and on bulletin boards on a myspace.com page. Comments with study information were left on group pages specifically aimed at OEF/OIF veterans. Examples of some of the social groups in facebook.com included; Student Veterans, Citrus College Veterans Association, OEF/OIF Veteran and Supporters, OEF/OIF Veterans, Vet4vet, and OIF Warriors. In addition to posting on bulletin boards, mass e-mails were sent directly to members of aforementioned groups. E-mails consisting only of a study flyer were sent to staff in organizations aimed at providing support services to military veterans, as they themselves might be veterans. The same flyer was used as an ad on Craigslist.org and posted under the *community* and *volunteer* sections in two cities, Brooklyn, New York and Los Angeles, California. Craigslist.com did not allow for multiple postings; therefore, these were the only locations that were used.

Recruitment at military veteran and government institutions was not possible due to separate Internal Review Board procedures needed for approval by those institutions.

However, paper flyers advertising the study were posted in public venues near Veteran Administration Health centers and Vet Center locations. Flyer locations included bus stops, bulletin boards, coffee shops, and libraries. Flyers directed participants to a URL provided by Survey Monkey where they consented to the online study and continued on to the survey questionnaire. The survey took approximately 10 to 15 minutes, all questions were voluntary in nature and participants were given the option of not responding or terminating their participation in the survey at any time. Interested participants screened themselves and read an online informed consent form (Appendix C) and if eligible, consented, and continued to the survey. Survey Monkey provided data with arbitrary and unique identification numbers. The only identifying information obtained was the participant's IP address, known and protected by Survey Monkey.

Ethics and Safeguard

There were few risks for participating in this study. Participation in this study potentially brought forth uncomfortable feelings for participants, as they were asked to reflect upon their experiences as military members, as well as, veterans. Questions in the survey asked participants to reflect on stressors faced during their own readjustment phase which may have been sensitive and brought up some disturbing thoughts, feelings and memories. Questions regarding how true some statements were regarding deployment experiences may remind participants about those individuals still involved in OEF/OIF, which could have potentially brought up feelings of sadness and guilt. Participants were asked the following two questions regarding combat: (1) Were you in a combat zone while in OIF/OEF? and (2) Were you involved in combat while in

OIF/OEF? Answering whether or not one has been in a combat zone or in combat might be emotionally triggering.

The Human Subjects Review Board (HSRB) at Smith College approved this study's recruitment method (Appendix G), questionnaire, resource page and flyers. This researcher protected participants by providing the study's goal, an informed consent form that explained the voluntary nature of participation, anonymity, and the right to discontinue the survey at any time. Additionally, a resource page (Appendix D) was provided at the end or at the termination of the survey. Ineligible participants were also directed to a "thank you" and resource page. Moreover a veteran service's resource page was provided at the end or at the time of termination of each survey to ensure that all participants could obtain services if needed.

Measures

Demographic questionnaire (Appendix E). Demographic questions sought to explore the characteristics of the study sample. The participants were asked to answer "yes" or "no" or to fill in questions regarding: gender, age, state of residence, military branch served, reserve status, ethnicity, marital status, education level, if deployed to OEF or OIF, if stationed in a combat zone, if involved in combat, and number of times deployed. Other questions asked participants if they had ever been diagnosed with Post-traumatic Stress Disorder (PTSD) or a Traumatic Brain Injury (TBI). Participants were also asked if they were currently seeking medical or mental health services from the Veterans Administration Medical centers. The demographic questions were created through a review of the literature, including post deployment assessments such as the Post Deployment Health Assessment (Deployment Health Clinical Center, 2009).

Post Deployment Readjustment Inventory (PDRI). The level of readjustment difficulty was measured by using the PDRI measure created by Dr. Lori Katz from the Long Beach, California Veterans Administration Medical Center. Dr. Katz created a 36 item inventory that examined if veterans were having a slight, moderate or considerable level of difficulty in their post deployment adjustment. Dr. Katz provided verbal permission for this researcher to use the PDRI scale and scoring method. Dr. Katz reports reliability and significant findings of the PDRI scale with the 36 items in an article currently in press. Moreover, Dr. Katz examines the reliability of the PDRI with a diverse sample of military veterans in several manuscripts in preparation.

The PDRI scale yielded an overall readjustment score post deployment and a score for each of the following subcategories (1) Career, (2) Health (3) Intimate Relationships (4) Social Readjustment (5) Concerns About Deployment, and (6) PTSD Symptoms. The questions in the PDRI ask respondents to report how true each item was since returning home from deployment. Items were rated on a Likert scale of one to five, with one being "Not at all," three being "Somewhat" and five being "Extremely" true. Based on responses given a total score was tallied, summed and reported as a slight, moderate, or considerable level of readjustment difficulty.

Of the 36 questions asked, five to six questions were designed to make a category. For example, to determine the adjustment level of the Career category, five questions were asked. Instructions to the five questions began by stating "*please rate how true the following is since your return from deployment":* (1) Feeling pressure to work, (2) Feeling unmotivated to work, (3) Wanting to work but not being able to, (4) Having difficulty finding a job, and (5) Not knowing what to do next. Answer options for all

questions were on a scale of one to five, with one being “Not at all” and five being “Extremely.” A total sum of answer options to the five questions mentioned above were then tallied and a cut off score and scale was used. The following cut off scores were used: 10 or below was considered to be “slight,” a score between 11-19 was “moderate,” and a 20 or above was scored as a “considerable” level of difficulty to adjustment. There were only three possible categories that scores could fall into, *slight, moderate*, or a *considerable* level of difficulty of adjustment. For example a score of 10 or below meant that the participant was categorized as having *slight* difficulty in his/her readjustment level. A *slight* level of difficulty refers to a less severe stressful level of readjustment. Respectively, a score of 20 or above was considered a severe form of readjustment difficulty. The Career score would be the sum of answer options that the respondent specified in the five questions mentioned above.

The same method was used to score all six categories; however, the categories of PTSD symptoms, Social adjustment, and Concerns of Deployment had six questions instead of five. Therefore, a different rating scale with higher cut off scores was used to score these specific categories. Although a different scale was used for these aforementioned categories, scores were consistent in yielding a *slight, moderate or considerable* level of difficulty.

The total and overall score was obtained by combining the sum of each category. By adding the scores from Career, Health, Intimate Relationships, Social adjustment, Concerns of deployment and PTSD Symptoms, an overall adjustment score was obtained. The total score was then categorized as *slight* (72 or below), *moderate* (73-144), or *considerable* (145 or above). A higher score was indicative of participants reporting a

considerable level of readjustment difficulty. A lower score indicated a slight, less severe level of readjustment difficulty.

Analysis

This study used descriptive statistics to analyze the demographic data. For the PDRI questionnaire, a scoring sheet for the PDRI was used to calculate six subcategory scores and one overall adjustment score. Moreover, inferential statistics were used to analyze relationships between characteristics and outcomes. Of the 15 completed surveys four participants each skipped one question in the PDRI section. The missing answer was coded as a zero, as this may have the least effect on the overall score of the participants. This study sought to explore adjustment issues among a Hispanic/Latino sample. The first goal of the study was to obtain and understand the overall adjustment score, post deployment, for Hispanic/Latino U.S. military veterans. Part of this goal was to examine the individual categories for this population and explore the most and least problematic areas. The second goal of this study was to explore the relationship between levels of adjustment and individual's characteristics.

