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Andrea Mitchell
Navigating War and
Reintegration Into Civilian
Life: Clinicians' Perspectives
on How Their Operation
Enduring Freedom (OEF)
and Operation Iraqi Freedom
(OIF) Clients Cope

ABSTRACT

This qualitative study examines the experiences of veterans and active duty service members who engaged in the current wars termed Operation Iraqi Freedom (OIF) in Iraq and Operation Enduring Freedom (OEF) in Afghanistan. The investigation is based on the perspectives of 11 mental health clinicians who work primarily with OEF and OIF veterans in the Department of Veteran Affairs (VA) medical facilities and Vet Centers. This study examines resiliency, risk factors, and coping methods utilized by warriors during deployment, in addition to specific questions regarding female service members and soldiers who have been deployed multiple times. The study investigates how warriors cope during reintegration into civilian life with an emphasis on psychosocial stressors, adjustment reactions, mental health symptoms and substance abuse, and perceived barriers to mental health care.

The findings of the research showed that social support, connection with loved ones, leadership, and unit cohesion were primary determinants of resiliency in the theater of war. Pre-existing trauma and mental health issues, inadequate military training, lack of recognition and military sexual trauma—specifically for female service members—poor leadership and young age posed as risk factors for mental health and increased challenges post-deployment. The primary struggles during reintegration were: issues with

relationships and redefining roles within the family system, financial stress, increased use and abuse of alcohol and drugs, coping with mental health symptoms and behavioral reactions. The primary barrier to care was the stigma attached to receiving mental health services.

NAVIGATING WAR AND REINTEGRATION INTO CIVILIAN LIFE: CLINICIANS'
PERSPECTIVES ON HOW THEIR OPERATION ENDURING FREEDOM (OEF)
AND OPERATION IRAQI FREEDOM (OIF) CLIENTS COPE

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

Andrea Mitchell

Smith College School for Social Work
Northampton, Massachusetts 01063

2010

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To all OEF and OIF veterans and active duty service members, I am humbled by your resiliency, bravery, strength, and service—Thank you.

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CHAPTER I

INTRODUCTION

The purpose of this study is to examine the experiences of veterans and active duty service members who engaged in the current wars termed Operation Iraqi Freedom (OIF) in Iraq and Operation Enduring Freedom (OEF) in Afghanistan. The central questions of this study focus on the coping methods warriors utilized during their tour of duty and as they navigated reentry into civilian life. As the military operations continue in both Iraq and Afghanistan, over 1.6 million military service members from the United States have been deployed at least once since 2001, to one or both of the theaters of war.

Authors Litz and Orsillo (2004) note:

It is safe to assume that all soldiers are impacted by their experiences in war. For many, surviving the challenges of war can be rewarding, maturing, and growth-promoting (e.g., greater self-efficacy, enhanced identity and sense of purposefulness, pride camaraderie, etc.). The demands, stressors, and conflicts of participation in war can also be traumatizing, spiritually and morally devastating, and transformative in potentially damaging ways, the impact of which can be manifest across the lifespan. (p. 21)

Toward that end, this study solicits the perspectives of 11 clinicians who work primarily with OEF and OIF veterans and active duty service members in the Department of Veterans Affairs (VA) health care facilities and Vet Centers. The study is a qualitative, flexible-methods research design with open-ended interview questions to gather the narrative data from the clinicians. This study examines resiliency, risk factors and coping methods utilized by warriors during the theaters of war, in addition to specific questions regarding female service members and soldiers who have been deployed multiple times.

The study investigates how warriors cope during reintegration into civilian life with an emphasis on psychosocial stressors, adjustment reactions, mental health symptoms and substance abuse, and perceived barriers to mental health care.

The military spends a significant amount of resources on the initial conditioning and training of its warriors. The battle-mindset of soldiers within the combat theater is what has kept them alive, yet one must question how soldiers are supported in abandoning these vital coping methods, which were adaptive and served as survival mechanisms during combat, but can develop into mental health issues and adverse adjustment reactions as they attempt to navigate reentry into civilian life and for years afterward. There is an ample body of empirical data that explores the pathological outcomes of war—specifically PTSD (Lewis, 2006; Paulson & Krippner, 2007; Hoge et al., 2004; Milliken, Auchterlonie & Hoge, 2007). However, there is limited research on how veterans cope on a daily basis, particularly during the reintegration process. Additionally, there is less focus on the behavioral outcomes of combat exposure (Killgore et al., 2008) and adjustment reactions for both the individual warrior and his or her family or loved ones during the reintegration period.

When returning to civilian life, factors confronting service members and causing increased stress during re-entry appear to be the challenges of adapting to changes within the family system—redefining roles and re-negotiating expectations and division of household responsibilities—financial stress, difficulty modulating strong emotional and behavioral reactions, high risk, adrenaline seeking behavior, use and abuse of drugs and alcohol and feeling that they no longer fit into civilian society.

This study will explore these aspects beginning with a comprehensive review of literature, followed by the narratives of 11 clinicians who intimately shared their perspectives and insight on how their OEF and OIF clients cope during war and as they navigate re-entry into civilian life.

CHAPTER II

LITERATURE REVIEW

The purpose of this study is to explore how the warriors of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) cope during reentry into civilian life. To gain an understanding of the complexities that can arise for warriors during reintegration, this review of literature examines military service members' experiences both in the combat theater and during reentry. The literature is reviewed in two main sections: 1) the warriors' experience in the combat theaters, and 2) reintegration of the transitioning warrior. Section one provides a brief overview of the military, military culture, and the wars in both Iraq and Afghanistan. I also examine mental health and adjustment risk factors (exposure to combat and traumatic events and pre-disposing risk factors), protective factors such as unit cohesion and morale, and the experiences of women warriors. Section two explores readjustment in the context of bio-psychosocial functioning, focusing on interpersonal relationships, mental health and behavioral issues, substance abuse, and stigma and barriers to mental health care. For this literature review, the terms warrior, soldier, and military service member are used interchangeably, however, the term soldier is generally used to define service members who are in the Army.

Operation Enduring Freedom and Operation Iraqi Freedom

The warriors' experience in the combat theaters

Overview of the Military

In 2007, the United States military force consisted of 2.2 million service members, 47% of whom were in the Army, 25% in the Air Force, 19% Navy and 10% in the Marines. Each military branch has both an active duty and reserve component, which also includes the National Guard (Sollinger, Fisher & Metcher, 2008). Ethnic minorities represent a significant proportion of the military, ranging from 24% in the Air Force to 40% in the Army (Cozza et al., 2004). Recent research on military personnel demographics determined that the military employs more African Americans than the civilian work force, in comparison to Whites, Hispanics, Asian/Pacific Islanders, and Indian/Alaskan Natives. The research also highlighted that military service members in the current conflicts in Iraq and Afghanistan are younger than the civilian work force, with 47% of active duty service members ranging between the ages of 17-24 years old, in comparison to 14% of that age group who are employed in the civilian work.

Military Reservists, however, tend to be older than active duty service members. In 2005, there were five times more Reservists age forty-five and older, as compared to active duty members (Sollinger, Fisher & Metcher, 2008), and 20% of the National Guard comprised that age group in comparison to only seven percent of active duty members (Matthews, 2009). In 2004, 52% of service members were married (Sollinger, Fisher & Metcher, 2008) and approximately 11% of those marriages were to other service members (Cozza et al, 2004).

Military Culture

Collectivism, which has been described as the cornerstone of military culture, is characterized by Christian, Stivers, and Sammons (2009):

Consisting of defining the self as part of a group, putting group goals ahead of personal goals, and having an emotional investment in the group...Service members are taught both explicitly and implicitly that an individual is of limited value, whereas the unit can accomplish anything. (p. 32)

Military training can be described as both a socialization process and indoctrination, with the goal being to create a new identity. During this initiation a civilian is transformed into a soldier by incorporation into the organization's value system. The goal of indoctrination is that by full emersion into a group, an individual will place the needs of the group before their own. This is accomplished by developing and accepting values and behaviors of the group, for example honor, selfless service and duty, and the willingness to sacrifice one's life and kill for one's country (Christian, Stivers, & Sammons, 2009). Indoctrination has three primary goals, "1) to remove characteristics that are detrimental to military life (that is, to subordinate self-interest to follow others), 2) to train individuals to kill when necessary, and 3) to enable recruits to view themselves in collective terms" (McGurk, Cotting, Britt & Adler, 2006, p. 14).

The "softening up stage" is the first stage of indoctrination. The soldier's individualistic identity is removed and the warrior in training is exposed to fear, physical, and psychological stress. Although military branches vary in how a warrior is trained, the transformation of identity occurs across all sectors. One's individual identity is stripped: all members must wear a uniform, have the same haircut and are either called by their rank, last name or have to refer to themselves in third person; first names are never used.

Compliance is the second stage at which point authors McGurk, Cotting, Britt and Adler (2006) describe:

Individuals are basically modeling what they believe is expected of them to avoid punishments or reprimands, not conforming because of an intrinsic interest in supporting the group...However, research has shown that behaviors initially performed for extrinsic reasons have a higher likelihood of being internalized by the individual when repeatedly performed and reinforced. (p. 19-20)

At this juncture the service member will begin the internalization phase, at which point they seek to become fully part of a group adopting the groups' norms and behaviors. The individual will begin to change his or her self-image, and the group will take on a central importance.

Consolidation is the final stage, at which time the service member has total commitment to the group and is taught to "dehumanize and deindividuate the enemy...the emotional distance created by these processes facilitate the ability to kill in context of combat" (Christian, Stivers, & Sammons, 2009, p. 43). It is assumed when a civilian enters the military they are inherently reluctant to kill. Therefore, one of the primary goals of indoctrination is to go against this belief system and to "shape attitudes toward killing and to train individuals in the behaviors necessary to kill" (McGurk, Cotting, Britt & Adler, 2006, p. 21).

Overview of Operation Enduring Freedom and Operation Iraqi Freedom

The war in Afghanistan, titled Operation Enduring Freedom (OEF) by the Bush Administration, began in October 2001 in response to the 9/11 terrorist attacks by al Qaeda on the United States. By 2005, there were between 15,000-20,000 ground forces involved in "stability operations"; however, the Obama administration authorized an additional 30,000 troops to be deployed by the end of 2009.

In 2002, the Bush administration began to deploy troops to Iraq. On March 21, 2003 the U.S. began major combat operations, titled Operation Iraqi Freedom (OIF). After the "fall of Baghdad" on April 9, 2003, President Bush declared an end to major combat operations in May 2003 (Sollinger, Fisher, & Metcher, 2008). To date, there continue to be thousands of U.S. troops in Iraq involved in continued "stability operations." More recently, however, there has been a demobilization of bases and U.S. troops are beginning to withdraw from major cities and towns.

By October 2007, 1,638,817 military service members had been deployed to either Iraq or Afghanistan since the hostilities began. Of that number, 1.2 million were active duty and 455,009 were Reserve service members (Sollinger, Fisher, & Metcher, 2008). As of March 20, 2009 the Department of Defense (DoD) reported the total of number of deaths in OIF had reached 4,261—102 of whom were female service members, and 31,131 service members were wounded. Over 50% of the wounds were the result of improvised explosive devices (IED), which are planted in roads, markets, trash cans, vehicles, and other hard to detect locations (Fisher, 2009). In OEF there have been a reported 663 deaths, fourteen of which were female service members, and 2,725 service members have been wounded (Fischer, 2009). The numbers of both wounded and killed have increased in both operations since the March 2009 report. According to the organization Iraq and Afghanistan Veterans of America (IAVA), as of June 2010, the DoD recorded that the fatalities in Afghanistan increased to 1,078 and the total of number of troops wounded in both OEF and OIF reached 36,757 (IAVA.org). Advances in both medicine, medical response in the combat theater, and evacuations have resulted in a dramatically reduced death rate as compared to past wars. The number of Iraqi casualties

has been more difficult to quantify. Estimates since 2003 determine that well over 70,000 Iraqi citizens have been killed during the OIF operation (Christian, Stivers, & Sammons, 2009).

The current wars differ greatly from past wars in that they are the first extended conflicts, post Cold War, employing an all-volunteer force. The primary U.S. armed force utilized in both OEF and OIF is the Army, which includes both the National Guard and Army Reserve, followed by both active duty and reserve Marines Corps members. A challenge for the military, placing a strain on the service members, is that the demand of the current conflicts are too great for the size of the military force. The impact on the troops has resulted in both multiple and extended deployments. A memorandum issued by the Secretary of Defense in January 2007, declared that, due to the strain on the Army, troops would be cycled to the combat theaters on rotation, ideally spending a year or less in combat, followed by two years outside of combat areas, and Reservists would spend one year in the theater followed by five years stateside. Although this policy remains in effect, the reality has been that there are not enough troops to meet the demand of both conflicts while adhering to the schedule described above. Therefore, many Army service members continue to be deployed multiple times and have endured extended deployments well beyond the one-year marker (Sollinger, Fisher & Metcher, 2008).

The current conflicts have weighed heavily on both the National Guard and Reserve units. According to authors La Bash, Vogt, King, and King (2009), 40% of the service members in Iraq are a combination of both National Guard and Reserve troops. They report that the experience for these units differ from active duty troops in that they tend to be older, have civilian jobs, and are not connected to military bases stateside.

Furthermore, they do not have the same intensive training as active troops. The National Guard and Reservists at home are “weekend warriors” and, therefore, are not as prepared to face combat as their active duty peers.

Mental Health and Adjustment Risk Factors for the Warrior

There are significant research data validating that deployment stressors and combat experiences alone, regardless of their previous history, places warriors at considerable risk for developing mental health problems. These problems include “post-traumatic stress disorder (PTSD), major depression, substance abuse, impairment in social functioning and in the ability to work, and increased use of health services” (Hoge, et. al, 2004, p.14). When warriors return from combat, faced with a myriad of mental health symptoms, the challenge of reintegrating into civilian life can result in their fighting new internal battles at home.

In every war, depending on the service member’s unit, Military Occupation Status (MOS), their combat experience, how they react and are affected psychologically by their experience, and the way warriors respond to combat stress will greatly differ depending on the individual. In an effort to manage the adverse effects of combat stress in the Iraq war theater, the Army has implemented a Mental Health Advisory Team (MHAT). The MHAT is comprised of mental health providers who are embedded within Army units to provide mental health care and conduct research in order to improve the Army’s response in caring for soldiers who are experiencing stress reactions in the combat theater. In addition to the stress of deployment, multiple tours, and the duration of deployment, there are a myriad of stressors that warriors have to cope with, such as being separated from

loved ones, environmental extremes, and their living conditions. The MHAT observed that the most predominant combat stressors include:

[S]eeing destroyed homes and villages; seeing dead bodies or human remains; engaging in firefights or coming under small arms fire; engaging in hand-to-hand combat; being attacked or ambushed; personally knowing someone who was seriously injured or killed; being wounded or injured oneself; and being directly responsible for the death of an enemy combatant. (Gifford, 2006, p. 17)

Gifford (2006) states that it is not known why some people experience negative reactions and others do not when faced with the same adversity. What is known is that everyone varies in his or her response during a traumatic or stress inducing experience. Although specific predisposing factors have not been identified, evidence has been presented on both personality factors and personality hardiness, defined by Gifford (2006) as the cognitive ability to process and adaptively integrate experiences into one's life. Reactions to stress manifest in numerous ways depending on the individual, and can occur during the precipitating event, or immediately after and for some individuals the symptoms can develop into long-term psychological breakdown, resulting in PTSD.

Authors Paulson and Kripper (2007) concur:

Each person faces potential traumatic stressors with a different set of predispositions that are activated by a traumatic event. Whether or not the stressor (or series of stressors) will trigger classic PTSD depends not only on its severity but also on its dispositional factors (at the time of experience), the environmental factors (many of them seemingly mundane at the time), and the interaction with one's predisposing factors. (p. 13)

Shaw (2005) describes how the "green troops" the new and inexperienced, tend to be the most vulnerable, accounting for three quarters of psychiatric casualties. The author illustrates by stating, "in the first week of combat, the sudden awareness of violence of war, the frequency of random death, inability to realistically evaluate danger, the lack of

confidence in soldierly skills, minimal group cohesion, and poor group solidarity may all contribute to these early failures in combat” (p. 24). He goes on to describe how over time, with increased experience the warrior learns how to navigate and adapt to the conditions and situations that he is confronted with, however, with increased exposure to combat, it is inevitable that warriors are more vulnerable to stress and traumatic experiences. Shaw (2007) notes how after thirty days in a combat theater, there is a slow, but observable decline in soldiers’ performances, and after one hundred days behavior becomes non-effective as “the soldier becomes increasingly aware that there is diminishing chance of survival” (Shaw, 2007, p. 24).

Lewis (2006) describes that there are biological, psychological, and situational risk factors that increase the likelihood of adverse mental health following a traumatic exposure. These factors, in addition to one’s personality traits, can also serve as protective factors. These include feeling as though one is in control, a commitment to one’s self, viewing change as a challenge and the ability to mitigate some of the negative effects of combat stress. That combat has a direct impact on ones’ psyche is not a new idea. The outcome of an adverse response or inability to cope with combat stress, known today as PTSD, was originally termed shell shock. It was perceived to be a reaction from being in the trenches and constantly exposed to artillery barrages.

By World War II, the term evolved to psychoneurosis, ramifications of combat exhaustion, which implied an emotional breakdown, attributed to both psychological and physical exhaustion. Today, a combat stress reaction is seen as a normal reaction, although extreme, to an abnormal situation. The Department of Defense (DoD) defines combat stress reaction as “the expected, predictable, emotional, intellectual, physical

and/or behavioral reactions [of] service members who have been exposed to stressful events in combat or military operations” (Lewis, 2006, p. 123).

The Army’s preemptive response to managing the mental health of its soldiers was to establish the Mental Health Advisory Team (MHAT), which monitors military personnel’s mental health status in the theater of war. However, the mental health screens conducted in the combat theater cannot determine if stress reaction symptoms will persist when the service member is removed from the combat situation. In April 2003, the DoD mandated all returning troops complete a Post Deployment Health Assessment (PDHA) in the country where the warrior was posted or within two weeks post-deployment. Studies conducted using data from PDHA screenings found that 10% of service members returning from Iraq screened positive for PTSD and 5% for depression. The authors indicated that the low rates may have been attributed to both the stigma attached to reporting mental health symptoms—the PDHA was not confidential—and military and service members’ concerns that a mental health diagnosis could potentially delay their return home (Ramchand, Karney, Oscilla, Burns & Caldarone, 2006).