CHAPTER IV

FINDINGS

This was an exploratory study with two main goals. The first goal of the study was to obtain and understand the overall adjustment score, post deployment, for Hispanic/Latino U.S. military veterans. Part of this goal was to examine the individual categories of the PDRI scale and explore what was the most and least problematic area for this population. The second goal was to explore the relationship between social adjustment and demographic characteristics. With the use of the PDRI, a quantitative measure, an analysis was conducted which obtained an overall adjustment score for each participant. Analyses explored if particular domains (i.e. Career, Health, Social Adjustment, Intimate Relationships, PTSD Symptoms and Deployment Concerns) were found to be more problematic or difficult than other categories for Hispanic/Latino veterans. Descriptive and inferential statistics were used to analyze characteristics of sample participants. Through the use of independent t-test analyses and the use of the PDRI scoring and descriptive statistics, results are explained and charted in this chapter. Due to a small sample size, the external and internal validity of findings is not reliable and should not be read as such. However, some assumptions and inferences can be made for further exploration. This chapter contains sample characteristics, descriptive analyses of the six dimensions of the PDRI, and analyses to examine the relationships between PDRI score and sample characteristics.

Descriptive Statistics

As mentioned earlier, sample size was N=15, of which 93% of participants were male participants (n=14). It is important to note only service members who belonged to the Marines (n=6), Army (n=5), and Navy (n=4) participated in this study sample. Overall, participants reported an average of 5.6 (SD=2.29) years in service with 67% of participants serving three to five years, and the remaining participants serving six to ten years. Participants reported discharge dates between 2004 and 2009 and table 1 depicts the number of individuals discharged from active duty per year.

Table 1. Frequency and Percentage of Individuals Discharged Per Year

Year Discharged	*Frequency*	*Percent*
2004	2	13%
2005	2	13%
2006	3	20%
2007	3	20%
2008	3	20%
2009	2	13%
Total	15	100%

(Percentages might not add up to 100 due to rounding.)

Highest educational level reached. Overall, participants reported having a high school diploma and some college experience. Results suggest that *some college* (67%) best categorized this sample (n=10). However, it is important to note that the question did not specify what type of college program or length of time. For example, *some college*

can include: community, trade, or four year college. Table 2 shows the education categories for highest education level reached.

Table 2. Frequency and Percentage of Individuals Educational Level

Educational Level	*Frequency*	*Percent*
Some College	10	67%
High School Diploma	3	20%
College Degree	2	13%
General Equivalency Exam (GED)	0	0
Total	15	100%

Employment and marital status. Overall participants reported working, with 73% of participants being *employed* either full or part time (n=11). Table 3 describes employment status of the sample. In relation to marital status, 46% of participants identified as being married or living together with a partner at the time the of survey (n=7), while the remaining participants reported being single (n=4), divorced (n=3), or separated (n=1).

Table 3. Employment Status

Employment Status	*Frequency*	*Percent*
Employed Full Time	10	67%
Unemployed	3	20%
Employed Part Time	1	7%
Student (not employed)	1	7%
Total	15	100%

(Percentages might not add up to 100 due to rounding.)

Self Reported Mental Health Diagnoses of PTSD and TBI

Participants were asked whether or not they had ever been diagnosed with Post Traumatic Stress Disorder (PTSD) or Traumatic Brain Injury (TBI). Nine of the participants reported they had not been diagnosed with PTSD, while four participants reported they had been diagnosed with PTSD in the past. The remaining participants either reported being unsure of a diagnosis (n=1) or omitted their response (n=1). Moreover, 87% of participants self reported that they had not been diagnosed with a Traumatic Brain Injury (n=13). However, those who reported a TBI diagnosis also reported being diagnosed with PTSD (n=2).

Moreover, in examining the role of ethnicity and diagnosis and health care services, ethnic group differences were found. Although this study had a very limited and small sample size, specific ethnic differences were noted by the PTSD diagnosis, with more Mexican, Mexican-American/Chicano reporting more often a PTSD diagnosis compared to veterans from Central and South America. Similar numbers were found for

those reporting mental health and medical services received. Table 4 describes those diagnosed with PTSD and those seeking services at VA Medical Centers.

Table 4. Frequency of Individuals Ethnicity, PTSD Diagnosis and VA Services Received

Ethnicity	Diagnosed with PTSD	Receiving MH Services	Receiving Medical Services
Mexican	3 (20%)	3 (20%)	2 (13%)
Mexican-American/Chicano	1 (7%)	1 (7%)	2 (13%)
South American	0	1 (7%)	1 (7%)
Puerto Rican	0	0	1 (7%)
Central American	0	0	0

Deployment, Combat Zone, and Combat Involvement

Participants were asked to specify whether or not they had been deployed to Operation Enduring Freedom, Operation Iraqi Freedom or both. Seventy three percent of participants had been deployed to both conflicts, OEF and OIF at least once (n=11). Three participants indicated serving only in OIF and (7%) only served in OEF (n=1).

While in OEF, 60% of participants reported being in a combat zone. However, only 27% reported being involved in combat (n=4). Moreover, six participants responded that they were *not* involved in combat, two did not answer this question and for three participants, this question was not applicable, because they did not serve in OEF. *While in OIF,* 87% of participants reported being in a combat zone, moreover, almost half of those participants (47%) reported being involved in combat (n=7). Seven participants

responded that they were not involved in combat, and for one participant this question was not applicable, because he/she did not serve in OIF. Fifty three percent of the sample responded that they were involved in combat while in *either OEF or OIF* (n=8). However, this number does not include those who said "yes" to being in combat at *both OEF and OIF*. A total of three participants (20%) reported being in combat while at OEF *and* OIF.

Mental Health and Medical Services

Participants were asked to report their current medical service use. It is important to note that the survey questions asked specifically *Are you currently receiving medical services from the Veterans Administration Health Services* and *Are you currently receiving mental health services from the Veterans Administration Health Services*, answer options were either *yes* or *no*. Even though respondents answered the following, it is unclear if participants were seeking services elsewhere. The following two tables (i.e. Table 5 and Table 6) show results regarding mental health and medical care utilization of sample participants.

Table 5. Mental Health Services Received at VA

Mental Health Services at VA	*Frequency*	*Percentage*
Yes	5	33%
No	10	67%
Total	15	100%

Table 6. Medical Services Received at VA

Medical Services at VA	*Frequency*	*Percentage*
Yes	6	40%
No	8	53%
Missing	1	7%
Total	15	100%

Post Deployment Readjustment Inventory Results

Results showed that 60% of participants were having a *moderate* level of readjustment difficulty post OEF/OIF deployment. The overall adjustment scores for participants in this study are explained in figure 1. After calculating the scores for each category a sum was obtained and the overall PDRI score was calculated. Figure 1 shows how many participants fell into each of the three scoring categories. Figure 1 shows the number of participants on the *(y axis)* and in relation to how they rated their level to overall readjustment difficulty is noted on the *(x axis).*

Figure 1. Level of Readjustment Difficulty Post Deployment

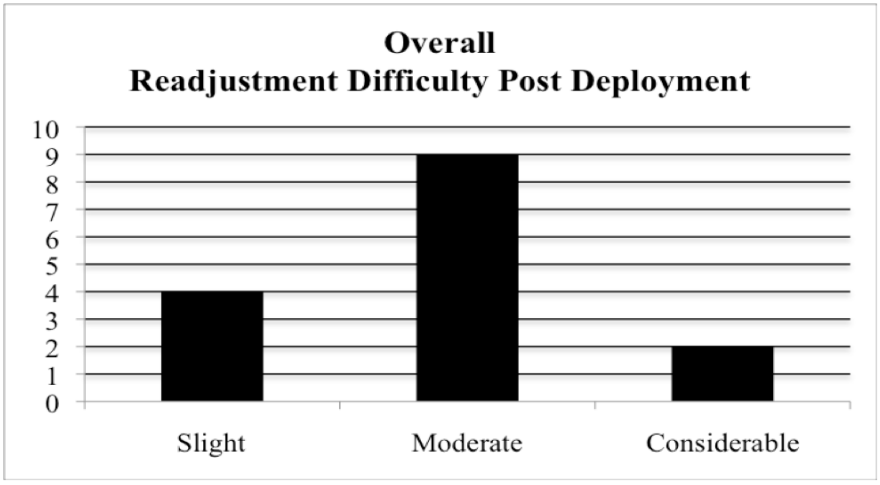
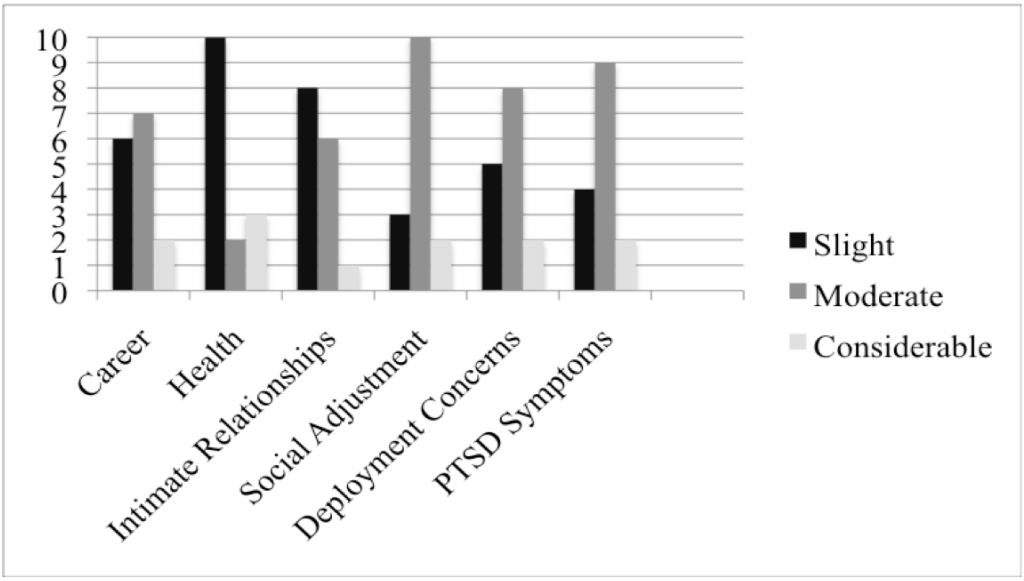


Figure 2 depicts the number of participants *(y axis)* that scored and were placed into the *slight, moderate* or *considerable* category for each of the specific six PDRI dimensions *(x axis)*. For example, 10 participants (67%) rated having a *slight* level of readjustment difficulty to the *Health* dimension. Participants reported having at least a *moderate* level of readjustment difficulty to the following categories: (1) Social Adjustment (67%), (2) PTSD Symptoms (60%) and (3) Deployment concerns (53%). A total of (80%) of participants indicated experiencing a *moderate* and *considerable* level of readjustment difficulty to Social Adjustment. The Social Adjustment category is important to note as this category asks for feelings of relating to social environments, community and whether or not one feels connected to others. Questions asked if participants were: *feeling pressure to be "back to normal," not fitting in socially, changed or others have changed, others don't understand what I went through, feeling alienated or alone, not wanting to talk about my experiences*. Results indicate that participants reported having at least a moderate level of difficulty to social adjustment. This finding may indicate that participants are having difficulty connecting to his/her community, family, friends and or social support networks.

Figure 2. Post Deployment Readjustment Dimensions



Fifty three percent of participants reported being discharged within the last two years, 2007 to 2009, of which 40% reported having a *moderate* level of readjustment difficulty (n=6). Similarly, 47% of participants discharged from active duty three to five years ago, 2004 to 2006, reported a 20% *moderate* and 20% *slight* level of difficulty. Also, PDRI findings show that although (73%) of participants were employed, (47%) reported having a *moderate* level of readjustment difficulty in the Career category. Although participants indicated being married, or living with a partner at the time of the study, the PDRI results show that (53%) of participants reported having only *slight* readjustment difficulty in the Intimate Relationship category.

Findings within the PTSD Symptoms category demonstrate a (60%) *moderate* level of difficulty. The majority of participants (73%) in this sample were deployed to both OEF and OIF (n=11), this may have greatly impacted participants and as a result more PTSD symptoms are reported. Even though only a total of four participants reported being diagnosed with PTSD, participants might have some acute stress responses due to

deployments. Moreover, given that sample participants were deployed at least once to both operations, OEF/OIF, participants could have been more susceptible to stress, combat, and possible loss of supports and thus reported more moderate levels of PTSD symptoms. As stated before, the number of deployments greatly affects health and mental health outcomes.

Findings among the Deployment Concerns category indicate that (67%) reported a *moderate* to *considerable* level of difficulty. Deployment Concerns specifically asked questions regarding: *worried about soldiers still deployed, mourning the death of fellow soldiers, missing structure and focus of deployment, life is on hold (could be redeployed), everything seems trivial since* deployment and *feeling useless since returning home*.

Results on the Health category indicated that (67%), more than half of participants reported only having a *slight* level of difficulty in readjustment to health post deployment, yet, interestingly (40%) of participants answered "yes" to receiving medical services at the VA medical centers. Questions regarding health stated: *having chronic pain, having health problems, my body not functioning like it used to, feeling like I am deteriorating* and *having lots of medical appointments*.

Relationship between PDRI Adjustment and Demographic Variables

A Pearson correlation was used to determine if there was a relationship between years served, the subscales and total PDRI score, however, no significant correlation was found. An independent t-test was used to determine if there was a difference in the mean score of those who were married or living with a partner compared to participants who were single, divorced or separated. No significant difference was found in any of the subscales or the overall PDRI score. Marital status with total PDRI adjustment score

yielded no significant findings. A one-way ANOVA was used to determine if there was a difference between mean of years served and overall PDRI score, results suggest no significant differences were found, overall adjustment score was not influenced by the amount of years individuals were in service. An independent t-test was used to determine if there was a difference in total adjustment score by whether or not participants were involved in actual combat (OIF or OEF) and no significant difference was found.