Ample research has determined that PTSD symptoms may take months if not years to present (Hoge, et al., 2004, Milliken, Auchterlonie & Hoge, 2007, Marmar, 2009, Seal et al., 2007). In 2006, the DoD reassessed the PDHA participants in a Post Deployment Health Reassessment (PDHR) three to six months post deployment in a group of 88,235 Army soldiers. The PDHR determined that the participants’ symptoms of both PTSD and depression had increased. In the PDHR, 17% of active duty service members screened positive for PTSD compared to 12% on the PDHA and 25% of Reservists screened positive compared to 13% who presented with PTSD symptoms on

the initial PDHA. In addition, two thirds of the positive PTSD screens on the PDHR were new cases, indicating that in the three to six month time frame post deployment, service members who did not present with symptoms on the PDHA did so on the PDHR. (Ramchand, Karney, Oscilla, Burns & Caldarone, 2006).

Results from the study conducted by Hoge et al. (2004) administered three to four months post-deployment—screening Army personnel following deployment to Afghanistan—found that 12% had PTSD and 14% were experiencing depression. The rates for military personnel deployed to Iraq were higher with 18% of Army service members and 20% of Marines presenting with PTSD, and 15% of both Army service members and Marines screened positive for depression. These studies indicate the need to monitor and provide adequate mental health and supportive services to military personnel during reintegration into civilian life, as it is clear that mental health symptoms tend to increase with time during the post-deployment period.

Gifford (2006) discusses the psychological cost to human beings when they kill. The social construct of PTSD focuses on what has happened to the individual and does not focus on the psychological impact of one's actions—what a person has done to others. Gifford (2006) states that the impact of killing needs further investigation as research studies that have been conducted suggest that killing may be the most severe stress of combat as well as the continued after effects of having to live with that act. An MHAT survey conducted in the OIF Theater found that service members, who believed they had killed, showed increased vulnerability to acute stress reactions and symptoms of PTSD. However, the study also concluded that the number one stressor was how often the soldier believed he or she could be killed or seriously wounded. A survey conducted

in 1994 on veterans from WWII and the Korean and Vietnam wars, determined that “the responsibility for killing another human being is the single most pervasive, traumatic experience of war” (Paulson & Kripper, 2007, p. 14).

There is ample research data documenting the known risk factors of developing a stress reaction or symptoms of post-traumatic stress such as fear of death, witnessing death, or wounded combatants and civilians, and handling or seeing dead bodies. Troops in OIF have reported that battle intensity and lack of officer support are predictors of both breakdown and combat stress reactions. Seventy-five percent of soldiers in OIF have reported witnessing both death and someone being severely wounded (Lewis, 2006). In addition, the accumulation of low level stressors over a period of time, for example, boredom, lack of sleep, long work hours, extreme weather conditions, and inadequate living quarters can have a negative impact on service members (Cozza et al., 2004, La Bash, Vogt, King & King, 2009). Exposure to low intensity combat situations and the chronic strain of deployment alone can place warriors at risk of developing adjustment, mood and anxiety disorders (Cozza et al., 2004).

In the current OEF and OIF operations, warriors have no way of identifying the enemy from the civilian population. Reports have indicated that both women and children are used as vehicles for bombs, and the use of IEDs leaves service members under constant stress not knowing who is friend or foe. In addition, there are extreme cultural differences and as the majority of service members are not able to use verbal communication and nonverbal cues are frequently misunderstood. These cultural differences are yet another source of stress. Authors La Bash, Vogt, King, and King

(2009), describe how not knowing the cultural norms for service members stationed at check points can result in grave consequences:

[T]he American hand signal used to indicate “stop” (arm straight out, palm out) is a welcoming gesture in Iraq. Other commonly used American hand gestures, such as pointing or giving a “thumbs up,” are extremely offensive in Iraqi culture, and may be interpreted as a sign of aggressiveness. This type of miscommunication may have played a role in a number of tragic accidents in which Iraqi civilians have been maimed or killed. (p. 238)

The constant exposure to and accumulation of multiple stressors, that may not necessarily be life threatening, appear to also have a significant impact on how service members’ cope during their tour and later as they navigate their re-entry into civilian life.

Predisposing Risk Factors

Research conducted by Bolton, Litz, Britt, Adler, and Roemer (2001) explored predisposing variables and post deployment symptoms of soldiers who are more vulnerable to PTSD, following an acute stress reaction during combat. They concluded that the level of symptomology had a direct link to a previous exposure to a “potential trauma experience” (PTE). A PTE in this study was defined as exposure to a natural disaster, sexual and/or physical assault, and experiencing or witnessing serious injury or illness. They determined that pre-military exposure to a PTE is a risk factor for the development of PTSD during or post combat, and needs further attention from the military. A study conducted on 2,947 military personnel found that 74% had been exposed to at least one PTE, and 60% had been exposed to two or more. The vast majority of PTE was from pre-military experiences. They noted that military personnel with an accumulation of PTE were more vulnerable in developing PTSD symptoms during their combat experience.

Kaysen, Resick and Wise (2003), theorize that the context of the trauma experience is key in determining increased vulnerability of PTSD. They concluded that repeated exposures to trauma stressors, and the duration of exposure, determine the level of vulnerability. Additionally, one does not have to be exposed to an actual traumatic event, if one's environment contains risk factors, the mere potential for exposure to danger and even harsh environmental factors can significantly increase risk of developing PTSD.

Although there is a significant body of research which indicates a direct correlation between a pre-existing history of trauma and the likelihood of an increased vulnerability in developing PTSD during or post combat (Bolton, Litz, Britt, Adler & Roemer, 2001; Kaysen, Resick & Wise, 2003; Basham, 2008; Brailey, Vasterling, Proctor, Constans & Friedman, 2007), there are additional arguments that prior trauma history and symptoms do not necessarily equate to developing a determined negative mental health outcome. Basham (2008) notes that:

Several factors operating during or after the traumatic deployment-related events—such as trauma severity, length of exposure, and absence of social support—had somewhat stronger effects as compared with pre-trauma factors ... soldiers who had successfully resolved trauma-related symptoms, attachment, and relationship issues related to their childhood experiences navigated better in acute combat situations. (p. 85)

However, this does not necessarily determine that they will return home without combat stress symptoms. Basham (2008) states that, “although a range of protective factors, in particular family and other social supports, mediate the harmful effects of combat exposure, many soldiers and their partners suffer with acute stress responses as well as more severe mental health problems” (p. 83).

Prior to engaging in military operations in Iraq and Afghanistan, a reported six percent of military service members utilized mental health services. Hoge et al. (2004) conducted a study on soldiers and Marines who were deployed to both Iraq and Afghanistan, administering a mental health screening both pre- and post-deployment. They reported that, to date the majority of studies examine the long-term mental health repercussions following combat experience, generally years after the veterans' military service. They argue that:

Many gaps exist in the understanding of the full psychosocial effect of combat. The all-volunteer force deployed to Iraq and Afghanistan and the type of warfare conducted in these regions are very different from those involved in past wars, differences that highlight the need for studies of members of the armed services who are involved in the current operations. (p.14)

The military has implemented both a pre- and post mental health screening protocol; however, the post-screening is measured upon direct reentry, which is problematic as many soldiers may experience delayed traumatic stress symptoms. Hoge et al. (2004) administered their questionnaires three to four months after the soldiers and Marines had returned home to better assess their mental health. Their study focused on the mental health problems, and the use of and perceived barriers to mental health services prior to and after combat deployment. They measured major depression, anxiety, misuse of alcohol and the presence or absence of PTSD using the 17-item National Center for PTSD Checklist of the Department of Veterans Affairs. The study concluded that participants who met screening criteria for PTSD, major depression, and alcohol misuse had increased post deployment and there was a correlation between the number of firefights and the prevalence of PTSD symptoms. In addition, only a small percentage of these participants sought mental health services. The greatest barriers in accessing

services were stigma and being judged or perceived as “weak” by members of their unit and leaders (Hoge et al. 2004).

Brailey, Vasterling, Proctor, Constans & Friedman (2007) discuss the need to further explore the impact of both risk and resilience factors that are in place prior to war and their relationship to post-war mental health. The authors emphasize that “Understanding how individuals’ pre-deployment personal histories and situational factors influence emotional functioning, including preexisting PTSD symptoms, prior to war-zone deployment may be critical to development of both pre-deployment preventative and post-deployment treatment interventions” (p. 496). The study concluded that there is a need for ongoing long-term efforts to decipher the interplay between the three factors listed above and their impact on mental health outcomes.

Protective Factors

The vast majority of research conducted on both active duty service members and veterans tends to focus on the pathological and psychological outcomes resulting from experiences in the theater of war (Lewis, 2006; Paulson & Krippner, 2007; Hoge et al. 2004; Milliken, Auchterlonie & Hoge, 2007). There has been less focus, however, on protective factors, how warriors adaptively cope when faced with extremely stressful and life threatening situations. Data from four infantry units in OIF and OEF detailed a high rate of combat experience and exposure. Army units in OIF described how 93% of soldiers report being shot at or receiving small arms fire, 95% report seeing dead bodies or seriously injured comrades, and 48% report being responsible for the death of an enemy combatant (Reger & Moore, 2009).

Authors Reger and Moore (2009) report that only 15% of OIF soldiers are developing symptoms of PTSD. There are arguments that few warriors return home from combat situations psychologically unaffected yet, how do the remaining 85% remain predominately stable in regard to their mental health? How are some warriors able to endure with a degree of resilience when faced with experiences that place them at a high risk for developing PTSD? Britt and Dickinson (2006) conducted research to compare discussions on PTSD and the protective element of the morale of troops. The authors concluded that there is a great imbalance in research data on maladaptive reactions as compared to adaptive responses.

Gifford (2006) also found that there is less focus on the positive impact of serving in combat, for example, a warrior's personal growth, training, and strength gained by coping in an adverse situation and finding meaning in one's work. The military focuses on the idea of group mentality and cohesion defined as "the bonding together of members of an organization/unit in such a way as to sustain their will and commitment to each other, their unit, and the mission" (Gifford, 2006, p. 20). Christian, Stivers and Sammons (2009) describe how strong group cohesion is a protective factor against stress and the "commitment and accountability to one's comrades becomes more powerful than the instinct of self-preservation" (p. 33). The MHAT's sixth mission to both OEF and OIF, determined that resilient platoons, defined as troops with low reports of mental health problems, were closely related to cohesion, feeling prepared for the mission and trust and belief in leadership (Harben, 2009). Research has also found that hardiness—the ability to find a sense of purpose and meaning and a belief that one has a sense of control and influence in events—may be a factor in mediating the interplay of combat exposure

and PTSD. Kelly and Vogt (2009), state that findings have indicated that “hardy people” have less maladaptive response to stress.

Morale is a key component as a protective factor and is defined as “a positive motivational state that should be related to superior performance under stress, adaptive responding to operational demands, and positive job attitudes” (Britt & Dickinson, 2006, p. 159). There are numerous definitions and ideas of what morale entails in the context of war. The authors created the following definition based on the idea that morale is an individual phenomenon that takes place in the context of a unit, defined as, “a service member’s level of motivation and enthusiasm for accomplishing mission objectives” (Britt & Dickinson, 2006, p. 162). A warrior’s morale is also greatly influenced by his or her belief in the mission, that the objectives are attainable, have a clear purpose and the public is in support of the operation. Leadership plays a vital role on the morale of the troops. The troops’ confidence in their leaders, as well as a service member being recognized for accomplishments with medals or praise, increases the level of morale. Cohesion is the collected efficacy of the group and is directly correlated to morale. Koffman (2006) describes cohesion as one of the most important protective factors stating:

While maladaptive strategies remain available to deployed personnel, some adaptive coping strategies are not only available but frequently engaged. One of the healthiest and most effective ways to mitigate the stress of combat is to burnish an organization’s sense of eliteness and esprit de corps. Cohesion is the fundamental principle behind a healthy organization. (p. 4)

Women Service Members

Women are being deployed to both Iraq and Afghanistan in record numbers. Thus far over 100,000 (La Bash, Vogt, King & King, 2009) women have served in the OIF

Theater and more than 212,000 (Muhall, 2009) female service members have served in either the OEF or OIF theaters. To date, women have been prohibited from serving in direct combat units. The Department of Defense “specifically prohibits women from serving in assignments whose primary mission is to engage in direct combat on the ground. While there is no law actively barring women from engaging in combat, women cannot be assigned positions that are likely to engage in direct ground combat, such as infantry” (Muhall, 2009, p. 3). However, in the current operations, authors La Bash, Vogt, King and King (2009) state that:

[I]nterviews with women reveal that they are being exposed to and participating in combat. “The rules of combat have completely changed . . . “[W]e’re already taking bullets” stated one female soldier. A number of women have confirmed kills, and women have received Army Commendation Medals, Purple Hearts for enemy-inflicted wounds, and Bronze Stars with combat “V” for valor under fire. (p. 241)

In current operations women are serving alongside men in every capacity.

Authors Katz, Bloor, Cojucar and Draper (2007) conducted a qualitative study assessing eighteen OEF/OIF female service members who sought mental health services at a VA in Long Beach, CA. The authors reported that women are the fastest growing sector of VA services and by 2010 women will account for 10% of VA patients. A record number of women have joined the service in recent years. Twenty percent of new recruits are women and at the time of research the authors stated that 10.5% of OEF/OIF troops were women.

Although there are multiple stressors for all service members in the theater of war, women are faced with a myriad of unique factors that can result in increased stress reactions and adverse mental health outcomes. The authors described the primary

stressors that were reported by the female service members that were interviewed. A number of the participants described the stress of being only one of a few women in the unit. They felt that as women, they were under the microscope at all times, and felt the need to prove themselves in order to be accepted as “one of the guys.” Fifty-six percent of the participants reported military sexual trauma (MST). The women reported being harassed on both a daily and weekly basis. Three of the participants reported rape and sexual assault. One woman reported that she was forced to have sex against her will with men on her unit on a monthly basis. Although the sample of participants was small, the authors found that their results were similar to national studies on MST, which report that in the military, harassment rates range between 55% to 70% and 11% to 48% of women veterans have reported sexual assault. A study conducted on 3,632 female veterans who sought VA services concluded that 23% reported sexual assault while in the military and 55% were sexually harassed (Katz, Bloor, Cojucar & Draper, 2007).

Benedict (2009) reported higher numbers in a survey conducted in 2003, where 30% of female veterans stated that they were raped in the military. In a 2004 study, of female veterans who sought mental health care for PTSD, 71% of the women reported sexual assault or rape during their military service. Benedict (2009) interviewed female service members, highlighting the position they are in while on tour. Veteran Specialist Suzanne Swift reported that when she refused to re-deploy under her sergeant who she had reported repeatedly raping her for months, the Army responded by threatening to Court Martial her for desertion. Her experience was not unique:

When Cassandra Hernandez of the Air Force reported being gang-raped by three comrades at her training academy, her command charged her with indecent behavior for consorting with her rapists. When Sergeant Marti Ribeiro reported

being raped by a fellow serviceman while she was on guard duty in Afghanistan, the Air Force threatened to court martial her for leaving her weapon behind during the attack. "That would have ruined my career," she said. "So I shut up." (Benedict, 2009, par 19)

Benedict (2009) reported that all of the men accused of committing the rapes described went unpunished. Many service women, therefore, do not end up reporting cases of MST. In the DoD assault reports for FY 2008 there were 2,908 reports of sexual assault involving service members, a nine percent increase from the previous year (Mulhall, 2009). Forty-nine percent of the assault cases were dismissed due to unfounded or unsubstantiated evidence. Only 10.9% of the cases resulted in the perpetrator being court martialed. More often, the perpetrators tend to receive mild punishments such as suspension or rank demotion as demonstrated in 2008 when 62% of the guilty offenders were given mild punishments. In 2008, following a number of Congressional hearings on military sexual assault after there were sixteen suspicious deaths of female troops whose deaths were labeled as either suicide or unexplained, the DoD responded by making an increased effort in educating troops on how to prevent sexual assaults from occurring (Benedict, 2009).

Benedict (2009) described how the Iraq war has brought about a historic change in the military for women in that more women have fought and died in OIF than all past wars since World War II combined. Currently, one in ten troops in Iraq is a woman and since 2003 over 206,000 women have served in the Middle East. La Bash, Vogt, King and King (2009) reported that over 100,000 women have served in the OIF Theater. However, Benedict (2009) argues that women's roles and contributions in the current conflicts go unrecognized. Considering that women are not "officially" authorized to be

in a combat role, they continue to not be recognized as real soldiers. In Iraq, with a shortage of troops, and the nature of the conflict, women engage in combat on a daily basis under the guise of “combat support.” Like their male counterparts, they are operating machine guns, driving tanks and convoys, raid houses and conduct arrests. There have been 2,000 women, both in OIF and OEF that have been awarded Bronze Stars—for bravery and valor in combat—the combat action badge, and two women were awarded the highest medal, a Silver Star for bravery in combat, yet the ban on women in combat which was reinforced in 2006, continues today (Benedict, 2009). The author notes:

The Pentagon justifies the ban by blaming civilian attitudes. American society, its policy statement says, believes that femininity is incompatible with combat, and will not tolerate the killing and mutilation of its mothers and daughters. Likewise, it argues, soldiers are more troubled by the sight of women being wounded and killed than of men, so will put themselves at extra risk trying to protect women in battle. And finally, women in combat would endanger men because of their lesser strength. (par 9)

Research on the mental health repercussions of MST has found that people with MST are more likely to suffer from depression and twice as likely to have anxiety and issues with substance abuse. The grave reality for service members who experience MST during service is that they are forced to live and work side by side with the perpetrator, and in many cases depend on that individual for their safety and life during combat situations. In IAVA’s monthly report, Mulhall (2009) stated that “Sexual assault and harassment threaten not only the individual victim; they undermine military cohesion, morale, and overall effectiveness. The majority of assailants are older and of higher rank than their victims, and abuse not only their authority but the trust of those they are responsible for protecting” (p. 6). Although there has not been extensive research on the

gender differences in PTSD, Paulson and Kipper (2007) found that female soldiers are just as able as their male peers to cope with stressors and that it has been found that the intense combat has more impact on male soldiers as compared to females.