Relationship between PTSD diagnosis and PDRI dimensions

The goal of the following analyses is to examine whether there were differences in PDRI dimensions for those diagnosed with PTSD versus those with no PTSD diagnosis. Table 7 shows means and standard deviations regarding PTSD diagnoses with PDRI category scores and overall readjustment score. Independent t-tests for equality of means examined those who were diagnosed with PTSD (n=4) compared to those who were not (n=9), on PDRI categories. Table 7 depicts significant findings between those diagnosed with PTSD and those who were not. Compared to those with no PTSD diagnosis, individuals diagnosed with PTSD scored higher on Health, t (11) = 2.215, p = .049, Intimate Relationships, t (11) = 4.653, p = .001, Social Adjustment, t (11) = 3.203, p =.005, Deployment Concerns, t (11) = 4.053, p = .002, and PTSD Symptoms, t (11) = 3.571, p = .004. A higher score was also found on the overall PTSD total score, with those being diagnosed with PTSD having higher levels of difficulty compared to those not diagnosed with PTSD, t (4.001) = 3.500, p = .025. These findings suggest that those diagnosed with PTSD are having more difficulty with readjustment in each of the subscales noted above. The overall adjustment score was also significant and thus it is suggested that those with a PTSD diagnosis were reporting much more difficulty in

overall readjustment post deployment. However, interestingly no significant differences were found in the Career score, suggesting that a diagnosis of PTSD may not impact adjustment in the category of career. It may be the case that with such a small sample size the groups differences are two small to be measured. Table 7 shows means and standard deviations for PDRI categories based on a PTSD diagnosis.

Table 7. Means and Standard Deviations for PDRI categories based on PTSD diagnosis

Category Score	Diagnosed with PTSD Mean (SD)	Not Diagnosed with PTSD Mean (SD)	Significance
Career	15.25 (7.274)	9.44 (3.609)	ns
Health	16.50 (5.916)	9.78 (4.684)	.049*
Intimate Relationship	18.75 (2.872)	9.33 (3.536)	.001**
Social Readjustment	24.75 (5.058)	16.11 (4.256)	.005**
Deployment Concerns	24.00 (4.899)	13.67 (3.969)	.002**
PTSD Symptoms	32.25 (5.909)	19.56 (5.918)	.004**
PDRI Total Score	131.500 (28.443)	77.889 (17.084)	.025*

ns= not statistically significant
*p≤.05 ; **p≤.01

Relationship between Mental Health Utilization and PDRI Dimensions

Lastly, table 8 demonstrates significant findings for the group of those receiving mental health services at a VA setting (n=5) versus those who were not (n=10). T-tests were run to determine if those using mental health services from the VA had different scores on the subscales than those not using such services. Significant differences were

found in the total PDRI score and the Interpersonal Relationship, Social Adjustment, Deployment and PTSD Symptoms subscales. Compared to those not using mental health services at a VA, individuals who did use VA services scored higher on adjustment concerns in Intimate Relationships, t (13) = 3.762, p = .002, Social Adjustment t (13) = 2.685, p = .019, Deployment Concerns t (13) = 3.706, p = .003, and PTSD Symptoms t (13) = 2.980, p =.011. This suggests that the group that was using mental health services had higher means on each subscale than the group that was not using VA mental health services and thus struggling with more readjustment difficulty compared to those who do not access VA mental health services. Individuals who seek mental health service at a VA facility report struggling with more readjustment difficulty compared to those who do not access VA mental health services, t (4.944) = 2.720, p = .042.

Interestingly, there were no significant differences in the categories of Career or Health, suggesting that utilizing mental health services at the VA may not have an impact on readjustment difficulty in career or health, or that such a small sample size does not allow possible differences to be detected.

Table 8. Means and Standard Deviations for PDRI categories based on receiving MH services at VA

Category Score	Receiving MH Services Mean (SD)	Not Receiving MH Services Mean (SD)	Significance
Career	14.40 (6.580)	9.40 (3.502)	ns
Health	14.40 (6.950)	9.90 (4.280)	ns
Intimate Relationship	17.00 (4.637)	9.00 (3.496)	.002**
Social Readjustment	23.00 (5.874)	15.90 (4.280)	.019*
Deployment Concerns	22.40 (5.550)	13.40 (3.836)	.003**
PTSD Symptoms	29.60 (7.829)	19.10 (5.705)	.011**
PDRI Total Score	120.80 (34.339)	76.70 (16.466)	.042*

ns= not statistically significant
*p≤.05 ; **p≤.01

It is important to note that statistical analyses that were done and could have been done were extremely limiting due to sample size. Results were inferred and should be read only as speculation as the sample size does not render this information generalizeable. The following section will interpret with caution the following results. The discussion of this study will mostly suggest possible implications for future research as this sample size was extremely limiting.

CHAPTER V

DISCUSSION

This exploratory study sought to investigate the readjustment issues among a Hispanic/Latino U.S. military veteran sample. The first goal of the study was to obtain and understand the overall readjustment score, post deployment, for OEF/OIF Hispanic/Latino U.S. military veterans. Part of this goal was to examine the individual categories for this population and to explore the most and least problematic areas of adjustment. The second goal of this study was to explore the relationship between levels of adjustment and the individual's characteristics. The following chapter describes the findings in detail discussing results and study limitations.

Post Deployment Readjustment Inventory

The overall level of readjustment difficulty score indicates that Hispanic/Latino veterans were moderately readjusting to civilian life post deployment. Moderate difficulty implies that the readjustment stress might not be as severe, however, it is still significantly affecting the veteran's overall quality of life, such results indicate some difficulty in readjustment for this population. This finding was not surprising as previous research suggests that deployment is linked to challenges in transitions (Hoge et al., 2004). Moreover, there may be many other post deployment factors that affect a racial or ethnic minority. For example, Kulka and colleagues (1990) reported more adjustment difficulties and higher rates of PTSD in ethnic minorities, specifically in Hispanic combat veterans.

Most Problematic Adjustment Categories

Several dimensions of the PDRI show high levels of adjustment concerns. The most problematic dimension was the Social Adjustment category with a 67% *moderate* level of readjustment difficulty post deployment. This finding indicates that post deployment may impact interpersonal functioning and therefore social adjustment. The social function of Hispanic/Latino military veterans is important to note as recent studies suggesting a higher risk for suicide in military combat veteran population may put certain groups with difficulties adjusting socially more at risk (Brenner et al., 2008). Moreover, social adjustment may impact social relationships such as family, friends, colleagues, and co-workers. Individuals who have difficulty belonging or feel as though they are a burden to their families or communities might be struggling with social adjustment difficulty and thus may be at an increased risk for poor mental health outcomes (Brenner et al., 2008). The value of *familismo* or *familism* may hinder the Hispanic family member, or make it so that readjustment is unique or difficult. Due to value of cohesion and familial support Hispanic/Latino military veterans may not want to burden the family system, and therefore, not seek their support systems in belief of not wanting to burden the family. The role of male gender roles among the family system may also impact the ability for the military veteran to seek familial support as he might be an essential male figure, who is supposed to be seen as the strong, resourceful provider.

A significant finding related to social adjustment was that the PTSD symptoms category also had higher means, indicating possible PTSD symptoms even though there was no official PTSD diagnosis. This implies that social adjustment might be affected

and attributed to possible PTSD symptoms. Furthermore, social adjustment score is important to note because difficulties in interpersonal functioning might increase impairment. Social Adjustment difficulties might be related to ways in which Hispanic/Latino veterans navigate amongst their community, relationship and family settings upon their return post deployment.

A total of 27% of the sample reported being diagnosed with PTSD. This finding suggests that soldiers who are returning post deployment are reporting higher PTSD symptoms and other mental health conditions compared to previous research. Indeed, this percentage is much higher than the 17% found among post deployed OIF military soldiers as noted by Hoge and colleagues (2004).

Intimate Relationships

Veterans indicated mostly a *slight* level of readjustment difficulty in the Intimate Relationships category. Intimate relationships were rated less severe than the remaining five categories. This is an interesting finding, as it does not support previous research by Nelson Goff and colleagues 2007 who found that intimate relationship satisfaction was lower among military veterans and their partners, thus causing more intimate relationship difficulties. It is important to distinguish between intimate sexual relationships versus relationships with family members, which this measure did not specify. It is also important to refer to the marital status of the sample size as that may indicate less intimate relationship hardships, for example, 53% of participants reported not currently being in an intimate relationship. It is possible that this population has lower levels of intimate relationships due to post deployment stressors.

Seeking Mental Health Services

Those who sought mental health services at a VA health facility indicated more *moderate* responses in the overall PDRI score compared those who did not seek services. Those seeking mental health services also had significantly different means in the PDRI subcategories, than those who were not receiving mental health services. Findings indicate that those seeking services reported more stress or readjustment difficulties among Intimate Relationships, Social Adjustment, PTSD Symptoms, and Deployment Concerns. These findings suggest that stressors were experienced much more among those categories mentioned.

Moreover, there were no statistically significant differences between those who did seek mental health services and those who did not in the Health and Career categories. Whether or not individuals used mental health services did not statistically distinguish individuals in the category of health. This finding may suggest that those who were seeking mental health services may not see health as a concern given the fact that they are already receiving assistance. On the other hand, a lack of statistically significant differences in the category of health between those seeking services and those who did not may be a result of a small sample size. When further examining means for each group, mental health service seekers report a higher mean (M=120.80) compared to those who do not seek mental health services (M=76.70). This finding is interesting as it questions service utilization in regards to self-rated health outcomes. Future research should examine if those who seek mental health services are fairing better in health outcomes. Future research should also examine why those who are seeking mental health

services are able to do so as barriers to care have been shown to be a growing concern (Hoge et al., 2004).

It is unclear how seeking services impacts concerns about employment issues. It can be inferred that because 73% of the sample was at least employed part time, participants may not have much stress regarding career concerns. Overall, 40% of the sample report low levels of adjustment in the category of career. Employment at least part time may provide a buffer to stress and level of readjustment difficulty in the Career category. Questions as to what role seeking mental health services has on career adjustment are important to explore in future research. The type of employment that military veterans are seeking is crucial to explore. If the type of employment that a veteran can obtain reflects the structure they had during their military career, then adjustment into a civilian career may be less difficult. Exploring careers that veterans seek out is important to investigate.

Interestingly enough, it was found that individuals who sought mental health services reported having been diagnosed with PTSD at some point in the past. There were no significant differences noted in the Career category for those who were diagnosed with PTSD and those who were seeking mental services. These results may indicate that those diagnosed with PTSD and who are employed might be able to function and fulfill their role by obtaining a sense of self efficacy and self esteem due to being employed. This finding may also indicate that being a male provider in a family system with cultural norms such as *familism* may make it so that those with employment may fair better in readjustment. This finding may also indicate that those seeking mental

health services were possibly adjusting as well to career as those not seeking mental health services.

Deployment Concerns

The Deployment Concerns category explored veterans feeling and ruminating thoughts regarding current soldiers in OEF/OIF. Veterans might be, worried, and concerned regarding other soldiers in OEF/OIF, therefore making their own readjustment to civilian life more difficult. This category also sought to explore feelings of unresolved finished business in OEF/OIF. It is an important area to explore as 53% of participants reported having a *moderate* level of difficulty in readjustment to this category. Veterans might be expressing wishes or desires to go back to duty as an obligation, which in turn may play an important role in the veterans overall readjustment. It is also assumed that possible survivor guilt may play a role in their anxiety or worry about current soldiers in a deployed setting, making it difficult for veterans to readjust to civilian life. This category makes a unique contribution to our understanding of adjustment and well-being of military veterans, as previous research has not directly addressed this concept (Katz, *in press*).

Ethnicity

A higher percentage of Mexican and Mexican-American/Chicano participants reported a PTSD diagnosis. A total of four participants (27%) reported a PTSD diagnosis in the past and 13% reported a TBI diagnosis, all of which were of Mexican, Mexican-American/Chicano ethnicity. The finding mentioned above notes that 27% of individuals who reported a diagnosis were of similar ethnic background and it is important to examine given that no other ethnicities within the Latino/Hispanic sample reported a

PTSD or TBI diagnosis. However, the study did not have a very diverse sample, given that only four other participants with different ethnicities were represented. Yet, it is interesting to explore differences among the Hispanic/Latino population as there might be cultural strengths, norms, beliefs and resources that may attribute to the high prevalence of PTSD diagnoses in Hispanic/Latino veterans. Previous research suggests that individual characteristics before enlisting will have an influence upon the impact of deployment on the individual (Maclean & Elder, 2007). Issues such as income, health, and education level before deployment will determine the level of adjustment post deployment.

Limitations

There were several limitations in this study. One limitation was the small sample size of 15 participants who completed the online survey, therefore, results cannot be generalized to the larger OEF/OIF Hispanic/Latino military population. Many inferences were made and they should be read with caution. The sample size also influenced the amount of analyses available, limiting our understanding of the relationships of various variables at a time. Correlations between ethnic groups was prevented due to only four other ethnicities reported among the Hispanic/Latino population, also no differences among gender were possible due to only one female participant, therefore limiting the Latina female experience.

Another limitation to this study was that it was an online survey. While using the internet provides a sense of anonymity given that there is no human contact, it limited the sample to individuals who had access to the Internet, a computer and a social networking page. Those who are using social networking sites might be fairing better in social

adjustment due to the social connections accessed online. This reality can therefore limit findings to a healthier more adjusted population. On the other hand, participants accessing online social networking pages might be avoiding friends and family and isolating themselves by using the Internet as a way to connect with strangers via email, www.myspace.com or www.facebook.com.