Female service members not only have to cope with stressors of being female in a predominately male occupation, many women must also balance their career with being the primary caretaker at home. As of March 2009, Muhall (2009) reported that more than 30,000 single mothers have been deployed to both Iraq and Afghanistan. In addition, about 10% of women become pregnant while in the military and in the Army are only given four months to be with their newborn child before they are re-deployed.

The Transitioning Warrior: Reintegration

Psychosocial

Kudler (2007) noted that the needs of recently returning veterans from Iraq and Afghanistan would be better met by a public health approach, focusing on outreach and re-engagement of returning veterans rather than solely focusing on a medical model approach, which tends to only pathologize, specifically in regard to PTSD, which is viewed as a biological disorder. There is ample research which explains the biological outcome of war—specifically PTSD; however, there seems to be less focus on the behavioral outcomes of combat exposure (Killgore et al., 2008) and adjustment reactions for both the individual warrior and his or her family or loved ones during the reintegration period.

Following September 11, 2001 there have been an estimated 1.6 million military service members deployed at least once to fight the Global War on Terror (GWT) (Kudler & Straits-Tröster, 2009); one third of the soldiers have served two tours of duty.

When returning to civilian life, the major issues post deployment appear to be PTSD, depression, substance abuse, poor impulse control and aggressive behavior and issues with intimate relationships (Bowling & Sherman, 2008). From 2001 to 2004 the divorce rate for the Army increased three-fold, in addition to an increase in domestic violence. The MHAT's sixth mission in OEF/OIF determined that marital problems (intent to divorce or separate) had increased yearly since 2003 and by 2009 16% of troops surveyed reported marital issues (Harben, 2009).

Factors confronting service members and causing increased stress during re-entry appear to be the challenges of adapting to changes in the family system—redefining roles and re-negotiating expectations and division of household responsibilities— financial stress and the difficulty of modulating strong emotional reactions. Within military culture, aggression and anger are acceptable emotions, and for many soldiers abandoning these learned behaviors that served as a survival mechanism during combat, can quickly become risk factors within civilian life as they navigate re-entry. In order to better serve our troops, there needs to be a multi-dimensional approach in assessing both their current level of functioning and their needs both as individuals, in the family system and within the community in which they are re-integrating.

The Pentagon Manpower Defense Data Center found that 3,325 army officers had divorced in 2004. This number represents six percent of all marriages among officers and the number of divorces has increased 78% since 2003. Studies have found that military personnel have a 62% greater divorce rate than civilians, and chances of divorce for soldiers who have been exposed to combat are greater. Hutchinson and Banks-Williams (2006) describe how PTSD symptoms make it challenging for soldiers to sustain

relationships and note that the family often suffers with secondary trauma symptoms similar to PTSD; for example, feelings of hopelessness, anxiety, feeling resentful and depressed. Not only is the soldier returning with severe stress reactive symptoms, but also the entire family system becomes traumatized. Soldiers with PTSD struggle with increased verbal and physical aggression both in the home and community. This problem has received a lot of attention and the Army has attempted to address the issue by providing workshops and a 24-hour hotline; however, this is merely scratching the surface.

There is a significant body of empirical data that discusses soldiers who are affected by PTSD (Lewis, 2006; Paulson & Kripper, 2007; Hoge et al. 2004; Milliken, Auchterlonie & Hoge, 2007); however, there is limited research on how veterans cope on a daily basis, particularly during the reintegration process. In addition, limited research has been conducted on the coping behaviors of soldiers with pre-war trauma histories, an extremely vulnerable population, as they are more prone to adverse stress reactions and developing PTSD when exposed to combat, or high levels of stress. Mandersheid (2007) emphasizes the dire need to focus on helping facilitate the reintegration process for soldiers returning from both Iraq and Afghanistan, on all levels within the community, family and job settings.

The current wars are very different from any other war the U.S. has been involved in, placing our soldiers at higher risk of both physical and mental health issues. In essence they are bringing the war home. In addition, the military is made up of both National Guard and Reserve troops who have more ties to civilian life at home than career military personnel. In addition, they may not have the same accessibility to mental

health services and support from military peers and the supportive infrastructure provided on post, as compared to active duty service members (Savtisky, Illingworth, DuLaney, 2009). Therefore, it is important to note that National Guard, Reservists and Active duty service members may face different reintegration issues.

Mandersheid (2007) describes the following factors that impact the re-entry process: the tour of duty, the danger level, lack of connection to and support from civilian culture and the current American ambivalence about the war in Iraq. One third of returning soldiers have self reported mental health symptoms related to depression, anxiety and PTSD symptoms. Soldiers who have reported pre-deployment symptoms tend to be more impacted, returning home with exacerbated symptoms. In 2007, an estimated 20,000 veterans were suffering from severe wounds, and it is speculated that an even greater number are struggling with mental health issues.

One of the many plights of soldiers with mental health issues is that they do not receive as much attention as those with physical wounds. The grave reality is that soldiers are returning home permanently changed by their experience. They are also returning home to changed families, jobs and communities. The ability to retain a job due to being deployed multiple times or due to physical or mental health issues, can present as a challenge for many service members. An estimated 10.2% of the total enlisted force receives government assistance, evidence that service members are struggling financially (Savtisky, Illingworth, & DuLaney, 2009). Soldiers who have a spouse and children are returning to changed roles within the family system, and may feel estranged from their spouse and children. For military couples where both are enlisted, the stress is even greater as they rotate deployments; when one comes home, the other is deployed.

Mandersheid (2007) highlights the dire need to identify the obstacles and issues soldiers are faced with upon return to civilian life. Mental health professionals who work with this population need to know what tools and interventions have worked, what services are needed, what is lacking and where the gaps are in order to effectively treat and care for veterans.

Authors Doyle and Peterson (2005) project that the current burden of re-entry and reintegration will fall on both Army personnel and society. They state that a “soldiers life exists on a continuum of readiness for deployment—the deployment cycle. Re-entry and reintegration—the return home and reunion with family and community—key the success of the deployment” (p. 316). Factors that need to be in place to mitigate stress include “inclusion of families and communities early into the planning for re-entry and reintegration; normalization (non-medicalization of distress); easy access to behavioral health professionals; and education of families on recourses and benefits” (Doyle & Peterson, 2005, p. 361).

For active duty soldiers and current service members who are being deployed on multiple tours the re-entry process is as vital as preparing to deploy. In addition, many warriors are planning their return home while simultaneously planning their imminent re-deployment. In the current OEF/OIF operations, how warriors are adapting during reintegration into civilian life is not a military issue and has received little attention aside from acts of suicide and homicide (Doyle & Peterson, 2005).

As mentioned previously, service members are screened pre- and post-deployment. Soldiers who are deemed “at risk” during reentry, report having interpersonal and issues with their marriage, financial stress, use of drugs and alcohol,

medical problems and mental health and behavioral issues such as depression and anxiety. Reservists and National Guardsmen depend almost entirely on the community during re-entry, especially if they are not in close proximity to a VA, in comparison to their active duty peers and their families who have the benefit of a supportive community on post (Doyle & Peterson, 2005).

Increased use and abuse of alcohol for both active duty and National Guard and Reservists during reentry has been identified as a risk factor for both OEF and OIF service members. Hoge et al. (2004) determined that 24% of returning OEF/OIF service members used alcohol to excess and 21% of OEF and 18% of OIF service members who participated in a survey reported that they wanted, or needed, to cut down on consumption of alcohol. Research conducted by Bernhardt (2009) on co-occurring post traumatic stress and substance abuse problems found that Reserve and National Guard service members reported a new onset of heavy drinking following their deployments and an estimated 30% of OEF/OIF Veterans who engaged in substance abuse treatment have a co-occurring PTSD diagnoses. A study conducted by SAMSHA from 2004 to 2006 determined that younger veterans are at higher risk for both psychological distress and substance abuse than older veterans. In recent years, 54% of OEF/OIF veterans seeking services at the Department of Veteran Affairs are younger than 30 years old and approximately half are between 18-24 years old (Bernhardt, 2009, Seal et al., 2007).

Authors Killgore et al. (2008) conducted an understudied aspect of reintegration; behavior outcomes of combat veterans, focusing on their propensity for increased risk taking following combat exposure. The authors noted that, there has been less focus on behavioral outcomes that can have adverse impacts on both the health and wellbeing of

warriors following combat compared to research that has been conducted on PTSD. The authors hypothesized that “greater exposure to violent combat experiences would be associated with an increased habituation to dangerous situations and, therefore, greater propensity to engage in dangerous and high-risk activities upon returning home” (Killgore et al., p. 1113, 2008). The study determined that soldiers who were exposed to higher levels of violent combat, human trauma, and had killed someone, were at increased risk of engaging in risky behaviors such as speeding, adrenaline inducing activities, increased use of alcohol and verbal and physical aggression towards others. Of note, soldiers who experienced the loss or injury of a buddy were less prone to the extent of high-risk behaviors as their peers. The authors cited this as a temporary protective factor and may have been associated sadness and grief.

Mental Health

Although many combatants do not develop PTSD, the struggle to adapt during reentry is a reality for many returning warriors. BATTLEMIND, developed by the Walter Reed Army Institute, is a mental health preparatory training given to soldiers three to six months post deployment and prior to redeployment. BATTLEMIND is a set of skills warriors have utilized during war. The following represents how this framework is a survival mechanism in combat and can potentially be maladaptive in civilian life.

BATTLEMIND

B= Buddies (Cohesion) vs. Withdrawal

A= Accountability vs. Controlling

T= Targeted vs. Inappropriate Aggression

T= Tactical Awareness vs. Hypervigilance

L= Lethally Armed vs. Locked and Loaded

E= Emotional Control vs. Detachment

M= Mission Operational Security vs. Secretiveness

I= Individual Responsibility vs. Guilt

N= Non-Defensive Driving (Combat) vs. Aggressive Driving

D= Discipline and Ordering vs. Conflict (Slone & Friedman, 2008, p 57).

Deconstructing these vital skills that are learned behaviors for warriors during combat is crucial in the reentry process. Authors Slone and Friedman (2008) describe, for example, how service members may feel that they and their buddies are the only ones who will ever understand what they experienced during wartime and what they may be going through in the aftermath. This may present itself as an issue in civilian life as the service member may long for the close bond of his comrades and present as closed down and withdrawn from partners, family, and friends who “will never understand” what the warrior went through.

The training highlights the warriors’ inner strength to face fear and adversity, complete tasks, with courage and that combat stress reactions in the theater are normal responses in reaction to an abnormal environment. The training emphasizes the combat skills that helped a warrior survive and how to transition those skills and ingrained way of coping in civilian life. Prior to returning home, warriors are reoriented to learning adaptive responses and habits that are acceptable in civilian life while still maintaining the discipline, safety and focus of a soldier. Issues during reintegration begin to surface when soldiers are not able to make the shift from warrior to civilian. As mentioned previously, aggression is an integral part of the warrior. In the combat theater, “combat anger” and being aggressive keeps the warrior sustained and alive and is an appropriate

response to the threats of being in a war. Research on Veterans with PTSD has shown that they tend to struggle with regulating strong emotional responses, have increased anger, hostility, aggression and interpersonal violence as compared to veterans without PTSD. In addition co-morbid diagnoses such as substance abuse and additional mental health issues contribute to an increase and in ability to modulate an aggressive response (Moore, Hopewell & Grossman, 2009).

Tactical Awareness is another key component of a warrior and is an adaptive battle response. Many service members who return home struggle with the ability to “shut off,” and this life saving skill in the theater is transformed into hypervigilance, a maladaptive response in civilian life. Authors Conoscenti, Vine, Papa and Litz (2009) describe how Veterans can become stuck in seeing the world through a “combat lens”, viewing their surroundings as both dangerous and a bad place, leaving them on high alert and preparing for danger at all times:

For service members with hypervigilance, trauma-related stimuli automatically trigger this network of trauma related responses...Traumatic experiences have the potential to freeze chronically activate cognitive networks that, while protective during true danger, tend to be maladaptive in normal conditions, for example...a traumatic explosion in a crowded Baghdad marketplace might establish a strong mental association between crowded spaces, the notion of being attacked, fear, and physiological responses to fear. (Conoscenti, Vine, Papa & Litz, 2009, p. 129)

These reactions can have a debilitating effect on veterans as even the thought of going to a location that activates fear could result in a hypervigilance response. Therefore, the veteran may utilize maladaptive coping mechanisms such as isolation, and alcohol and drugs as a means to escape. Both hypervigilance and a state of hyperarousal can eventually become habitual and a great challenge for veterans to overcome.

Authors Cozza et al. (2004) from the National Center for Post-Traumatic Stress Disorder and Walter Reed Army Medical Center, outlined a “Multi-Phasic Stress Response,” describing the three phases a warrior may go through following a traumatic event.

Phase	Description	Diagnostic Considerations
Immediate	During or immediately after traumatic event(s): Strong emotions, disbelief, numbness, fear, confusion, anxiety, autonomic arousal	Battle Fatigue, Delirium (from toxic exposures, head injury), Acute Stress Disorder, Adjustment Disorders, Brief Psychotic Disorder, exacerbation of Substance Abuse, Personality disorders or traits, or premorbid mood, anxiety, or thought disorders
Delayed	Approximately one week after trauma or in the aftermath of combat: Intrusive thoughts, autonomic arousal (startle, insomnia, nightmares, irritability), somatic symptoms, grief/mourning, apathy, social withdrawal	PTSD, Substance Abuse, Somatoform disorders, Depression, other mood and anxiety disorder, Bereavement
Chronic	Months to years after: Disappointment or resentment, sadness, persistent intrusive symptoms, re-focus on new life events	PTSD, Chronic effects of toxic exposure, Dysthymic Disorder, other mood disorders, Substance Abuse Disorders, Emotional Recovery – perspective

(Cozza et al, 2004, p. 12)

Barriers to Mental Health Care

How soldiers are received, and the expectations of both the soldier and his or her friends and family members can become skewed and confusing and depending on reactions from community and family members, there is a chance that soldiers may be re-traumatized by questions and situations that arise when they return home. Hutchinson and Banks-Williams (2006) describe the stigma associated with receiving mental health diagnoses and treatment. In many instances if the soldier does not seek help, neither will the family. The authors noted “the stigma associated with seeking mental health services may appear greater once the soldier has been discharged from the military. One soldier stated that asking for mental health services was like saying ‘I just could not cut it’ ” (Hutchinson & Banks-Williams, 2006, Introduction section, par 3).

Hutchinson & Banks-Williams (2006) describe a typical scenario of a soldier who returns home after being treated at his army base for depression and PTSD symptoms. At home he is asked if he has killed someone during combat; his friends and family are not sure how to act. The soldier is unable to continue treatment due to a long waitlist at the VA, and is forced to cope with his reactions and symptoms on his own. There are also cases where soldiers may be discharged from the military without VA benefits or refuse to engage in military veterans’ services. In 2005, a study conducted by the Army Center for Health Promotion and Preventative Medicine found that 1,700 service members had thoughts about hurting themselves and believed they would be “better off dead” (Hutchinson & Bank-Williams, 2006). Of the 1,700 participants, 250 reported that they experienced these thoughts frequently and a total of 3,700 participants had fears and thoughts of hurting others and losing control.

One's racial, ethnic, and cultural background has been found to impact both stigma and barriers to care and stress reactions. A study of non-white Vietnam Veterans found that they had increased PTSD symptoms and African American and Hispanic Veterans had more challenges during the readjustment period compared to White Veterans. How the family and community respond to returning soldiers is a key component in aiding the recovery process. Some of the prominent challenges for soldiers returning with severe intra-psychic injuries are a great sense of guilt—these injuries are not validated or as important in comparison to soldiers who are wounded. The wounded soldier will most likely be perceived as a hero, one who is brave, strong, and honored whereas the stigma associated with mental health wounds deems those who have them as weak. Therefore, it has been found that 60% of soldiers do not seek mental health treatment, fearing the stigma and possible loss in career advancement. The outcome is that they are forced to cope with substance abuse, depression, anxiety and both suicidal and homicidal thoughts on their own (Hutchinson & Bank-Williams, 2006).

The stigma associated with seeking services for mental health is also a contributing factor to the increased use and abuse of substances for returning service members, as they will use as a means to self-medicate (Savitsky, Illingworth & DuLaney, 2009). Recent studies have determined that only 37% of eligible veterans are receiving care at VA medical centers. Authors Batten and Pollack (2008) described how many OEF/OIF veterans who initially come to the VA for care are seeking assistance for physical complaints and will not acknowledge concerns about their mental health due to stigma. The authors emphasized that the current OEF/OIF veteran population served at the VA varies greatly from previous eras, 12% are women, 50% are in the National

Guard or Reserves, and addressed the need to expand and modify services to meet the specific, multifaceted needs of this unique population. The authors argue that:

Effective care for returning veterans must incorporate all aspects of care. Functional impairments such as marital discord, parenting difficulties, employment problems, and difficulties with emotional regulation (e.g. “road rage”) need to be integrated... Additionally, given the high co-morbidity of PTSD with other problems, such as mild traumatic brain injury (mTBI), depression and substance abuse, it is imperative that an individual’s treatment is coordinated across domains. (Batten & Pollack, p. 929, 2008)

One of the devastating realities of recently returning soldiers that has received a great deal of attention in the news is the high rate of suicide and homicide. In 2003 the DoD reported that suicide rates in the military ranged between 10-13 per 100,000 troops depending on the military branch (Karney, Ramchand, Oscilla, Calderone, & Burns, 2008). In January 2009 the army released data showing the highest suicide rate of soldiers in three decades. In 2008, at least 128 soldiers committed suicide, and during the month of January 2009 twenty-four soldiers had committed suicide, this was more than the number of U.S fatalities in both Iraq and Afghanistan combined during the same month; from January through mid July 2009 there were 129 suicides. These high numbers provide implications for the dire need to address stigma in regards to mental health care, and address the full spectrum of both psychological and psychosocial stressors presenting in the current population of OEF and OIF active duty service members, Reservists, National Guardsmen and veterans.