The diversity of the sample in both gender and ethnic subgroups was another limitation. The sample was compromised of male participants with only one female participant. Gender may play a role on how individuals adjust, as literature is emerging regarding specific challenges that women in a deployment setting might face (Katz, Bloor, Cojucar & Draper, 2007). The already small sample of Hispanic/Latino military veterans was not very diverse in terms of ethnic and cultural identity. The majority of the sample reported being Mexican, or Mexican-American/Chicano. Military veterans with ethnic background from central and South America may have had a different upbringing or experience in the U.S. compared to Puerto Rican veterans.

Lastly, the type of questions included in the assessment limit our understanding of the experience of Hispanic veterans. The questionnaire could have included the following questions or measures: (1) Job duties while in service and post deployment, to better understand type of work and duties in a deployed setting. Post deployment job duties may help explain the type of skills that are being transferred from military to civilian employment. (2) Deployment stressors experienced while in the deployment setting, such as being ambushed or shot at, seeing dead bodies, Improvised Explosive Device's (IED), lack of sleep, harsh weather conditions etc. (3) Cultural values and levels of acculturation, as both are different areas that may be pertinent to Hispanic/Latino

veterans. The measures and questions mentioned above could have helped explain the lack of group differences in the area of career, as well as, elaborate upon the role that culture plays on adjustment.

Implications

Trauma, racism and discrimination may continue to affect ethnic minorities in the U.S. Trauma and combat are a real possibility for current soldiers involved in OEF/OIF. Race related trauma and discrimination is a real possibility for ethnic minorities. Future studies should explore those most at risk for developing trauma related stress and a potential PTSD diagnosis especially after deployment to a combat setting. Combat veterans will be returning in large numbers from both conflicts in Afghanistan and Iraq, services should be created and catered to their specific challenges and needs. Similarly, racial and ethnic minorities are also in need of culturally relevant services.

More information regarding Hispanic/Latino veterans' needs post military life and deployment is important so that interventions can be created to enhance well-being in all areas of the their civilian life. Health care providers need to have a better understanding of how military personnel deal with some of the challenges faced in their transition into civilian life. Clearly, those discharged have been greatly impacted by military life, war or deployment at some point in their service to our country. The physical health and emotional well-being of military personnel are critically affected by their time in service (MacLean & Elder, 2007; Maguen et al., 2006). Military personnel are at considerable risk of developing a range of psychopathologies (Gould, Greenberg & Hetherton, 2007 p.505). In order to create appropriate interventions, more research is needed on learning

about the protective factors that can assist specifically the military veteran population in their transition back into civilian life.

The Department of Defense and the Veteran Administration (VA) should not be the only entities responsible for providing services for our military veterans. In 2005, the VA projected that 23,000 veterans would seek treatment, however, it has since been revised upward to 103,000 (Hoshmand & Hoshmand, 2007). A lack of access and barriers to VA services such as; stigma and availability (Hoge et al., 2004) make it so that the VA alone is unable to meet the needs for returning personnel returning from Afghanistan and Iraq (Hoshmand & Hoshmand, 2007). This fact makes local communities and state funded programs as supportive resources for military families a realistic need (Hoshmand & Hoshmand, 2007). The community members, health care providers and social workers need to explore ways to create interventions that will enhance military veteran's overall health and well-being.

Conclusion

This study sought to explore the readjustment level of OEF/OIF Hispanic/Latino U.S. military members, with the hope of shedding light on this vulnerable population. There is a limited amount of research that fails to discuss the reasons why Hispanic/Latino military members have poor health outcomes compared to veterans of European descent. The information gathered from this study, helped highlight the need to address social adjustment issues specific to Hispanic/Latino military veterans. The data obtained can provide useful information for providers, who can target certain issues that

are problematic within this population and create specific services that are culturally relevant.

It is important to consider how racial minorities are affected by trauma. Deployment stressors may impact life outcomes and potentially be a traumatic event in the soldier's life span. Ethnic minorities are an underserved population and it is important to seek reasons as to how culture impacts an individual. Research that is currently available is centered on mostly creating one demographic category for the Hispanic/Latino population without regard to ethnicity and diversity among the Latino population. It is imperative that clinicians and researchers seek to create services that are culturally relevant. Additional research is needed and should explore:

> the significant within-group variability factors such as geographic origin, citizenship or immigration status, circumstances under which the person may have left his or her country of origin, generational level, acculturation level, educational back ground, political affiliation and socieoeconomic status (Pole, Gone, & Kulkarni, 2008, p. 41).

There is an important need to incorporate all aspects of self when considering treatment options. It is imperative to consider how culture, values, norms, race and racism all affect an individual. Most importantly, as clinicians, one must be aware of the implications that deployment stress and combat have upon ethnic minorities, most specifically Hispanic/Latino individuals.

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APPENDIX A

Study Screener

Thank you for your time and participation. The screener portion will ask questions and will cue you to the appropriate sections. Please remember that participation in this study is voluntary, confidential and anonymous. You can terminate participation in this study at any time without any penalty. Please answer the following questions:

Are you 18 years old or older? Yes____ No____

Have you ever served and been a member in the U.S. military service? Yes__ No_

Are you currently an *active* member of the U.S. military? Yes__ No____

Did you or (unit) ever *deploy* to Operation Enduring Freedom (OEF) or Operation Iraqi Freedom (OIF)? Yes__ No__

Do you identify as Hispanic or Latino?
Yes____ No____

***Not* Eligible if:**
No to question #1
No to question #2
Yes to question #3
No to question #5

If veteran is eligible, they will be cued to continue to Informed Consent and Assessment

If veteran **NOT** eligible they will get the Thank You For Your Time page and a list of services will be provided.

APPENDIX B

Online Flyer

Are you an Operation Enduring Freedom (OEF) or Operation Iraqi Freedom (OIF) U.S. military Veteran?
and Do you identify as Hispanic or Latino?

If so you might be eligible to participate in a study aimed at finding out more about

Hispanic/Latino U.S. military veterans' readjustment stressors faced after deployment!

Are you 18 years old or older?
Are you interested in volunteering 20 minutes of your time to help out a
Social Work graduate student complete her thesis?

If you answered YES to all of these questions please go to

https://www.surveymonkey.com/s.aspx?sm=mDdDMYuusMAATeQA2rYb_2fA_3d_3d

www.veteransurvey.com

for more information.
THANK YOU IN ADVANCE FOR YOUR TIME AND SERVICE!!!!!!!

For further information please contact:
Susana Ochoa at 323-907-0128
sochoa@email.smith.edu
Smith College, Northampton MA 01063

APPENDIX C

Informed Consent Form

Dear Veteran,

Hello! and thank you for your interest in participating in this study. My name is Susana Ochoa and I am conducting a brief, anonymous and confidential survey to assist with research for my Masters Thesis at Smith College School for Social Work. My research will explore how Hispanic/Latino U.S. military veterans who served in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) are facing the readjustment period, back to civilian life. Each participant's experience of the readjustment phase will be unique. It is very helpful to understand and explore the stressors and the experiences faced during the readjustment period after discharge and deployment. Your participation in this study will contribute to the research and knowledge about the challenges and situations that are commonly faced during the readjustment period to civilian life that is commonly experienced by U.S. military veterans.