The next section contains the Methodology of the study followed by the Findings from eleven qualitative interviews with clinicians who work primarily with OEF and OIF veterans. Their responses shed light on how they perceive their OEF and OIF clients’

cope both during their tour of duty and during re-entry, as they navigate their way back in civilian life.

CHAPTER III

METHODOLOGY

The purpose of this study is to investigate clinicians' perspectives on how their Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) clients cope during re-entry into civilian life. I examined resiliency, risks factors, and coping strategies utilized by OEF and OIF Combat Veterans during the post deployment reintegration process. The investigation explored clinicians' perspectives and their personal insights on veterans' coping mechanisms when faced with factors that make the transition a challenge such as: combat experiences, mental health symptoms, medical issues, psychosocial stressors, stigma and perceived and actual barriers to resources and care. The population under investigation was both male and female combat veterans who have deployed to Iraq and/or Afghanistan. The information and data was obtained from clinicians who currently work or have worked directly with OEF/OIF Combat Veterans and active duty service members.

The study was a qualitative, flexible methods research, using open-ended questions to gather the narrative data. Anastas (1999) describes how "in flexible methods research, unstructured data are used in order to capture the phenomena of interest in the words or actions of those who embody or live them and to capture them in context in terms that are as "experience-near" as possible" (p. 57).

Sample

This researcher used a purposive, snowball sampling technique to recruit participants. I contacted specific individuals, in person and via email whom I already knew fit the criteria, or who may be able to refer me to clinicians who may be interested in participating. Inclusion criteria for participation were the following: 1) clinicians who held one of the following degrees: MSW, MFT, MA in Psychology or counseling, RN, PsyD, MD specializing in Psychiatry or PhD. 2) Participants had to have worked with veterans for a minimum of two years and maintain a current case load that consisted primarily of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans. Participants were employed at VA Hospitals/Medical Centers and Vet Centers. The sample size was 11 participants.

I made every effort to recruit a diverse sample in regard to race, ethnicity, gender, age, and varied professional work experiences with veterans. During my initial contact with a potential participant, I stated the required credentials needed to fit participation criteria, if they have worked with veterans for the past two years and if their caseload consisted of primarily OEF/OIF Veterans.

Ethics and Safeguards

The interviews were conducted in person, in a public space, that was semi-private to protect confidentiality. I conducted phone interviews if the participant did not live in the same area as the researcher. The interviews were audio recorded with the consent of the participant. To ensure confidentiality per Federal Guidelines and the mandates of the social work profession, once recorded this researcher transcribed the data, which were analyzed thematically and all identifying information was removed and/or disguised. The

coded information and other documents were password protected during research activity and will be stored for at least three years in a secured location, after which time all information will be destroyed if no longer needed by this researcher.

I explained to them the purpose and design of the research project, and the nature, benefits, and risks of participation. I informed them that participation is voluntary and that all the information gathered will be held with strict measures of confidentiality per Federal Guidelines. I informed them that they were free to withdraw at anytime during the interview, or after the interview has been conducted and that all of their information will be withdrawn from the study and immediately destroyed provided it was before March 30, 2010. All participants were provided with an informed consent (see Appendix B).

Participants were informed that there would be no financial compensation for their participation in the study. They were informed that although they may not directly benefit, aside from sharing their experience, their participation could provide assistance and insight regarding the reintegration process for veterans that could potentially assist other social workers, mental health clinicians and community members better understand how to meet the needs of returning soldiers. By learning what has helped the veterans, and what their struggles have been, clinicians, individuals, and agencies that work with this population may develop and implement improved treatment interventions; they may be able to remove barriers to care, and gaps in services, for soldiers during the transition process.

Data Collection

The Smith College School for Social Work Human Subjects Review Committee approved this study (see Appendix A). Participants were provided with the informed consent at the time of the face-to-face interview and in advance, if the interview was conducted over the phone.

Data collection was obtained through semi-structured interviews that ranged between 30 minutes to one and a half hours, depending on the length of their answers. Participants were asked a total of ten open ended questions pertaining to their perceptions of their OEF/OIF clients' coping mechanisms, resiliency and risk factors during the reintegration period. Additional questions included the following: relevant combat experiences, mental health symptoms, psychosocial stressors, stigma and perceived and actual barriers to resources and care. Participants were also asked basic demographic information; gender, race, educational degree, if they served in the military, a brief description of their clinical role and number of years they have worked with veterans (see Appendix C). Narrative data were gathered by means of audio recording. The researcher later transcribed the interviews, and identifiable information was disguised or removed to ensure confidentiality.

Data Analysis

The data coding was manually analyzed thematically, observing both similarities and differences in response. The transcripts were grouped in relation to each interview question and then placed into categories based on the occurrence of emerging themes, phrases and words. The themes emerged directly from the interview questions.

CHAPTER IV

FINDINGS

The purpose of this study is to identify clinicians' perceptions on how their Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) clients cope during re-entry into civilian life following a tour(s) of duty in Iraq and/or Afghanistan. This section contains findings that are based on 11 interviews conducted with clinicians whose current caseload consisted primarily of OEF and OIF veterans. Interview questions were designed to gain the perspective of clinicians on the challenges and coping strategies that their clients report as they make the transition back into civilian life. Interviews began with demographic information about the participants, which included: race, gender, clinical degree, number of years they have worked with veterans, if they have served in the military, a brief description of the work they have done with veterans, and the current number of OEF/OIF clients they serve. The second section focused on how warriors describe their combat experiences and coping strategies utilized—including risk and resiliency factors—while they were deployed. The third section concentrated on reintegration into civilian life with an emphasis on psychosocial stressors, multiple deployments, and mental health symptoms. The fourth section is based on what clinicians perceive to be barriers to mental health care. Questions were also asked that specifically pertained to the experiences of women in the military. The data are organized as follows:

- 1) Demographics of the participants
- 2) The Warriors Experience in the combat theaters

- a) Women Warriors
 - b) Coping Strategies
- 3) Reintegration into Civilian Life
- a) Psychosocial Stressors and Multiple Deployments
 - b) Mental Health
- 4) Perceived Barriers to Mental Health Care

Demographic Data

Demographics of the Participants

This chapter is comprised of the responses of 11 clinicians who currently work with veterans who have been deployed to the current wars in both Iraq and Afghanistan. Seven of the participants are female and four are male, when asked to identify their race, ten of the participants identified as Caucasian and one participant identified as Biracial (“black/white”). In terms of educational degree, five participants are licensed social workers, four participants hold a PhD in Psychology, one participant is a Registered Nurse and one participant is a Licensed Mental Health Clinician. Four of the participants are Veterans, two were in the Army, one was an Army Reservist and one was in the Air Force. One of the participants was deployed to the current war in Afghanistan. The Veterans described their duties in the military as follows: administrative and telecommunications, civil affairs, infantry, medical unit, mental health technician, a B-52 gunner and the director of mental health services on a base in the United States.

Two of the clinicians have worked with veterans for 30 years and one has worked with veterans for 17 years, the remainder ranged between two to nine years. When asked how many years they have worked specifically with OEF/OIF veterans the range was two

to eight years. Two of the participants worked at Vet Centers and nine participants worked at a VA. Seven of the clinicians were employed in agencies in Massachusetts, the rest were based in New York, California and Rhode Island. The clinicians caseloads of OEF/OIF veterans ranged between ten to twenty-five clients, two participants reported that they see “hundreds, too many to count.”

Experiences in the Combat Theaters of Iraq and Afghanistan

Questions related to OEF/OIF service members’ experiences in the theater of war elicited a range of responses with the vast majority of participants reporting that their clients’ experiences depend on a multitude of factors. Although some of the respondents spoke of the relief veterans feel after sharing their experiences, others cited that many of their clients are initially hesitant or not willing to detail events that took place during their tour of duty.

A number of respondents (n=5) described how their clients’ experiences in both Iraq and Afghanistan varied greatly and depended on their Military Occupational Specialty (MOS)—their rank, skill level, duties and training—where they were stationed, and the stage of the war when they were deployed. Participant One, described how “some of them will talk about experiences in the Green Zone, meaning that they were not engaged in combat activities...and others were in much more danger and high stress situations...so there is a very wide range.” Here, Participant Nine, discussed the wide spectrum of experiences while noting a common theme he has observed, regardless of their MOS:

It really varies widely on what their duties are, when they are overseas, where they were, when they were there. Some of the clients that I have worked with have been involved in the first wave of fighting... some have been involved in

trying to maintain peace, some have been involved in literally taking over a giant city like Fallujah [and] some are involved in running transport and all kinds of things. So it really is a wide spectrum of experiences... I think that the unifying factor has been that none of them, no matter what they were doing, felt particularly safe. All were exposed to at least mortar attacks, or the threat of an IED and, as I am sure you know, one of the character or signature features of the Iraq war is IEDs. So there's always the threat, every time you get on the road, of something happening. And it doesn't matter if you are infantry, or a combat soldier or if you are part of the mental health team that is just being transported to another FOB (Forward Operating Base), the danger is there every time you get out of the gate. So it's a common thing that I think all of them have. But I think in terms of experience and exposure to actual fighting that varies pretty widely.

More than half of the participants interviewed (n=7) talked about how their clients reported exposure to life threatening situations such as: exposure to IED (Improvised Explosive Device) and RPG (Rocket Propelled Grenade) attacks, suicide bombings and the constant stress of not having clarity about who the enemy is. Participant Four, explained how many of her OEF/OIF veterans, who were in Infantry, described their combat experience as “chaotic and crazy...very intense” as opposed to a client whose MOS was in Civil Affairs and “describes having a great experience, he really enjoyed interacting with the locals and they were doing a lot more humanitarian missions.” Another clinician, Participant Two, cited that some of her clients describe their experience “as the best experience of their life that it was great and the high was so high, they felt like God.” She gave an example of one of her clients whose dream was to be in the Army, to be a hero, “he will talk about how he went to Iraq and he found out that he was not a hero, that he is not even sure if he is a man, but he's definitely not a hero and he will talk about the loss of that dream.”

The extent to which veterans detailed their experiences appeared to also depend on the clinician's role or specialty while working with veteran clientele. Participant

Three, who focused on reintegration issues described how, “they typically don’t go into detail [about their combat experience], initially with me, that part of it, as much as the difficulty they are having readjusting.” Whereas Participant Six, who conducts exposure therapy with veterans, mentioned how clients detail their most traumatic experiences, as it is a part of the therapy. Participant Eleven, is the first therapist to meet with clients before they are referred to the mental health clinic. She describes how, “a number of them are definitely presenting with survivors guilt...A lot of them report being horrified by the aftermath of IEDs blowing up their fellow soldiers, finding body parts and that sort of thing.” Participant Seven was the only clinician who mentioned her clients’ affect when they describe what they experienced. She describes how her clients present themselves as:

Flat, very flat... The majority of these guys I talk to, that talk about their combat experience and their traumas, as [though] it’s very matter of fact...and the things that they are saying are horrendous, but they are talking about it, they are expressing it, it’s nonchalant, it’s peculiar to me because it’s not punctuated...this somber, flat reporting.

Two participants identified both the environment and living conditions as factors that were very challenging for their clients. Participant Nine spoke of how soldiers do not get enough sleep, and that four consecutive hours can be a luxury. He went on to describe how the environmental factors alone, are very challenging for soldiers:

I hear a lot about it being very cold at night and above 120°F or 130°F in the daytime. I worked with a number of soldiers who were one of the National Guard units...assigned to Abu Ghraib prison. And they talk about having heat upwards of 130°F during the day and this wearing full battle fatigues and also Kevlar, the protective armor.

Three of the respondents identified how some of their clients have described coping with their experiences by maintaining the mindset that they are there to complete

a job—regardless of their duties or belief in what they were doing. Participant Five described how a theme with the veterans that she serves is “that they are there to do a job, that they feel this high level of camaraderie amongst each other, and that there isn’t a good understanding as to why they are there...And that they are there to follow orders and that’s it, but they don’t necessarily agree with what is going on.

Women in Combat

Recognition and Training

In the current conflicts in both Iraq and Afghanistan there has been a historical shift in the role that women play and in the number of women that are serving in the military. A number of women warriors are in active combat roles, however do not receive recognition or adequate training needed to perform their jobs, which can have a negative impact on both their experience in the theater and this is reflected once they return home. A number of respondents (n=4) described how their female clients have discussed both stress and frustration with the lack of training and the absence of recognition they received as women in the military. Participant One described how:

Female combat veterans talk about the lack of validation... that they get from their combat experiences. For example when a female is a combat veteran, when a male is in the service... during these current wars they are assumed to be combat veterans. Females are just the opposite, assumed not to be combat veterans and yet there are increasing numbers of women in the military who are called upon in combat situations so there is this lack of validation for them. And they always have to prove their service. And so because there is that lack of validation and lack of assumption, they are not offered the same services. They are not treated as if they have had the same experiences and potential impacts so that is really difficult for them.

Participant Three spoke of how it is very important for his female clients to be perceived as being a soldier, just like their male counterparts, “that they were doing their

job, not that they were a female. They don't often acknowledge or even want to validate as that being different for their experience. Now they know that internally, but they want to be just another service member." A common theme identified by respondents (n=5) was that since women are not recognized as combat soldiers, they do not receive the same training as their male counterparts, which ultimately places them at higher risk when they leave "the wire" and go on missions. Two participants described how women often accompany combat missions to assist in searching the Iraqi civilian women and their houses. Participant Nine emphasized the changes that have taken place for women in the current wars describing how:

I think one of the things that is happening with this war, that is coming to light, is that more and more women are involved in not just support operations but front line operations. They are in vehicles that are being transported and in many instances they are fighting.

The clinician provided an example about a specific team of women in the Marines, called "Team Lioness" who goes on missions to provide:

A calming force with the families...and with the taboos of Muslim women being touched by men, they needed the women to do pat downs and stuff like that...And this particular group of women was often in the midst of fire fights and were often exchanging fire as well. And kind of the sad irony is that women in the military are not trained as combat soldiers. So reports that these women have given, has been that there were points in combat when they would realize that they might be overrun and they might be the last person standing and they didn't know how to operate the big weapon that they were sitting right next to. So lack of training and yet probably more combat experience than some of the infantry soldiers.

Participant One also detailed the increased stress and danger for female warriors due to their lack of training and the positions that they are ultimately placed in under the guise of combat support. She highlighted how women can be trained in the Army and then embedded in a Marine unit:

They will go into that unit in a combat situation and they won't understand the commands, they won't understand the lingo that the Marine leaders are using...Its very dangerous situation for them and that is something that is being looked at and addressed.

She went on to describe how there have been some changes in the military and women are now being trained on all levels of weaponry, however, she stressed that women warriors' trauma can be a result of the stress attributed to both lack of training and preparation because they did not expect to be in direct combat situations. When women are embedded in other military units other than the one they have been trained in,

Participant One emphasized how:

It could be a very quick learning curve for you in that stressful situation to figure out how to operate [the weapon]. We have heard people talk about things as simple as trying to figure out where the safety is in the moment of having to use the weapon, being under fire and being left behind. They talk about being left behind when the squads or platoons they are assigned to move out because they don't recognize the signals...so those kinds of things happen and are at the forefront. They are pretty concerning for women and would definitely have an impact on post deployment health.

Participant Five also discussed how, for example, a female service member would be deployed to Iraq or Afghanistan expecting to be a cook, do administrative work, or assist with language and end up "holding a gun and being out on the force...unsure about what you are doing day to day and week to week."

Military Sexual Trauma

Many of the participants (n=8) identified military sexual trauma (MST), which includes sexual harassment, as a factor that specifically effects women in the military, although respondents' also identified MST as risk for male soldiers. For the most part, participants mentioned MST as a factor, but did not elaborate on specific details. One participant, Five, described how "from the women I have interviewed, there is a rule that

you never go anywhere alone, they always go in twos. So not only are you alert about the enemy but you are also alert about the enemy within your own team.”

Participant One described the challenges for women as they are the vast minority in units consisting of all men; “Women talk a lot about MST as a result of being in these units and deployed with men who are away from their wives, you know the scenario...so they have these components to deal with as a very vulnerable part of that deployment because they are a minority.” Participant Six stated that he has worked with very few women, but “women that I have worked with...sexual harassment or abuse is sort of the primary concern that they are presenting with.” Participant Three said that he currently works with one woman who has MST, “and her focus is entirely different” than the other women with whom he works.

It should be noted that all eleven participants, when asked about women warriors’ experiences, remarked that they work with very few female veterans. And although women comprise approximately 14% of the current military force, women are not coming to the VA and Vet Centers at the same rate as the male veterans.

Coping Strategies Utilized During the Tour of Duty

During deployment, the ways in which a warrior is able to cope with the daily stressors of being in a combat environment can impact or aid their emotional and mental health and potentially determine how well they will cope during re-entry. There are numerous risk factors associated with being a warrior in a combat situation. Therefore, by asking participants what protective or resiliency factors their clients have shared with them and ways they coped during their tour of duty, the intention was to elicit the less known factors of what keeps a warrior thriving when faced with constant adverse

situations and threat to their lives. Participants identified a number of ways their clients have coped, including both healthy, protective ways, and maladaptive means.

Social Support

All eleven participants identified social support as a key protective factor for their clients during deployment. Eight of the respondents identified family and loved ones back home as one of the main ways their clients described surviving the mission.

Participant One commented how:

I can't think of anyone when they talk about their military experience that doesn't talk about family...somebody back home, some link to their family that keeps them strong, keeps them going, keeps them counting down the days until they come back.

Another participant, Five, described how knowing that they have family or someone waiting for them when they completed their tour was a significant protective factor. The clinician also described how both the age of the service member and whether or not they were on active duty or in the National Guard or Reserves made a difference:

I think [it] is a bit harder for the younger guys, and this is so general, but the younger guys who aren't married, who don't necessarily have a family outside of their parents and sibling and maybe not having the same "family" to come home to...not having that [someone to come home to] tends to make things a little scarier for people.

Participant Three also stated that the National Guard and Reservists tend to place more weight on the family system as a means for coping during their tour. Participant, Seven, described how older service members, who are more likely to be in the National Guard and Reserves, tend to cope better than the younger OEF/OIF soldiers. She noted that, "the older OEF/OIF veterans I see have a maturity about them that I think made them resilient. They are not talking about the small things, they seem stronger than the

younger ones.” Participant Eleven also remarked how older service members tend to be more resilient than the younger veterans, “I am not seeing as many veterans in their forties or late thirties with PTSD. They may have PTSD symptoms but they seem more resilient.”

A number of participants described how the availability and access to technology has allowed troops to communicate with loved ones by email and phone. They described this as being both a protective factor and a risk as some service members will worry about things they are not able to take care of on the home front. In addition, service members are not able to disclose to loved ones details of what they are dealing with on a daily basis, which can increase stress for both loved ones and the service members.

Another protective factor mentioned was the social support of the unit, including leadership, training, unit cohesion, and the bond with their peers. Eight of the participants reported that one of the primary coping mechanisms during deployment for military service members is the connection and support of their military peers. Participant Three described how: “They talk about the unit cohesion being important, regardless if on active [duty] or reserve. If they were on a combat patrol together, if they experienced something together, they have that level of connection with another individual.”

Participant One also stated that, “Their peers in the military are essential and they form their own family within their units and that’s partly why it is so hard for them to adjust post-war, post-deployment, because that family unit kind of breaks down a bit as they are expected to readjust.” Another responded, Four, mentioned how, “I really think that the only thing that gets you through that, the main mission of bringing yourself back home

alive and bringing your buddies home alive...the mentality of 'I have to keep myself and my buddies alive.' ”

Leadership and training was mentioned by two of the participants. One participant, Nine, reported that:

Some of the soldiers did really well...who their commander was, and in particular who their NCO (non-commissioned officer) was and how they approached problems was a big factor. Some soldiers had first sergeants who, for example, would just really, what they call 'smoke them' when they got into trouble, really make their life miserable. Others had NCOs who were tough but also very compassionate and really went the extra mile for them. And I could see the difference in the soldier when they brought them in. It was very clear the ones that felt like they were being ostracized by the unit versus the ones that felt like they were being supported. It made a big difference.

Participant Two described how having a belief in the cause and the mission was both a protective and a risk factor. She commented that for some of her clients:

Especially initially, there's that belief that they are doing the right thing, a belief in the military and in their cause. And I think some times, when that falls apart and they become disillusioned...I have a few when they started to doubt the rightness of what they were doing, that is kind of when they started to have some troubles.

Three of the clinicians described how their clients played video games as a way to escape their current reality and relax. Two of the participants indicated that becoming numb and compartmentalizing their experiences was a common theme that they observed with their clients. Participant Seven described:

They tell themselves that they had a job they had to do, that they needed to do a good job and that job would end. They made that their banner for being there, and that was their list for how they were going to feel, and they did do it. And they are back here, but I think that they compartmentalize everything, put it in a little box, trying not to get affected by the other stuff. You know its not really a job, it's a life threatening experience...[but] that's how they protected themselves and that's how they coped.

Three participants mentioned faith as a way to make meaning and get through the mission. Participant Four stated that, “faith...is another coping mechanism that has been mentioned, just praying to God or believing that God will help them get through this.” Another participant described how, in all of the veterans that she serves, only one has mentioned faith:

He is the only one that said his faith in God got him through; got him home and I see a lot of veterans, which is kind of sad. Maybe they lost their faith; maybe their faith didn't fit into the “box”, they had to give it away.

Participant Three, mentioned how the military has implemented more combat stress debriefings in both Iraq and Afghanistan, however, he stated that:

Most of the Marines or soldiers that I talk to would often do that only in the worst-case scenario or as a mechanism they had to go through because there was a fatality. But they would not actively seek out those [mental health team] individuals. There is still a stigma that exists within the military.

Only one clinician, Nine, mentioned the level of one's education and rank as a protective factor that he observed when working with active duty service members on base in Germany. However, he noted that the stigma in regard to mental health services and being perceived as weak could have been a contributing factor to the low numbers of officers seeking mental health services on base.

Risk Factors

Although alcohol is officially prohibited on military bases, the use of alcohol as a means to cope was a very common response from seven of the clinicians. Participant Nine commented how he observed the norm of alcohol consumption for active duty Army members to be very high:

It's really not considered a problem if you drink 10 beers a night as long as you make call in the morning...it only becomes a problem when you are not

functioning at work adequately...typical pattern was to work hard and party hard and there was no in between.

One respondent, Participant Three, who is an OEF veteran, stated that, “general order number one is that there is no alcohol” in both OEF and OIF. He described how soldiers tended to escape “internally,” and either workout, listen to their iPods or watch DVDs.

Three of the participants mentioned having adverse childhoods or a history of abuse and mental health issues pre-deployment was a risk factor for service members, both during and post-deployment. Participant Eleven remarked how:

Certainly, we know that a lot of them have dysfunctional families to begin with. A veteran who died recently...he had a very poor attachment with his parents. He definitely had PTSD and we would say complex PTSD because of that, so with that missing that made him less resilient.

Participant Nine summarized by stating:

Many of the soldiers that I worked with overseas had histories of abuse and of very difficult childhoods. That is one of the things that I learned about the Army—I worked with the Army—is that the Army is a really diverse community. There are highly educated people in the Army and there are also folks in the Army who, this is kind of their last recourse. I ended up working with a good number of them who, I think they saw the army or the military as being kind of their way to pursue the American Dream. And when you listen to their childhoods they had really difficult, painful childhoods—foster care, etc., sometimes jail and saw the military as a way to kind of straighten themselves out and maybe even kick a drug habit or something. And get on the path to making something of their lives and having the kind of white picket fence that they dreamed of. Soldiers with those kinds of backgrounds, I think, had a harder time...they hadn't learned how, other ways to deal with stress and difficult situations and didn't have the protective factors to begin with.

Only one participant, Eight, mentioned the increased rate of suicide as a potential risk factor for both active duty service members and veterans of the current OEF/OIF wars. The participant stated that in the first eight days of 2010 there were eight recorded suicides in the Army alone. He noted that a high number of service members are

presenting with co-morbid diagnoses, i.e., depression, PTSD, substance and alcohol abuse, and attributed these factors as contributing to veterans' increased risk of suicide.

Reintegration into Civilian Life

An Outsider Looking In.

Without hesitation, all of the respondents noted that their clients reported that their experiences as a warrior had both changed them and had a significant impact on who they are today. Nine of the participants stated that many of their clients do not initially identify the changes themselves and may not be aware of the extent of the impact their tour had on them. The clinicians noted that the changes tend to be identified by a family member or spouse who then encourages the veteran to seek treatment. Participant Eight commented how, "when they are threatened by divorce or they were identified by another person that recognizes the changes that have taken place, [then] they are forced to come into the clinic." Participant Three commented how no one can go into combat without being changed, even if it is a peacekeeping mission. He described the experience as an "existential crisis...they don't use that term, but it was an existential crisis. They come back and things just don't fit anymore; they question core beliefs they had before."

Participant One also described how:

Some of them have an existential crisis within, where they struggle with things that they may have found necessary to do, or ways of being in the military that do not sit well with how they identify themselves...They are in that crisis, they are in that lost period where they are trying to figure out who they are.

The same clinician described how the majority of clients who come for mental health services are the ones who are in distress, who have identified within themselves, or by

others, that they have been significantly changed by their experience. The respondent summarized by stating:

They talk about changes in their relationships, they talk about changes in their finances, they talk about being in crisis in all aspects of their lives—emotional well being, not being able to sleep, drinking more, utilizing drugs when they would have never done that before. Changes in their behaviors, changes in their personalities, not being able to tolerate people, not being able to find or hold a job, having difficulty in social interaction with their children, difficulty in feeling that they can fit into relationships that they were in before. Being changed in so many ways that people don't understand.

The inability to relate to civilians was a theme that was identified by many of the participants. Participant Four commented how her clients have told her:

When they come back home they often feel they are 'an outsider looking in.' It's hard for them to relate to their peers, to identify with the things that their peers are doing. Their perspective on life has changed... And, you know, veterans think that they can just come back and pick up where they left off, and they are completely caught off guard when they can't... They are completely unprepared for this emotional battle that is huge; between not being able to relate to their peers, to feeling like they are an outsider in their families. Wondering what to do with the memories, the flashbacks, the anger and these other feelings that are now brewing inside of them as a result of their experience. And I think that also, people's faith in humanity just also shattered. After you witness things in a combat zone or have to commit atrocities... I just think they don't know what to do with that... No one will really be able to understand that unless they have been in a combat zone, they cant understand.

The participant described how she has an OIF client who held his buddy in his arms while he died. The client explained to her that he feels like his experiences in Iraq were surreal, "they were almost unbelievable to him. He can't believe that he went through that stuff." Participant Nine also discussed how his clients feel that civilian life is a world they can't be apart of as much anymore; that they do not fit in. He spoke of how:

It's not just because of their own agitation or anxiety, it is because they have seen and witnessed things that people can't imagine and they feel as a result, that no one shares their experience and pretty quickly [they] can develop stories about themselves that 'this is how I am, civilians can't get me'... So they can very

quickly get a kind of isolative marginalized existence...when you listen to their lives, they just got increasingly smaller and smaller to the point that some of them are literally hiding out in their basements most of the day.

Participant Seven gave an example of when a client's father wrote her a letter for a disability claim. The client's father described how when his daughter had returned from her second tour of duty she would sit in a chair staring out the window, and he believed that his daughter did not come back from war, that she was looking for herself as she stared out the window.

A common theme shared by the majority of the respondents when describing how their clients have changed was a low tolerance level for situations that used to not bother them, feeling that they cannot fit in with civilians, hypervigilance—more cautious and being constantly aware of their surroundings, less trusting of people and socially isolating—and everyday tasks of living became very difficult. Participant Ten noted that her clients feel that “they don't belong here, back in the U.S. A lot of them want to go back, even though they didn't necessarily like it when they were over there [but] most of them determine it was easier over there.” Participant One also noted that veterans struggle with “trying to figure out why [civilians] don't get it. They recognize that we don't get it...but they have a really hard time finding the words to make us get it and they give up. They feel like they are on the periphery within a community that they were once a part of.” Another participant, Nine, remarked how his clients also describe this:

Life suddenly got hard. They weren't able to make the switch. I often hear from the combat vets that they feel like if they could, if they were given the chance, they would love to go back. Which makes sense, it seems like they are almost programmed to be over there and all their reactions, all their startle reactions all the hypervigilance, all the agitation makes total sense in a combat environment is actually adaptive and they are back here and all that stuff is running.

The same clinician described how some of his clients have discussed being afraid of themselves, “of their anger reactions here and are afraid, are very afraid that they will unleash the monster here and lose control.” He went on to describe how some clients struggle with coming to terms with how they reacted in certain situations during their tour of duty and struggle with their core belief system because they did things they did not believe they were ever capable of doing. He provided an example stating:

Reacting with rage, or overkill, or doing something that they would have never thought, or seen themselves doing, and excitement about doing it. A very, very common experience with combat vets, veterans who have been in a combat situation and been fired upon and fired back, is the experience, that they describe it as being kind of strangely the greatest rush that they have ever experienced in their life, and that everything else has paled to that. One of the vets said... “there is no greater rush then prevailing over your enemy, that was a few seconds ago trying to kill you.” And so it really is an intoxicating feeling and they find themselves, many of them report missing that rush.

Participant Two mentioned how all of her clients describe being changed and doing things differently than they used to. However, she stated that it is hard for many of them to articulate how they have changed:

They are kind of caught in this transition, but they don't yet know what to do with it...it's changed them because they don't know who they are...[it has] changed their identity. I have had a few who have said, “If people found out what I did there, they wouldn't love me anymore, if my parents knew, if my wife knew.” So there is definitely that difficulty with their identity and their sense of value in the world, which changes them.

The participant also described how her younger clients who are in their early twenties, tend to struggle more with their identity. She discussed how the questions they grapple with and the experiences they have had created a further divide between them and their civilian peers who are the same age. Participant Eleven commented how “being

changed,” and not knowing how to cope with the changes, is one of the main reasons veterans are presenting for mental health care.

Psychosocial Stressors During Re-entry

The re-entry stage following a tour of duty in Iraq or Afghanistan can be an extremely difficult stage for military personnel. The re-entry phase does not have a definitive time frame and although there are service members who are able to adjust without significant problems, all service members have to adapt and make the adjustment from a battle mind frame to one of a veteran in the civilian world. This alone can be a challenge. The predominant stressors for service members during re-entry identified by respondents were: employment and financial issues, relationships with families and partners and interacting with civilians. The service member is not only trying to adjust to external stressors but also has to learn how to cope in a civilian environment. Many struggle with the inability to shut off their battle mind mentality, responses that have been protective and kept them alive during the combat theater, quickly become reactions that interfere with their reentry. What has kept warriors going and helped them cope with their tour in the combat theater, including connections with loved ones at home, during reentry, can become their primary stressor as they attempt to navigate their way back into civilian society.

Nine of the respondents described how one of their clients' primary stressors during re-entry is their relationship with loved ones, specifically, immediate family and peers. They described how, when a service member is deployed, the partner who is left at home has to take on new responsibilities in their spouse's absence. When the service member returns home, challenges arise when the roles have shifted and the service

member may struggle with having to find their place within a family system that may appear to have been functioning fine without them. Participant Four described how:

A lot of times the parent that was left behind during deployment has had to take on the role of mom and dad, so the person who comes back feels that they can kinda just, jump back into that role and there is a lot of tension, marital tension within the family because sometimes the veteran feels like, ‘Oh my gosh I don’t even know what to do within my own family.’

The clinician noted how many times they would feel like a stranger in their own family. She also mentioned that younger veterans, who return home to their parents, tend to struggle more with social relationships and with their parents who themselves have no idea what their child has experienced. Participant Nine also mentioned how, for parents who have been deployed, missing milestones and the developmental stages of their children is a huge stressor. Participant One discussed how the family system which was a source of support during the tour, can become a significant source of stress especially for National Guard and Reservists who return to their community, as opposed to active duty members who return to base and have more support within the military community.

Veterans not only struggle with their relationships at home and redefining their place in the family system, but face challenges relating and integrating back into the civilian world. Two of the participants described how veterans struggle with how they are perceived by civilians—specifically their attitude and their frustration with civilians’ attitudes. Participant Four stated his clients have reported to him that they struggle with social relationships because they are “sometimes perceived as kind of cool, which was not their normal behavior prior to” deployment. Participant Three described how:

Dealing with the community at large—being respected as a veteran, being recognized for what they have done, and a negative way to look at it is that they have a chip on their shoulder but they are really feeling a need to be validated.

There's a sense of not necessarily being validated, regardless of programs and parades and honors that are bestowed upon people, that sense of not being validated. And again, depending on their MOS, they get tired of that BS after while.

Another participant, Six, described how his clients are more prone to struggle with “control issues...sort of an exaggerated need for control and frustrated at lots of things they don't have control over.”

Financial stress, the economy and finding employment are factors that were discussed by more than half of the respondents. These clinicians described how, for many of their clients, readjusting to a civilian job presents a significant challenge. A common theme was that many service members are not able to translate or transfer their military skills into civilian jobs. It was also mentioned that service members who held a position in the military where they were in charge, it was extremely challenging to come home and not be able to find a job or have to work at a “supermarket.” Participant Three elaborated by stating:

How do you integrate, how do you go back to a job being a plumber after your duty assignment was maybe a truck driver where you are getting blown up—IEDs are going off and you experience life, death, you helped Iraqis or Afghans and then you come back and now you are going to crawl under a sink or fix toilets? It doesn't fit so the stressors revolve around work, family, that whole reintegration, and it's normally not one or the other...there are multiple stressors.

Participant Four described how her OEF/OIF clients either don't have jobs or are not able to translate the skills that they have learned in the military into civilian jobs, she described two of her clients, stating, “one was an armor guy and one was an infantry guy and they both have these skills that unless they are going to be cops or something, are difficult to transfer.” The participant also discussed how her clients, who have jobs when

they return, struggle with their civilian co-workers. There can be tension due to the veterans' low tolerance of frustration and adapting to a new routine.

Participant One summarized and outlined the predominant psychosocial stressors during re-entry:

Service members returning now, are returning to very poor economic times. Families that are stressed. When they deploy they receive combat pay, special incentive pay in order to be in harm's way. When they return they lose that. So their family members may have become very dependent on that, acquired a certain living style that is based on that pay level. And they are coming back to jobs that are not available, so they are stressed out about the lack of economic opportunities for them and for their families. And they may be facing homelessness in some cases, but certainly, joblessness is apparent. The guarantees that were once in place for employment, are still in place, but a lot of times the employers may have gone out of business or don't have the capacity to keep them on. Those safeguards cannot be recognized. So of course, all of the things that I have already talked about: the relationship issues, the needing to be able to relate to people who are military, who are non-military. Often times, they are impacted in such a way, both physically and psychologically, that they can't continue military service that they always had a full expectation of being in for a career. So now they are having to make career adjustments and retrain. A lot of the jobs in the military are not transferable skills to the civilian world. So someone who is really highly trained and has been validated for their skill level in the military may come back and find themselves with skills that are unusable. That's really difficult for them. There is a loss of self-esteem, and worth.

Participant Six mentioned that returning to civilian life, the lack of structure can present a challenge for clients. He described how the structure provided in military, the missions, a daily schedule and being instructed on what to do, and when to do it, becomes their norm, and can be challenging and overwhelming when adjusting to the freedom of making decisions in civilian life.

High Risk Behaviors and Methods of Coping Post-deployment

When describing how they cope with re-entry the vast majority of clinicians reported that there is an increase in primarily alcohol abuse but also substance abuse

when service members return from a tour of duty. It was evident that many of the issues veterans struggle with are closely related to symptoms connected to their mental health, specifically PTSD. Therefore, it was difficult to separate psychosocial stressors from mental health wellbeing. High-risk behaviors included: excessive drinking, drunk and reckless driving, physical aggression (getting into fights), suicidal ideation and suicide completion, isolation, and hours of video game playing. Participants remarked that due to their position as clinicians, they were not likely to see the veterans who utilized healthy means to cope with the stressors of readjustment. However, the fact that the veteran was seeking mental health care was identified as the first step in the process.