Besides being a part of my Masters requirements the research will be used for my thesis, possible presentation and publication. The research study findings will be accessible via the worldwide web and stored in the Smith College library. The data from this study will contribute to the valuable research on the experiences of Hispanic/Latino OEF/OIF U.S. military veterans.

The survey will be accessed through the internet survey vehicle called Survey Monkey. Your confidentiality, anonymity and responses will be protected. Information that you provide will not be used in any way that can identify you. To be eligible for participation you need to 1. Identify as a military *veteran* of The United States Armed Forces, 2. Identify as Hispanic/Latino 3. Identify as serving in Operation Enduring Freedom or Operation Iraqi Freedom, 4. Be discharged from active duty between January 2007 and January 2009, 5. Be 20 years old or older. The survey is estimated to take 20 minutes of your time. The survey will ask demographic information such as gender, age, race/ethnicity, marital status, branch of the armed forces you belonged to and dates served.

There will be questions regarding your experiences of situations that you might or might not have experienced during your readjustment back into civilian life, for example, feeling alienated or alone, feeling tense, jittery or anxious, and having difficulty finding a job. Other personal questions relate to how many times you have been deployed and two questions of whether or not you were in a combat zone and in combat. But please remember that ALL questions are optional and you do not have to answer anything that might make you feel uncomfortable. Participation in this survey could potentially bring up uncomfortable feelings as you reflect upon your experience as a military member while serving in OEF/OIF and now as a veteran adjusting to civilian life.

The combat questions and other questions in the survey may be considered sensitive and might bring up disturbing thoughts, feelings and memories. However, you may discontinue the survey at any point once you have begun and without any penalty. A list of online and telephone referral resources will be provided for counseling and support.

There will not be any financial compensation for participating in this study. However, one benefit is the opportunity to share your experiences with others and to be a part of a research study that may increase the understanding of the readjustment difficulties faced by Hispanic/Latino U.S. military veterans deployed to OEF/OIF.

The internet survey vehicle of Survey Monkey guarantees to provide confidentiality and anonymity regarding any identifying information. I will receive a unique ID number assigned by surveymonkey.com and that will be used to identify only the survey answers you submit. I will not receive your name but Survey Monkey will obtain your URL address. All unidentified materials will be kept in a secure place and destroyed after three years.

Participation in this study is voluntary. Once you have signed onto the survey through the Survey Monkey web site, you will be able to withdraw participation at any point before you have submitted your survey. Regardless of whether you choose to discontinue before submitting your survey or if you choose to complete the survey you will be directed to a page thanking you for your time and you will have a list of support resources provided. Please keep a copy of this consent form and the resources provided for your records. Once you have submitted your survey there will not be any means of discontinuing participation, as your submission will be unidentifiable.

If you have any questions or concerns you may contact me at:
By Email: sochoa@email.smith.edu
By Phone: 323-907-0128
Or you may contact the chair of the
HSR Committee
By Phone: 413-585-7974

YOUR SUBMISSION OF THE SURVEY INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

If you choose to participate in this study, or not, I would like to offer my thanks and appreciation of your time, service and contribution.

Sincerely,
Susana Ochoa
Smith College School for Social Work

APPENDIX D

Resource Page for Veterans

1-800 Phone Numbers for Veterans

Veteran National Suicide Prevention Lifeline: 1-800-273-8255 (1-800-273-Talk)

Education 1-888-442-4551
Health Care Revenue Center 1-877-222-8387
Life Insurance 1-800-669-8477
Special Health Issues 1-800-749-8387
Telecommunication Device for the Deaf (TDD) 1-800-829-4833
VA Benefits 1-800-827-1000

ONLINE RESOURCES

VETERANS HEALTH & HEALING

Vets 4 Vet Program
http://www.vets4vets.us

Battlemind Training
http://www.battlemind.org/

The Coming Home Project
http://www.cominghomeproject.net/cominghome/

Department of VA Disability Programs
http://www1.va.gov/gulfwar

Dept of VA Returning Service Members (OEF/OIF)
http://www.oefoif.va.gov/

Gold Star Families Speak Out
http://www.gsfso.org

Heal Our Warriors
http://www.healourwarriors.org/

Healing after the War, film http://www.healingafterthewar.org/aboutthefilm.html

Iraq and Afghanistan Veterans of America
http://www.iava.org

Iraq War Veterans, Inc. (PTSD)
http://www.iraqwarveterans.org/ptsd.htm

The Lehner Foundation
http://www.lehnerfoundation.org/mission.html

Not This Time Vets
http://www.notthistimevets.org

Operation Helping Heal Inc.
http://www.helpingheal.org

The Raven Drum Foundation
http://www.ravendrumfoundation.org

Return to Honor
http://www.returntohonorworkshop.com/

United States Welcome Home Foundation
http://www.uswelcomehome.org

Veterans for America
http://www.veteransforamerica.org/

Veterans for Peace
http://www.veteransforpeace.org/

WOMEN'S ORGANIZATIONS

CodePink
http://www.codepink4peace.org/

Women Organizing Women: Veteran Advocacy
http://www.vetwow.com/

Service Women Action Center
http://servicewomen.org/projects.shtml

APPENDIX E

Demographic Questionnaire

Hispanic/Latino U.S. Military Veteran Survey
Thank you for your time and participation. You have completed the initial screener and the Informed Consent Section. The survey consists of 2 short sections. The first section consists of demographic data and questions that have you reflect on information regarding times deployed, health conditions, ethnic identity and employment. The second and last section is a set of 36 questions regarding readjustment issues that may or may not be true for you. Please remember all questions are voluntary, confidential and anonymous. You can terminate participation in this study at any time without any penalty.

Section A: Demographic Section

1. Gender: Male_____ Female_____

2. Age: _____

3. What state do you live in?_____

4. What branch of the armed forces did you serve?
   - Air Force
   - Army
   - Marines
   - Navy
   - Other:_____

5. Are you currently in the reserves? Yes____ No____ Other_____

6. Which of these best categorizes your ethnic background?

_____Mexican
_____Mexican-American/Chicano
_____Puerto Rican
_____Cuban
_____Central American. From what country? _____ (Honduras, Guatemala, Belize, El Salvador, Nicaragua etc.)
_____South American. From what country?_____ (Venezuela, Colombia, Ecuador, Peru, Brazil, etc.)