Participant One provided examples of ways in which veterans are able to navigate their re-entry in a healthy way:

There is a lot of positive ways they cope; they'll become mentors, volunteer, go to support groups and talk to other veterans. Some will get involved with anti-war activism; some will go into law enforcement. Law enforcement and the criminal justice system are very parallel to military service, so there is a comfort zone for some for that. Some will file claims for disability, which will enable them to seek out services that will help them. Some will engage really well with mental health services that are provided.

The same clinician mentioned that she believes the age of the service member and their level of leadership plays a role in how veterans are able to cope during their tour and post deployment. She reported that older service members and individuals who had leadership roles tended to fare better than the younger veterans.

Mental Health Symptoms, Behavioral Responses and Coping Strategies

When asked how their clients cope with their mental health symptoms and how they identify emotional and behavioral responses during re-entry, the primary mental health symptoms appeared to be directly correlated to symptoms of PTSD. Also, all of

the clinicians focused on behaviors that the clients were exhibiting rather than identifying specific pathological diagnoses.

Six respondents noted that avoidance of symptoms, at least initially, and isolation are a common factors observed with the veterans they serve, and again, the veteran will tend not initiate treatment until his or her behaviors are identified by loved ones.

Participant Three described how many returning service members come home expecting to jump in where they left off:

So typically when these people finish rotation they come off and view themselves as still hard charging...and it's not until their family systems, their wives, their husbands...or the police are involved that they realize that they are having problems; that they are have issues with anger, they have issues with anxiety, they have issues with depression. They won't use those terms. Its rare for a person to say, 'Yeah, I feel I am depressed,' ...often its 'angry' or 'stressed out.'

Three participants mentioned that some of their clients, initially, were not able to identify how they had significantly changed, and how those changes were impacting their lives.

And for many, they did not seek professional services until they "hit rock bottom," relationships dissolved, were unable to keep a job or got into trouble with the law.

Participant One described how many clients will come to seek a service connection and medical care and do not realize that they may be struggling in other ways, "it's become their norm." She went on to describe how:

These guys come back and they are proud of their service so they don't recognize the way they are behaving, that "gung ho" kinds of military behaviors are problematic for them if they don't learn how to adjust back. So they don't engage readily, they don't come through the door and say, "I've got mental health issues." What they usually do is come through the door and say, "My ankle hurts, my back hurts...I can't hear the way I heard before." The stance is usually, "there's nothing wrong with me." When we start asking specific questions, then it's, "oh yeah I have that, oh yeah," without realizing that it all adds up.

Seven respondents identified anger, rage, and being easily irritated as very common behavioral and emotional responses in addition to depression, anxiety, and sleep issues. Participant Two described how clients may isolate, not leave their homes due to anxiety, or because they are afraid of their anger, “If I go out and I get angry, I may hurt people.” Participant Six commented how; “Anger seems to be a pretty common complaint, how they express anger, easily irritated, easily frustrated, angered by common everyday things that people around them do.” He went on to describe how he rarely gets reports of physical abuse, “but occasionally that’s a problem.”

Participant One noted that she tends to see an increase in anger, violence, hypervigilance, and high-risk behaviors in veterans who were “engaged in true combat and or exposed to combat residuals.” She also commented how, although deployments are stressful regardless of a service member’s MOS, she has observed that one’s response depends on the veteran’s nature and life experiences prior to their tour. She also stated that she expects her clients to present with a degree of symptoms and behaviors, and discussed the challenge of adjusting and de-conditioning one’s mindset from:

That very clear battle-mind posture to a non-war posture...I expect for people to say to me, ‘yeah I react to sounds,’ and compared to me, yes they will over react. But for them, what they have been through, it’s not an over reaction. So our measures are not particularly savvy at picking up the differences...Avoidance, yes they are going to keep themselves safe, hypervigilance, high risk behaviors, that adrenaline seeking kind of thing, that is how they maintain their normalcy. Within the first year, I would expect to see all of [that]. And if someone says to me; ‘Nope, nope, I don’t have any of that,’ I’m thinking, ‘Oh ok, this guy is not in touch yet.’ Because I would expect to see some level of it in anyone, particularly someone who has been deployed more than once.

Alcohol and Substance Abuse

All of the respondents identified drugs and alcohol—primarily alcohol—as their clients’ primary means of coping with their symptoms. And although this may provide them with temporary relief, with increased substance use, the clients’ lives tended to spiral out of control, their symptoms were exacerbated and eventually, veterans sought treatment as life at home started to fall apart, there were issues with employment, or they had legal trouble. Respondent Three described alcohol as the “go to” as a means to cope with symptoms and issues his client’s are facing during reentry. He stated that, “As the stats would probably support too, about 80% will use substances because alcohol is quick and what does it do? It does the opposite of everything hyper-arousal does.” He went on to describe how many of his clients are opposed to taking prescription medication for their symptoms, “they don’t want to be ‘drugged up’”, and instead resort to alcohol and marijuana to self medicate. Participant Eleven also commented how many of her clients are opposed to psychopharmacological drugs and she wondered if the resistance is associated to the potential “sexual side effects.” Participant Nine described how clients tend to “do whatever [they] can to feel better now, to avoid things that make you not feel good. Which unfortunately means starting to avoid more and more of life.” Participant Seven also described, how she sees her clients using alcohol and substances to “dull the anger, dull the violence and dull them from being so hypervigilant.”

Respondent Nine, described how everyday experiences in civilian life can result in veterans becoming triggered and/or having flashbacks about their combat experiences:

They are experiencing traffic as being very stressful, being on the road is very stressful...So things that we take for granted back here, they are learning very quickly are signs of real danger, like a broken down car by the side of the road is

often a sign of an IED...children running on the curb or near the side of the road into the yard can be very stressful because kids would often be hovering around an IED.

Although many participants identified that their clients have not utilized the healthiest means to cope, respondents did mention the fact that their clients were in treatment (therapy and medication) and this was huge step in both their recovery and navigating their re-adaptation into civilian life. Two participants noted that those clients who have children, were observed as a protective factor in that they wanted to be able to be present for their children. Two participants, identified group therapy, and the ability to recognize that they were not alone in their experiences', as a healthy coping mechanism. One participant, Seven, noted that some of her clients are engaged in alternative therapeutic treatments, such as yoga, massage, and acupuncture/acupressure.

Multiple Deployments

Respondents were asked if their clients, who were deployed multiple times to the combat theaters, differ in terms of issues they were facing during re-integration. All of the participants stated that their clients who were deployed more than one time present with increased stressors and mental health symptoms. In the current conflicts, with an all-volunteer force, many of the troops are being deployed multiple times. In addition to multiple deployments, there is a mandate called "Stop Loss" which allows the DoD to extend service members' tours beyond the time they expected. Participant Three, an OEF veteran, described how the length of the tour depends on each unit; Marines typically are deployed for 6-8 month time periods, Air Force personnel can be deployed for as short as three months, therefore, they could be deployed twice in one year. In the Army, soldiers are generally deployed for 12-18 months:

So you have fewer Army guys that have gone more than 2-3 rotations...but a Marine could have done four months in Afghanistan, six months in Iraq, another 6 months in Iraq, [and go back] to Afghanistan so then they are already on their 5th [tour], but they have served maybe the same as an Army soldier for two rotations.

One participant described how “you just compound the trauma, you compound the family tension...it creates a lot of family conflict because the person who is left behind is like ‘Oh my god, not again.’ So I think that it can be really difficult, it puts a lot of strain on the family.” Another clinician, Five, described how the military provides many of her clients with a sense of identity, especially the service members in their early twenties. “That’s what they feel they are good at...and there’s that certain personality [trait] that goes into someone that wants multiple deployments. There’s that fighter, ‘I’m a soldier, it’s my identity and that’s it.’” Clinicians also described how clients become “more withdrawn,” more “isolative,” “more depressed,” there is an “increase in alcohol abuse” and the risk of PTSD. Participant Eight summarized by stating, “You could go on and on naming it. The bottom line is that multiple deployments increase the risk—across the whole spectrum—of psychiatric diagnoses.”

Clinician Seven described how she worked with a veteran who had been deployed six times. The clinician detailed how she sees a huge difference in her clients depending on the number of times they have been deployed:

And there is a big difference between one deployment and three deployments. There is a broad difference between three and six. We just actually had someone who committed an accidental overdose that was three deployments, and I still can’t get over that that kid was 23 years old and had three deployments. It’s just unbelievable to me, and he must have been sick through all of them; and sicker when he got home. But yet, the more deployments the more damaged.

The clinician went on to describe a client with whom she currently works. He has been deployed three times:

And I find him so scarred from these three deployments... I was like oh God, there is a reason that you came in here... There is something about that intensity in him, that way that he is very injured inside, very angry, so intense. I think that if there were ten pictures there and they all had the same pose, I could tell you the three deployment guys. It's that look; that pained, intense, 'I have been somewhere awful,' it's kind of a robotic. I think I can tell the guys who have had the most deployments, by looking at them and talking to them a little. They do present with this intensity, it's like this controlled, intensity that, ah something bad has happened... They act like something bad has happened, and they are dealing with it. They are experiencing it. Some of them are dealing with it in an ok way, some are dealing with it in a fair way, and the ones that have a lot of deployments are dealing with it in this really, tight, way. Sometimes I find myself thinking that I don't want to anger them. Because, I am not exactly sure how they would handle it. I do know that I don't want to piss them off, at all; I recognize that in myself.

Participant Eleven described a client she worked with who had been deployed six times.

"He was totally numbed out, he just stared at me and all he worried about was getting a job. He was not accessing any emotion really, he just had to get a job because he had three kids to support."

Four clinicians described how some of their clients depend on being deployed multiple times for financial reasons or because they are having a challenging time coping with civilian life. Participant Eight mentioned how service members most likely will not address mental health issues during the dwell time between deployments:

When they come back, they are already preparing for their next deployment so...the majority don't want to talk about the 'so called defect' of PTSD or depression and stress because the stigma is that they are not a good soldier, they are inadequate...they tough it out, and of course that has its dire consequences.

He also stated that there is a fear of being discharged from the military if a soldier receives mental health services or diagnoses, while they remain on active duty.

Support System

Participants were asked who their clients identify as their primary support system when they return home. Two clinicians mentioned that it depends on the nature of their

separation from the military and whether or not they were Active Duty, or in the Reserve or National Guard. All of the respondents mentioned that family or spouse, military buddies, friends, and the VA (clinician and doctors) have been identified as primary support systems. Three participants described how some clients feel that they do not have any means of support aside from themselves and the VA.

Grief and Coping with Loss

Participants were asked if their clients discuss whether or not they been able to grieve and how they have coped with loss of a buddy and casualties of war. The common response was that many veterans are not willing to detail specific events that occurred, will grieve “silently” and will not address it unless they are specifically asked. The tendency appears to be that expressing and experiencing grief are to be avoided, resulting in unresolved grief. Six participants reported that they believe that their clients have not allowed themselves to fully grieve, and although they may mention specific losses, they avoid the process of grieving. Three participants described how there is a memorial service held for fallen soldiers in the theaters of war, at which time emotions are expressed. However, participant Nine noted that:

The reality also is, for many of the troops, that they don't have the time to grieve because they've got to still, the next day, be back up and running. And so...they don't allow themselves that luxury and then when they come back they are busy trying to pull together a life that seems very difficult.

In addition, three participants noted that “it's right back to the mission” and the focus is “to keep your self and your buddies alive.” Anniversaries of the losses were noted by two participants, who described how veterans will get together to commemorate the loss of a their fallen comrade. It was also mentioned that these dates act as a trigger for many of

their clients. Respondent Two described a theme she observed, with some of her clients, the belief that if they don't think about the person everyday, "they are disrespecting that person or that person was lost in vain, that they have to hold on to it." Another clinician, Four, mentioned that one of her clients wears a bracelet in remembrance of a buddy he lost, "and he told me he was never going to take it off." The same clinician described how her clients:

Don't usually talk about it unless you bring it up to them, because that is probably one of the most painful things and one of the most intimate things that they have had to endure in their lives. I think that it's completely heartbreaking to them. It's the one thing that they usually get extremely emotional about, so there is not really resistant to it at all they are just fragile about it, they feel very vulnerable...It really chokes them up, because on some level it feels like a bit of a failure, for some, that they were not able to bring everyone home alive.

Survivor's guilt was mentioned by five of the participants—their clients can get stuck in "hindsight bias thinking"—which does not allow them to move forward in their lives.

Participant Eleven discussed some of her client's reactions:

Survivor's guilt, [they] are asking 'why didn't I die,' why did their buddy die and not them? And some of them are freaked out by the fact that if something had been different they would have been the one who would have died. Like one guy, who literally said, 'Ok you take this mission, you take my vehicle and I will take your vehicle later', and the guy who took his vehicle got killed. He had to pull him out of the wreckage. So, he is really confused about that.

Participant One described how some veterans will "talk about the direct loss of the buddies that they witnessed when they were in battle together. That could have been me; that should have been me, in another moment that would have been me. Why them?" And for service members who have to return home early due to medical or mental health issues there is "the shame and guilt about having left individuals behind and wanting to go back even though they are so severely impacted they can't." The same clinician also

described how many veterans continue to face the loss of the buddies post deployment from suicides, drug overdoses, and car accidents. She described how, “they are re-injured, or re-impacted by that loss. There is a prevailing sense in this group of sadness, that just kind of prevails and they struggle with hope and trying to figure out how to look forward to something that feels so insurmountable.” This clinician stated that many veterans will reenlist and redeploy as a means to both avoid and escape their internal emotional battle:

But it’s a process for all of them. Sometimes they win that battle and sometimes they don’t. Sometimes they end up being that next loss, or the next victim of war related death... Yes they talk about grief, they are often tearful, they are also blustery, ‘Oh no that doesn’t impact me.’ And it’s only in their talking and talking, and bringing up their behaviors, that you see the impact and help them recognize it. They often share more with each other than they share with us. And that’s right, I think, it’s often a really hard area for them.

Women Warriors and Reintegration

Participants were asked if they identified any significant differences in the challenges faced by their female veteran clients during reintegration. Six participants discussed how, for women, it was evident that they tended to struggle more with being away from their families, specifically their children, and that missing developmental milestones and re-bonding with their children appeared to have a greater impact on them as compared to their male counterparts. Two participants mentioned that women tend to be “nurtures” and when they return home from the theater of war, they try to pick up the caregiver role where they left off. Participant One, stated that, “they pour themselves back into their family...they pick up those roles as mother and wife and all those other roles that go with those two roles immediately.” Participant, Five, described how a number of her clients separated from the military because they were pregnant or recently

had a baby. She discussed how her focus with these women is entirely different, “you have single women dealing with new babies and not only are they reintegrating into society, they also have someone who is completely dependent upon them.” She described a client who was struggling with depression and her role, as a clinician, was to “help her bond with the baby so that the baby [was] not at risk, and then deal with her combat issues later.” It was noted by a number of clinicians that women struggle with the same re-integration issues in terms of relationships, marital difficulties, substance abuse, isolating and being hypervigilant, therefore, four participants noted that most of the reintegration issues are the same as the male veterans. One clinician described how, similar to their male counterparts, women try to stay busy, “just trying not to slow down for the stuff to hit them.” Three participants mentioned that their female veterans are “more open to talking” about their experiences and what they are going through as opposed to the males. Two participants noted that women tend not to use as much alcohol and drugs as a coping strategy and are less prone to engage in high-risk behaviors. Two clinicians identified pain issues as a factor that is impacting the female veterans to a higher degree. Participant One noted how, “women are carrying hundreds of pounds on their backs, they are in situations where they are wearing gear that is designed for men, ill-fitting gear that is causing muscular skeletal problems for women at a different rate than for men.”

The challenge of not being recognized for their service, that they were engaging in combat, and having to justify why they chose to serve were discussed by three participants. As noted previously, the majority of clinicians identified that they do not serve as many women as they do men. Five respondents discussed how their agencies

provide limited services for women and issues related specifically to female veterans. It was mentioned that it is a challenge for women to enter a system and feel comfortable in a setting where they were, once again, the vast minority. Participant Nine, discussed military sexual trauma (MST), and although men are also subjected, women are affected to a higher degree. He described, “so coming back I think some of the challenges they face with regard to [MST] are...the fact that they don’t feel there is a place where they can share it and tell somebody openly and are often carrying it privately, more so then the men carrying combat trauma. I think our VA is case in point. We don’t, as of yet, have groups for women with PTSD.” Participant Eight also discussed how there are only three or four VA’s in the nation that have treatment programs exclusively for women. He stated that, “it poses a lot of difficulties especially when they have a lot of military sexual trauma, or some other sexual trauma.” Participant One described how the VA does not provide childcare, which is a huge barrier for women in terms of being able to seek care, specifically, if they are the primary care giver. In addition, she described how at the VA where she is employed, women are not provided with the same comprehensive services as compared to the male veterans. “Women have to go to multiple providers...so we fee out, or send them out into the community. A woman who is getting a mammogram, for example, or who needs specialty reproductive care, who needs OBGYN. So they have to go to multiple providers to get comprehensive care.” She went on to state that, “we need to become more receptive to the needs of women and value their service by providing them the same benefits...women’s adjustment needs are compounded by these obstacles, getting the services they need.”

Barriers to Care

All clinicians identified the stigma attached to receiving mental health care as the primary barrier to seeking mental health treatment. The principal concern was the belief that seeking services for mental health targets the veteran as “weak” and indicates that “something is wrong with me...I have a deficit...I’m crazy” or that “I just couldn’t cut it.” One clinician, Eight, described how the stigma is perpetuated by the military with slogans such as “Army Strong” and “Be all you can be.” Another clinician, Four, also stated that in the military, “you are taught to be a warrior and it doesn’t fit into the warrior mindset to ask for help.”

Participants discussed that there was currently a push, from both the VA and DoD, to breakdown the stigma associated to treatment, for example, a new slogan, “It takes the courage and strength of a warrior to ask for help.” However, participant One noted:

That’s counter to what they have been taught, to be tough to not show emotion, not to show weakness, and mental health issues mean that you are weak. So they are indoctrinated into this mindset that they need to have in order to survive, to be tough, to be strong, to be resilient in the face of war.

Participant, Four, described changes she observed while working on an army base. She stated that there was a significant difference when she left the base in 2007 as compared to 2003, in terms of how the Army responded to mental health. She stated that, “there was a much bigger push to do mental health screenings to every soldier when they got back from theater.”

Another barrier that was mentioned by eight participants was the fear of accessing mental health services, as it may have negative repercussions on advancing one’s military

career or gaining employment in alternative careers, such as law enforcement or criminal justice. It was noted that the DoD has full access to both active duty service members and veterans' mental health records at the VA. Therefore, many veterans are not willing to access VA mental health services if they are considering re-deployment or are still active duty. Participants stated that they would refer active duty or veterans who plan on re-enlisting to a Vet Center or community based mental health clinic, agencies where the DoD cannot access records without the service members' consent.

All of the participants were employed at either a VA (n=9) or Vet Center (n=2). Both of the institutions operate a traditional workweek with hours from 9am to 5pm. Therefore, it was mentioned by five participants that the hours of operation and availability of service hours was a barrier to care. They suggested the need to expand service time, offering both evening and weekend appointments, to better meet the needs of the new veteran population, many of whom are active members of society and in the current work force.

Two participants discussed the need to create more job training opportunities. Participant Nine described how:

A lot of the younger vets that we are seeing don't have the job skills, they are financially strapped, they don't even have housing so I think a big service would be providing them with a space to literally be, other than the homeless shelter, while we start to look at some of their problems and we can get them plugged into services like substance abuse, PTSD treatment, TBI evaluations, so they literally just need a place to stay that is safe, that's drug and alcohol free...they also need job skills. I think we do a crappy job with that. I have had a number of veterans say, 'If I just had a job that I could go in and get trained and have an apprenticeship somewhere, that's all I need.'

Participant One, noted that, "This is a very young group of veterans...we need to provide a system of care that meets them where they are...so we really need to expand resources within our system to meet the needs of this young group. We need to adjust our

philosophy.” She described how she feels the current VA system is hindered by regulations that inhibits collaboration with non-federal agencies, and although these regulations are in place to avoid “conflicts of interest,” she stated that, “If we are going to bring veterans in, we need to meet their needs. I don’t think we are now, we are moving in that direction but we need to continue to move as quickly as we are creating veterans. We are creating veterans every day, every single day a new veteran is created.”

Respondents discussed the need to expand services to engage veterans’ families by providing couples’ counseling and psycho education, in addition to the involvement of the civilian community. Participant Six stated that, “I guess I would like to see at some point a couples group or more attention to families, education, not necessarily therapy but some common post deployment readjustment problems.” Participant Five remarked how the VA where she is employed, provides a psycho education mental health group called “Operation Families.” The group serves veterans, their friends and families with the goal to teach members about common mental health symptoms (PTSD, depression, anger) post deployment. She described how, “even though the VA is pretty adamant [that] we are only allowed to treat veterans, and maybe a couple in couples’ therapy, we offered it to everyone to try to break down the barrier of talking about mental health issues, without calling it a ‘mental health group.’ ”

Clinicians noted that there are outreach efforts, such as the “Yellow Ribbon” program, where veterans are informed of services they are eligible for at the VA. However, three respondents discussed the need for a better transition process from the DoD into the VA system, once service members return home. Participant Seven described how OEF/OIF service members are not prepared or properly informed about

the process of engaging in service connected benefits, once they are relieved from active duty. She stated that, “they are so uneducated about their options for care. The outing processes...they are really floundering around and just don’t know what to do about it.” Participant Ten stated that veterans would be better served if they were automatically enrolled in VA services. The clinician described how filling out an application could present as a barrier as some veterans become overwhelmed with the process. She commented how:

I deal with the same things with everyone that comes in; sleep issues, anger problems; you know all these concentration problems a lot of them have the exact same things. And we should, when they come home, just address it. Assume that everyone is going to have some degree of these things. Keep for example, National Guardsmen and Reservists on orders for a month or whatever it takes as part of their training, continued training, to get some of these mental health interventions. That everyone gets it, it’s not that they come in one at a time and are singled out for getting it...So I think across the board, require a de-conditioning and on going training about how to get back into civilian life. The way we are doing it now, we are just releasing them into their homes, it’s ridiculous, I mean they fly home and let them go...Anyone who would argue that it’s too expensive to do that is not looking at the bigger picture.

Summary

This chapter presents and summarizes the findings of 11 interviews with clinicians who are employed at both Vet Centers (n=2) and VA Medical Centers (n=9) with a primary caseload consisting of OEF and OIF veterans. Participants were asked a series of 10 questions, in addition to probe questions. The questions were designed to elicit the perspectives of the clinicians’ on how their OEF and OIF clients cope during reintegration back into civilian life. Clinicians described the experiences their clients have shared with them in the combat theaters and coping mechanisms that their clients

utilized both on tour and as they navigate re-entry into civilian life. In addition, there were specific questions regarding multiple deployments and the experience of women warriors' both in the theater of war and reintegration into civilian life. Clinicians detailed the multifaceted psychosocial stressors, mental health symptoms and behavioral responses that their clients struggle with as they attempt to navigate their way back into civilian life post deployment. In addition, the clinicians addressed aspects of resiliency, barriers to mental health care and suggestions for needed changes in order to better serve returning service members in the current wars in both Iraq and Afghanistan. The following chapter will discuss these findings and the relevance to the previously reviewed literature and consider the implications of the data and the relationship to social work practice.

CHAPTER V

DISCUSSION

The objective of this qualitative study is to explore clinicians' perspectives on how Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veteran-clients cope as they reintegrate into civilian society following a tour, or multiple tours, of duty in Iraq and/or Afghanistan. The complexities of these warriors' experiences in the combat theaters and their reintegration process back into civilian life, following life-changing experiences, were explored through the narratives of 11 clinical professionals who were employed at Veteran Affairs Medical Facilities and Vet Centers. This chapter reviews the findings in the following order: 1) key findings, 2) limitations, and 3) implications and conclusion.

Key Findings

The central questions of this study explored clinicians' perspectives on how their clients cope during both wartime and reentry into civilian life. Information was collected from the study participants through questions pertaining to their clients' description of their experiences in the theater(s) of war and how their clients coped with adversities including risk and resiliency factors. Clinicians were asked how their clients navigated and coped with post-deployment as they reintegrate into civilian life. Questions focused on psychosocial stressors, mental health symptoms and behavioral responses, primary support systems, and multiple deployments. Specific questions were asked with regard to

the experience of women warriors. Clinicians also shared their insights on what they perceive were barriers to care. In addition, the participants of this study highlighted what they believe were changes that needed to be addressed within the medical, mental health care systems and communities, and how to better care for our returning service members.

A significant proportion of the key findings obtained from the narratives of 11 clinicians were supported in the literature. The open-ended questions provided more insight into the everyday struggles and resilience of OEF/OIF veterans, whereas, the vast majority of the literature focused on the pathological outcomes of war, and did not provide the same intimate framework as the findings from this study.

Many of the study participants cited that their clients' experiences in both Iraq and Afghanistan varied greatly and depended on their Military Occupational Status (MOS), and the stage of the war when they entered the combat theater. A small number of clinicians also highlighted that young age, a lower rank, and the education of the service member, posed as a predictor of potential risk factors, such as adverse mental health reactions and poor coping strategies. These findings were supported in the writings of Shaw (2007) and Seal et al. (2007), who reported that 18-24 year old OEF/OIF veterans were found to be high-risk candidates for PTSD and other mental health diagnoses as compared with veterans 40 years and older. Seal et al. (2007), noted that younger service members were more likely to be on active duty, of lower rank and have greater combat exposure as compared to older service members.

Study participants supported the theory found in the literature by Basham (2008); Paulson & Krippner (2007); Bolton, Litz, Adler & Roemer (2001); Kaysen, Resick & Wise (2003); and Brailey, Vasterling, Proctor, Constans & Friedman (2007); that

veterans with a previous history of abuse, mental health issues and poor attachment with nuclear family, posed an increased risk factor yielding potential adverse mental health and post traumatic stress reactions, during both deployment, and re-integration. It was cited that these clients did not have the same resilience as their peers who did not have pre-existing trauma histories.

It was noted by more than half of the participants that their clients reported exposure to life threatening situations such as: exposure to IEDs, RPGs, and suicide bombings, regardless of their MOS. However, infantry service members were reported to have the highest exposure. Participants also cited environmental factors—extreme weather and living conditions—as factors that challenged their clients on a daily basis. The accumulation of these low level stressors were discussed in writings by Cozza et al. (2004); and La Bash, Vogt, King & King (2009), as placing warriors at risk for developing adjustment, mood and anxiety disorders. It should be noted, that although all of the clinicians who participated in the study worked directly with OEF/OIF veterans, their clinical roles and objectives varied, resulting in clients sharing different aspects of their experiences.

Women Warriors

As previously discussed in the findings chapter, in the current wars in both Iraq and Afghanistan there has been a historical shift in the role of female service members in these military operations. Women warriors are fighting alongside their male counterparts in every capacity, including direct combat. Participants in the study described how their female clients are often not adequately trained to perform duties required of them in combat theaters. There were examples of female soldiers in positions in active combat,

engaging in firefights, while not knowing how to properly operate their weapon. More than half of the participants cited that “women are not recognized as combat soldiers.” Therefore, they do not receive the same training, validation or recognition as the male warriors. These findings were consistent with the writings of Mulhall (2009); La Bash, Vogt, King & King (2009); Katz, Bloor, Cojucar & Draper (2007); and Benedict (2009), each of which mentioned the lack of recognition for female service members who are engaging in “direct combat” and the increased presence and role of women in the military. Women are assigned MOS’s that are theoretically not combat specialties but the nature of the in-theater experiences is that they find themselves, in performing their duties, in direct combat situations under the guise of “combat support.”

The majority of clinicians identified Military Sexual Trauma (MST), which includes sexual harassment, as a factor that many female service members were subjected to during their service. Respondents mentioned the fact that a significant proportion of female service members were impacted by MST, however, they did not go into specific details. The reports on MST were consistent with the literature. A national survey of women veterans who sought VA care, determined that half of the female service members reported sexual harassment and one quarter reported sexual assault (Owens, Herrera, & Whitesell, 2009); and writings by Katz, Bloor, Cojucar & Draper (2007); Mulhall (2009); and Benedict (2009), documented the high rates of MST and highlighted a myriad of unique factors female service members were faced with which not only impact their tour of duty but also reintegration and their willingness to access VA services. Katz, Bloor, Cojucar & Draper (2007) noted that, “MST has a more robust association with symptoms and readjustment difficulties than being injured or witnessing

others injured or killed” (p. 247). The authors remarked how the women accepted witnessing atrocities as part of the conditions of war, and noted that although their experiences may not have fully manifested, additional research is needed on the effects of MST in the combat theaters of war.

When discussing reintegration, a number of study participants remarked how their female clients tended to struggle more with being away from their families, specifically missing milestones and having difficulties re-bonding with their children. It was mentioned, that women tend to “pick up where they left off,” as mother, wife and nurturer. This theory was supported by Mulhall (2009). Women continue to have to balance their career and life at home and over 30,000 single mothers have been deployed to Iraq and Afghanistan. Study participants cited alcohol and substance abuse as a coping mechanism for female veterans, however, to a lesser degree, than their male counterparts. Pain issues and muscular skeletal problems as a result of carrying hundreds of pounds of gear, was identified as affecting women more so than men.

In terms of services, the vast majority of study participants discussed how their agencies do not provide the same comprehensive services, groups, or inpatient facilities or gender specific care, for women as they do for the male veterans. This was supported in literature by Owens, Herrera, & Whitesell (2009) who assessed barriers identified by female veterans who sought mental health care at VA facilities. Although there were similarities with male veterans’ concerns, the report indicated that 33% reported long wait periods, 28% had prior bad experiences (i.e. not being understood by civilians, insensitivity towards women’s issues, and a lack of female practitioners). Female veterans who sought services outside of their local VA cited their reasons as: being

perceived as weak (57%), embarrassed about engaging in services at the VA (57%), not feeling welcome (43%), concerns about harming their career (36%), and 43% reported not feeling comfortable to share in treatment groups because they consisted primarily of men.

A key finding to note, was that all of the participants cited that there is a very small percentage of female veterans who present themselves for services at both VA Medical Centers and Vet Centers. And although women currently comprise approximately 14% of the current military force, they are not accessing services at the same rate as the male veterans. Although the literature review was not an exhaustive representation, there was little discussion as to why there is a limited representation of women service members seeking care at VA Medical. The VA has recognized that women veterans are chronically underserved. In June 2009, all VA hospitals were required to have a Women's Veteran Program Manager to help coordinate services for women. However, Mulhall (2009) cited that "despite its commitment, the VA has still not established a deadline for its facilities to meet the requirement of comprehensive primary care for women veterans, and some VA officials are even unclear on the steps needed to implement this new plan" (p. 10). Although access to care was noted as the primary obstacle for women service members, an additional barrier to care, cited by Mulhall (2009) was that many women service members are not even aware what services they are eligible for.

Methods of Coping

Social support was identified by all of the clinicians as one of the key protective factors for their clients during deployment. Family and loved ones, knowing they have

someone to come home to, and the ability to be connected via telephone and email while they are on tour, were mentioned as a means to maintain resiliency. However, it was also noted that the ability to keep in touch using modern technology could also present increased stress for both the service members and the families back home.

Leadership, unit cohesion and training were identified as key components in resiliency. The majority of respondents described how the connection and bond to military peers were essential for their clients during their tour of duty. It was also mentioned, that the loss of cohesion, and support from the unit, post-deployment, could result in challenges during reintegration. Faith, belief in the mission, and maintaining the mentality that the tour is “a job,” were also mentioned as ways in which service members coped with adversity and being in a theater of war. Writings by Harben (2009); Gifford (2006); Christian, Stivers & Sammons (2009); Kelly & Vogt (2009), Britt & Dickinson (2006); and Koffman (2006), supported the findings that unit cohesion, morale of the troops, trust and belief in leadership, having a sense of purpose and training were determinants of resiliency and could mitigate adverse stress and mental health reactions. Many clinicians discussed the use of alcohol both on base and during their tour, as well as video games as a way that their clients escaped their current reality. The literature highlighted alcohol and substance abuse during post-deployment more so than during the tour of duty.

Reintegration into Civilian Life

All of the study participants discussed factors that contribute to their clients struggle during reintegration. The predominant themes were primarily related to psychological and psychosocial stressors. The vast majority of clinicians commented that,

due to their position as mental health professionals, they were going to come into contact with the veterans that were struggling during re-integration, and that they would most likely not be exposed to veterans who are able to adapt and make a smooth transition back into civilian life. What was not mentioned, but important to note, is that the clinicians also do not come into contact with veterans who may wish to use services but are not able to access them. These include veterans who become homeless and come into contact with the criminal justice system, are incarcerated, etc., or veterans who do not qualify for VA benefits due to the nature of their discharge from the military. It was mentioned by the majority of respondents that for the most part, their clients are encouraged to seek treatment by their partners or family members, and it was not until they “hit rock bottom” and their lives at home were in disarray, that they sought professional mental health services. Clinicians also mentioned that veterans might enter the system for medical reasons or to obtain a service connection through the VA, at which time they were identified as having mental health concerns, and were referred to the mental health clinic. Veterans who suffer from a medical condition/illness, mental health or a disability related to, or exacerbated by, their military service can apply for a disability compensation. If eligible, veterans are given a service connection rating (0%-100%) that determines future access to benefits and a monthly monetary compensation. The service connection rating is based on an assessment of the degree to which an injury is service connected.

The primary struggles during reintegration were: issues with relationships, redefining roles within the family system, lack of employment and financial stress, increased use and abuse of alcohol and substances as a means to cope and self medicate,

and feeling that they just “don’t fit in” to a society they were once a part of. Literature by Hoge et al. (2004); Bernhardt (2009); and Seal et al. (2007), supported these findings. They highlighted the increased use and abuse of alcohol and substances in addition to the co-morbidity of substance abuse and PTSD diagnoses. In addition, writings by Mandersheid (2007) and Bowling and Sherman (2008) detail the strain of deployment on the family system and the challenges that arise when managing reintegration. Bowling and Sherman (2008) cite that “four of the major tasks are: [1] redefining roles, expectations, and division of household responsibilities; [2] managing strong emotions; [3] abandoning emotional constriction and creating intimacy in relationships; and [4] creating a sense of shared meaning surrounding the deployment experience” (p. 452).

Clinicians described how their clients felt as though they were unable to relate to civilians and civilian life and became easily frustrated and agitated because of their life changing experiences that civilians will never be able to understand, therefore, they end up feeling like they are on the periphery within a community that they were once a part of. Study participants described how some of their clients experience an “existential crisis,” they begin to question their identity and no longer know who they are or where they belong. One significant thing to note, is that many of the factors that sustained service members during their tour, specifically connection to partners and family members, tends to be their main source of stress as they navigate re-entry. Following the “honeymoon” period after their return, study participants described how, when a service member is deployed, the partner who is left at home has to take on new responsibilities in their spouse’s absence. When the soldier returns home, challenges arise when the roles

have shifted and the service member may struggle with having to find their place within a family system that may appear to have been functioning fine without them.

All of the clinicians identified coping with symptoms related to PTSD and behavioral responses, during reentry, as one of the primary struggles for their clients. These findings were supported extensively in the literature, namely writings by Hoge et al. (2004); Hoge, Auchterlonie and Milliken (2006); Milliken, Auchterlonie, & Hoge (2007); Moore, Hopewell & Grossman (2009); and Conoscenti, Vine, Papa & Litz (2009). The inability to “switch off” the battle-mind mentality, an adaptive survival mechanism in wartime, can present as maladaptive in civilian life. Clinicians remarked how their clients present with hypervigilance, tend to socially isolate, fear their that they will react with uncontrollable rage and anger, are anxious, depressed, have difficulty sleeping, and attempt to avoid their symptoms and society.

Clinicians reported a tendency to engage in high-risk behaviors such as: excessive drinking, drunk and reckless driving, physical aggression (getting into fights), and suicidal ideation, as common ways they have observed their clients react post-deployment. Although there was limited literature on the correlation of combat exposure and high-risk behavior post-deployment, a study by Killgore et al. (2008), highlighted this understudied phenomenon. All of the respondents cited alcohol and substance abuse as their clients’ primary means of coping, self-medicating, and avoidance of their symptoms. Although study respondents tended to focus on maladaptive coping methods utilized by their clients, it was also mentioned that some of their clients were actively engaging in anti-war movements, were mentors to other veterans, attended support

groups, engaged in therapy, attended college, and utilized services provided to them through the VA, Vet Centers and the community.