7. Marital Status:

Single Divorced Separated Married Living w/Partner Widow

8. Highest Education Level Reached:

High School Diploma GED Some College College Graduate Other

9. Dates served: From_____ To_____

10. Were you or (unit) ever deployed to Operation Enduring Freedom (OEF)? Yes___No___
    a. How many times did you deploy to a country in "theatre" WHILE IN OEF ?_____
    b. Were you in a combat zone WHILE IN OEF? Yes_____ No_____
    c. Were you involved in combat WHILE IN OEF? Yes____ No_____

11. Were you or (unit) ever deployed to Operation Iraqi Freedom (OIF)? Yes____ No_____
    a. How many times did you deploy to a country in "theatre" WHILE IN OIF?_____
    b. Were you in a combat zone WHILE IN OIF? Yes_____ No_____
    c. Were you involved in combat WHILE IN OIF? Yes____ No_____

12D. Have you ever been diagnosed with Post Traumatic Stress Disorder (PTSD)?
Yes No Unsure

13D. Have you ever been diagnosed with a Traumatic Brain Injury (TBI)?
Yes No Unsure

14D. Are you currently receiving mental health services from the Veterans Administration Health services? **Yes_____ No_____**

15D. Are you currently receiving medical health services from the Veterans Administration Health services? **Yes_____ No_____**

16D. Are you currently employed?
Yes Part Time____ Yes Full Time_____ No_____ Other:_____

APPENDIX F

Post Deployment Readjustment Inventory

Section B: Post-Deployment Readjustment Inventory (Created by Dr. Lori S. Katz, VA Long Beach)

This second section focuses on a set of statements that are very common for some individuals to encounter soon after being deployed and discharged from the military. They are readjustment feelings, situations, and scenarios that may or may not be true for you. Please rate **how true** each of the following is since your return from deployment by typing in the number that corresponds to the scale below.

Not at all	**Slightly**	**Somewhat**	**Considerably**	**Extremely**
1	**2**	**3**	**4**	**5**

1R. Feeling pressure to work

Not at all	**Slightly**	**Somewhat**	**Considerably**	**Extremely**
1	**2**	**3**	**4**	**5**

2R. Having chronic pain

Not at all	**Slightly**	**Somewhat**	**Considerably**	**Extremely**
1	**2**	**3**	**4**	**5**

3R. Feeling pressure to be “back to normal”

Not at all	**Slightly**	**Somewhat**	**Considerably**	**Extremely**
1	**2**	**3**	**4**	**5**

4R. Feeling tense, jittery, or anxious

Not at all	**Slightly**	**Somewhat**	**Considerably**	**Extremely**
1	**2**	**3**	**4**	**5**

5R. Difficulty returning to my role in my family

Not at all	**Slightly**	**Somewhat**	**Considerably**	**Extremely**
1	**2**	**3**	**4**	**5**

6R. Feeling unmotivated to work

Not at all	**Slightly**	**Somewhat**	**Considerably**	**Extremely**
1	**2**	**3**	**4**	**5**

7R. Not fitting in socially

Not at all	Slightly	Somewhat	Considerably	Extremely
1	2	3	4	5

8R. Having health problems

Not at all	Slightly	Somewhat	Considerably	Extremely
1	2	3	4	5

9R. Worried about soldiers who are still deployed

Not at all	Slightly	Somewhat	Considerably	Extremely
1	2	3	4	5

10R. Avoiding social situations or crowded places

Not at all	Slightly	Somewhat	Considerably	Extremely
1	2	3	4	5

11R. My body not functioning like it used to

Not at all	Slightly	Somewhat	Considerably	Extremely
1	2	3	4	5

12R. Mourning the death of fellow soldiers

Not at all	Slightly	Somewhat	Considerably	Extremely
1	2	3	4	5

13R. Wanting to work but not being able to

Not at all	Slightly	Somewhat	Considerably	Extremely
1	2	3	4	5

14R. Feeling like I am deteriorating

Not at all	Slightly	Somewhat	Considerably	Extremely
1	2	3	4	5

15R. Not wanting to be touched or hugged

Not at all	Slightly	Somewhat	Considerably	Extremely
1	2	3	4	5

16R. Missing structure and focus of being deployed

Not at all	Slightly	Somewhat	Considerably	Extremely
1	2	3	4	5

17R. Having demands from my partner or family

Not at all	Slightly	Somewhat	Considerably	Extremely
1	2	3	4	5

18R. Having difficulty concentrating

Not at all	Slightly	Somewhat	Considerably	Extremely
1	2	3	4	5

19R. I've changed or others have changed

Not at all	Slightly	Somewhat	Considerably	Extremely
1	2	3	4	5

20R. Feeling tired and worn-out

Not at all	Slightly	Somewhat	Considerably	Extremely
1	2	3	4	5

21R. Being easily irritated with others

Not at all	Slightly	Somewhat	Considerably	Extremely
1	2	3	4	5

22R. Having difficulty finding a job

Not at all	Slightly	Somewhat	Considerably	Extremely
1	2	3	4	5

23R. Having frequent thoughts about deployment

Not at all	Slightly	Somewhat	Considerably	Extremely
1	2	3	4	5

24R. Others don't understand what I went through

Not at all	Slightly	Somewhat	Considerably	Extremely
1	2	3	4	5

25R. Feeling useless since returning from deployment

Not at all	Slightly	Somewhat	Considerably	Extremely
1	2	3	4	5

26R. Feeling alienated or alone

Not at all	Slightly	Somewhat	Considerably	Extremely
1	2	3	4	5

27R. My life is on hold (could be redeployed)

Not at all	Slightly	Somewhat	Considerably	Extremely
1	2	3	4	5

28R. Having difficulty completing tasks

Not at all	Slightly	Somewhat	Considerably	Extremely
1	2	3	4	5

29R. Having lots of medical appointments

Not at all	Slightly	Somewhat	Considerably	Extremely
1	2	3	4	5

30R. My partner/family does not understand me

Not at all	Slightly	Somewhat	Considerably	Extremely
1	2	3	4	5

31R. Having nightmares or difficulty sleeping

Not at all	Slightly	Somewhat	Considerably	Extremely
1	2	3	4	5

32R. Not wanting to talk about my experiences

Not at all	Slightly	Somewhat	Considerably	Extremely
1	2	3	4	5

33R. Not knowing what to do next

Not at all	Slightly	Somewhat	Considerably	Extremely
1	2	3	4	5

34R. Coping with being disfigured or injured

Not at all	Slightly	Somewhat	Considerably	Extremely
1	**2**	**3**	**4**	**5**

35R. Wanting to avoid intimate time with others

Not at all	Slightly	Somewhat	Considerably	Extremely
1	**2**	**3**	**4**	**5**

36R. Everything seems trivial since deployment

Not at all	Slightly	Somewhat	Considerably	Extremely
1	**2**	**3**	**4**	**5**

Thank you so much for your time and participation. You are now done with the survey. The following will be a list of resources and phone numbers for you to keep and review.

****You have chosen to terminate the survey. Thank you for your time and participation. The following will be a list of resources and phone numbers for you to keep and review.****

APPENDIX G

Human Subjects Review Approval letter

March 14, 2009

Susana Ochoa

Dear Susana,

Your revised materials have been reviewed. You have done an excellent job in their revision. Your project is now well focused and set up appropriately as an anonymous study. It shows a lot of thought and work! We are happy to now give final approval to your project.

There are three very small corrections we would like you to make. They are as follows: In paragraph 7, page 2, you say "11% of Hispanic military are in the military." We think that is an error. At the end of your section of **Characteristics**, you say "interview." Don't you mean "receive surveys from" or something? You won't be doing any interviews.

Finally, at the end of the Consent, in the BOILERPLATE, you say "COMPLETION." Please delete that because it implies that they have to have answered every question and you have told them they don't have to. Just saying "submit" is enough.

Just send the corrected sections to Laurie Wyman (lwyman@smith.edu) for your permanent file.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your very interesting project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Heather Pizzanello, Research Advisor