Clients, whom have been deployed multiple times, were identified by study participants as presenting with increased mental health symptoms and psychosocial stressors. It was also reported that a number of veterans re-enlisted or deployed multiple times because of challenges they were facing reintegrating into civilian life, or due to financial struggles. The poor economy, unemployment, and the challenge of not being able to translate the skills they have learned in the military into the civilian workforce, was noted by clinicians as a primary stressor for their clients.

Barriers to Mental Health Care

Study participants identified stigma attached to receiving mental health care as the primary barrier for veterans seeking treatment. The ideology that one is “weak,” “crazy,” “has a deficit,” or just “couldn’t cut it,” was a common theme observed by study participants. In addition, it was mentioned that the military’s stance with slogans such as “Army Strong,” and “Be All You Can Be,” tends to perpetuate the stigma. Study participants also expressed that the military has made significant changes in regard to breaking down the stigma associated to mental health care. The Army’s response to implement Mental Health Advisory Teams (MHATs) in the theaters of war, a new campaign stating, “It Takes a Warrior to Ask For Help,” in addition to mental health screenings, post-deployment for all service members were noted by participants as attempts in mitigating the barriers and stigma related to mental health care.

Seal et al. (2007) noted that approximately 29% of returning OEF/OIF veterans are currently enrolled in VA health care, a historically high rate as compared with only

10% of Vietnam veterans. The authors noted that the majority of mental health diagnoses were given in primary care and non-mental health settings. Clinicians in the study, who mentioned medical care as a gateway into the mental health system, noted the latter finding. However, it is evident that there are still significant changes that need to be made in order to address and combat stigma associated with mental health care including personal, public and institutional perceptions. Hoge et al. (2004) conducted a study to assess both mental health problems and barriers to care and cited:

In the military, there are unique factors that contribute to resistance to seeking such help, particularly concern about how a soldier will be perceived by peers and by the leadership. Concern about stigma was disproportionately greatest among those most in need of help from mental health services... This finding has immediate public health implications. Efforts to address the problem of stigma and other barriers to seeking mental health care in the military should take into consideration outreach, education, and changes in the models of health care delivery. (p. 20-21)

A predominant barrier to mental health care, noted both in the literature and study findings, is that the DoD has access to veterans' mental health records at VA Medical Centers. Therefore, veterans who wish to re-enlist and active duty service members are wary of engaging in mental health services because of the fear that it will negatively affect their military career. Research by Kudler and Straits-Tröster (2009) found:

When OEF/OIF veterans present to VA health care programs, they often express concern that their commanding officers might gain access to their medical records. They fear that any mention of a mental health problem in their VA chart might have an adverse effect on their military careers, their units, the mission and their families. (p. 65)

Participants also identified hours of operation at VA facilities and Vet Centers as a significant barrier in receiving care, especially for veterans who are in the workforce. In addition, the lack of childcare and comprehensive services for couples and the families of

veterans was cited as an important expansion needed in order to better serve returning military personnel. Clinicians suggested the need for “job training” programs and an effective and efficient hand off from the DoD to the VA when service members return home.

Study participants provided recommendations that they believe should be implemented in order to provide comprehensive care to returning service members. It was noted that National Guardsmen and Reservists are in need of special attention because they do not return to a military base, and tend to be isolated and may not live close to a VA or Vet Center. A number of clinicians reported that there needs to be more focus on the families of veterans, coordination of services and both outreach and psycho-education to communities on typical readjustment issues. It was noted that the VA would benefit from focusing on retention rates of veterans, and gain their perspective on how the VA is meeting, and not meeting their needs. Clinicians also discussed how the needs of therapists need to be addressed in order to avoid high rates of burnout.

Limitations

The limitations of this research were that: the sample size was small (n=11) and, therefore, limits the generalizability of the findings; it was racially homogenous (10 of the clinicians identified as Caucasian and only one clinician identified as a person of color); ten of the clinicians were employed at the VA, and two were employed at Vet Centers; and although there was variance in gender and clinical expertise, it is unknown if the perspective would have differed if the sample included clinicians in community based mental health clinics. Due to the limited amount of time to conduct the research, the researcher was only able to interview 11 clinicians. Additional clinicians were

recruited, however, the facilities where they were employed required an internal IRB, and due to time constraints this was not feasible. Future research would benefit from a larger, more diverse sample size, in addition to the crucial insight and voices of military service members themselves. However, it is important to note that four of the clinicians were veterans, one of whom was a veteran of OEF.

Additionally, the research questions were designed by the researcher and in retrospect, a number of the questions were extremely broad in context. Therefore, as this was a qualitative study with open-ended questions, clinicians' interpretations varied in some cases, as did the length and depth of the responses to the interview questions. However, the qualitative interviews allowed for rich, personal and meaningful responses, and all of the study participants were forthright and willing to share their experiences and appreciative of the interest in this current topic.

It is also important to mention that during the time of this study the researcher was a graduate school intern in social work at a VA medical center. Every effort was made to recognize any biases when analyzing the data and maintain neutrality in terms of my perceptions and observations of both psychological and psychosocial stressors observed within the population I was working with.

Implications and Conclusions

Implications of this study include suggested methods and practices social workers, mental health clinicians, and the community can implement, or redesign to better serve veterans during the reintegration process. Investigating both resiliency and vulnerability factors for warriors and their coping mechanisms during reintegration into civilian life, this study could identify implications for the mental health field by learning

about gaps and barriers in existing services and what has helped and hindered this population during the reintegration process. Evidence in both the literature and the findings implicate that there continues to be a high level of stigma attached to receiving mental health services, and there is the continued need to focus attention on how best to care for veterans and provide adequate services to them. Implementing training practices for social workers and mental health personnel within the military and community that can highlight veterans' barriers to accessing care, their typical adjustment reactions, psychosocial stressors and their coping mechanisms will be a step towards better serving this specific population.

Research conducted by RAND on the “invisible wounds of war,” namely PTSD, TBI, and major depression, documented concerns regarding soldiers returning from the war theaters of Iraq and Afghanistan. The study's concerns highlighted that:

More is needed to ensure equitable and sustainable solutions. Our data show that these mental health and cognitive conditions are widespread; in a cohort of otherwise-healthy, young individuals, they represent the primary type of morbidity in coming years. What is most worrisome is that these problems are not yet fully understood, particularly TBI, and systems of care are not yet fully available to assist recovery for any of the three conditions. Thus, these invisible wounds of war require special attention and high priority. An exceptional effort will be needed to ensure that they are appropriately recognized and treated. (Tanielian & Jaycox, 2008, p. xxvii)

Social workers have a unique opportunity to be a pivotal force in identifying early interventions and in providing support to both veterans and their family members during the re-integration process. Although it may take years before the full impact of these wars is fully manifested within the OEF and OIF veteran population, identifying risk factors early on is key in aiding service members navigate their way back into civilian society.

References

- Anastas, J. W. (1999). *Research design for social work and the human services*. New York: Columbia University Press.
- Basham, K. (2008). Homecoming as safe haven or the new front: Attachment and detachment in military couples. *Clinical Social Work Journal*, 36:83-96. Springer Science + Media, LLC (2007).
- Batten, S., & Pollack, S. (2008) Integrative outpatient treatment for returning service members. *Journal of Clinical Psychology: In Session*. Vol. 64(8), 928-939.
- Benedict, H. (2009) The plight of women soldiers. *The Nation*. May 5, 2009. Retrieved November 11, 2009 from <http://www.thenation.com/doc/20090518/benedict/single>.
- Bernhardt, A. (2009). Rising to the challenge of treating OEF/OIF veterans with co-occurring PTSD and substance abuse. *Smith College Studies in Social Work*, 79: 344-367.
- Bolton, E. E., Litz, B. T., Britt, T. W., & Adler, L. R., Roemer, L. (2001). Reports of prior exposure to potentially traumatic events and PTSD in troops poised for deployment. *Journal of Traumatic Stress*, Vol. 14, No. 1.
- Bowling, U. B., & Sherman, M. D. (2008). Welcoming them home: Supporting service members and their families in navigating the tasks of reintegration. *Professional Psychology: Research and Practice*, No. 4, 451-458.
- Brailey, K., Vasterling, J. J., Proctor, S. P., Constans, J. I., & Friedman, M. J. (2007). PTSD symptoms, life events, and unit cohesion in U.S. soldiers: Baseline findings from the neurocognition deployment health study. *Journal of Traumatic Stress*, Vol. 20, No. 4, pp 495-503.
- Britt, T. W., & Dickinson, J. M. (2006). Morale during military operations: A positive psychology approach. In T.W. Britt, C.A. Castro & A.B. Adler (Eds.) *Military life: The psychology of serving in peace and combat. Volume 1: Military performance* (pp. 157-184). Westport, Connecticut: Praeger Security International.
- Christian, J. R., Stivers, J. R., & Sammons, M. T. (2009). Training to the warrior ethos: Implications for clinicians treating military members and their families. In S.M. Freeman, B. Moore, A. Freeman (Eds). *Living and surviving in harm's way. A psychological treatment handbook for pre- and post-deployment of military personnel* (pp. 27-47). New York: Routledge. Taylor & Francis Group.

- Conoscenti, L., Vine, V., Papa, A., & Litz, B. (2009). Scanning for danger: Readjustment to the non-combat environment. In S.M. Freeman, B. Moore, A. Freeman (Eds). *Living and surviving in harm's way. A psychological treatment handbook for pre- and post-deployment of military personnel* (pp.123-146). New York: Routledge. Taylor & Francis Group.
- Cozza, S. J., Benedek, D. M., Bradley, J. C., Grieger, T. A., Nam, T. S., Waldrep, D. A. (2004). Topics specific to the psychiatric treatment of military personnel. Iraq war clinician guide 2nd edition. Department of Veterans Affairs and National Center for PTSD.
- Doyle, M. E. & Peterson, K. A. (2005). Re-entry and reintegration: Returning home after combat. *Psychiatric Quarterly*, Vol. 76, No 4, pp 361-370.
- Fischer, H. (2009) United States military casualty statistics: Operation Iraqi freedom and operation enduring freedom. Congressional Research Service. March 25, 2009.
- Gifford, R. K. (2006). Psychological aspects of combat. In T.W. Britt, C.A. Castro & A.B. Adler (Eds.) *Military life: The psychology of serving in peace and combat. Volume 1: Military performance* (pp. 15-30). Westport, Connecticut: Praeger Security International.
- Harben, J. (2009). Mental health advisory team VI. U.S. Army Medical Department, Office of the Surgeon General. Retrieved January 13, 2010 from <http://www.armymedicine.army.mil/news/releases/20091113mhatvi-p.cfm>
- Hoge, C. W., Auchterlonie, J. L., & Milliken, C. S. (2006). Mental health problems, use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan. *JAMA*. 295: 1023-1032.
- Hoge, C. W., Castro, C. A., Messer, S. C., McGurk, D., Cotting, D. I., & Koffman, R. L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *The New England Journal of Medicine*, Vol. 351.
- Hutchinson, J., & Banks-Williams, L. (2006). Clinical issues and treatment considerations for new veterans: Soldiers of the wars in Iraq and Afghanistan. *Primary Psychiatry*, 13(3), 66-71.
- Iraq and Afghanistan Veterans of America (IAVA). *Honor the fallen*. Retrieved June 10, 2010 from <http://iava.org/>
- Katz, L. S., Bloor, L. E., Cojucar, G., & Draper, T. (2007). Women who served in Iraq seeking mental health services: Relationships between military sexual trauma, symptoms, and readjustment. *Psychological Services*, Vol. 4 No. 4: 239-249.

- Karney, B. R., Ramchand, R., Oscilla, K., Calderone, L., & Burns, R. (2008). Predicting the immediate and long-term consequences of mental health problems in veterans of operation enduring freedom and operation Iraqi freedom. In Tanielian, T., Jaycox, L.H. (Eds). *Invisible wounds of war. Psychological and Cognitive injuries, their consequences and services to assist recovery*. RAND Corporation.
- Kaysen, D., Resick, P. A., & Wise, D. (2003). Living in danger: The impact of chronic traumatization and traumatic context on posttraumatic stress disorder. *Trauma, Violence, & Abuse*, Vol. 4, No. 3, 247-264.
- Kelly, M., & Vogt, D. (2009). Military stress: Effects of acute, chronic, and traumatic stress on mental and physical health. In S. M. Freeman, B. Moore, A. Freeman (Eds). *Living and surviving in harm's way. A psychological treatment handbook for pre- and post-deployment of military personnel* (pp. 85-106). New York: Routledge. Taylor & Francis Group.
- Killgore, W., Cotting, D., Thomas, J., Cox, A., McGurk, D., Vo, A., Castro, C., & Hoge, C. (2008). Post combat invincibility: Violent combat experiences are associated with increased risk-taking propensity following deployment. *Journal of Psychiatric Research*, 42, 1112-1121.
- Koffman, R. (2006). Kilroy was here: Reflections of a psychiatrist in combat. In A.B. Adler, C.A. Castro, T.W. Britt (Eds). *Military life: The psychology of serving in Peace and combat. Volume 2: Operational Stress* (pp. 3-10). Westport, Connecticut: Praeger Security International.
- Kudler, H. & Straits-Tröster, K. (2009). Partnering in support of war zone veterans and their families. *Psychiatric Annals*, Vol. 39, Issue 2: 64-70.
- Kudler, H. (2007). The need for psychodynamic principles in outreach to new combat veterans and their families. *Journal of The American Academy of Psychoanalysis and Dynamic Psychiatry*, 35 (1) 39-50.
- La Bash, H. A. J, Vogt, D. S., King, L. A., King, D. W. (2009). Deployment stressors of the Iraq war insights from the mainstream media. *Journal of Interpersonal Violence*, Vol 24, No. 2: 231-258. Sage Publications (2009).
- Lewis, S. J. (2006). Combat stress control: Putting principle into practice. In A. B. Adler, C. A. Castro, T. W. Britt (Eds). *Military life: The psychology of serving in peace and combat. Volume 2: Operational Stress* (pp. 121-140). Westport, Connecticut: Praeger Security International.
- Marmar, C. (2009). Mental health impact of Afghanistan and Iraq deployment: Meeting the challenges of a new generation of veterans. *Depression and Anxiety*, 26: 493-497.

- Matthews, M. D., (2009). The soldier's mind: Motivation, mindset, and attitude. In S.M. Freeman, B. Moore, A. Freeman (Eds). *Living and surviving in harm's way. A psychological treatment handbook for pre- and post-deployment of military personnel* (pp. 11-24). New York: Routledge. Taylor & Francis Group.
- Manderscheid, R. W. (2007). Helping veterans return: Community, family, and job. *Archives of Psychiatric Nursing*, Vol. 21, No. 2, 122-124.
- Milliken, C. S., Auchterlonie, J. L., & Hoge, C. W. (2007). Longitudinal assessment of mental health problems among active and reserve component soldiers returning from the Iraq war. *JAMA*. 2007. 298 (18): 2141-2148.
- Moore, B., Hopewell, A., & Grossman, D. (2009). After the battle: Violence and the warrior. In S.M. Freeman, B. Moore, A. Freeman (Eds). *Living and surviving in harm's way. A psychological treatment handbook for pre- and post-deployment of military personnel* (pp. 307-328). New York: Routledge. Taylor & Francis Group.
- Mullhall, E. (2009, Oct.). *Women warriors. Supporting she 'who has borne the battle.'* Retrieved November 5, 2009, from Iraq and Afghanistan Veterans of America Issue Report October 2009, Web site: http://media.iava.org/IAVA_WomensReport_2009.pdf
- Owens, G., Herrera, C., & Whitesell, A. (2009). A preliminary investigation of mental health needs and barriers to mental health care for female veterans of Iraq and Afghanistan. *Traumatology*, Vol. 15, No. 2, 31-37.
- Paulson, D. S. & Krippler, S. (2007). *Haunted by Combat. Understanding PTSD in war veterans including women, reservists, and those coming back from Iraq.* Westport, Connecticut: Praeger Security International.
- Ramchand, R., Karney, B. R., Oscilla, K. C., Burns, R. M., & Caldarone, L. B. (2008). Prevalence of PTSD, Depression, and TBI among returning service members. In Tanielian, T., Jaycox, L.H. (Eds). *Invisible wounds of war. Psychological and cognitive injuries, their consequences and services to assist recovery.* RAND Corporation.
- Reger, G. M, Moore, B. A. (2009). Challenges and threats of deployment. In S. M. Freeman, B. Moore, A. Freeman (Eds). *Living and surviving in harm's way. A psychological treatment handbook for pre- and post-deployment of military personnel* (pp. 52-64). New York: Routledge. Taylor & Francis Group.
- Seal, K., Bertenthal, D., Miner, C., Sen, S., Marmar, C. (2007). Bringing the war back home. Mental health disorders among 103788 US veterans returning from Iraq and Afghanistan seen at department of veteran affairs facilities. *Arch Intern Med*, Vol. 167.

- Savitsky, L., Illingworth, M., DuLaney, M. (2009). Civilian social work: Serving the military and veteran populations. *Social Work*, Vol. 54, Number 4.
- Shaw, J. (2007). The acute traumatic moment—Psychic trauma in war: Psychoanalytic Perspectives. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, 35(1) 23-38.
- Slone, L. B., & Friedman, M. J. (2008). *After the war zone: A practical guide for returning troops and their families*. Philadelphia, PA: Da Capo.
- Sollinger, J. M., Fisher, G., & Metcher, K. (2008). The wars in Afghanistan and Iraq: An Overview. In Tanielian, T., Jaycox, L. H. (Eds). *Invisible wounds of war. Psychological and cognitive injuries, their consequences and services to assist recovery*. RAND Corporation.
- Tanielian, T., Jaycox, L. H., (Eds) (2008). Summary. *Invisible wounds of war. Psychological and cognitive injuries, their consequences and services to assist recovery* (pp. xix-xxxiii). RAND Corporation.

APPENDIX A
HSR APPROVAL LETTER



Smith College
Northampton, Massachusetts 01063
T (413) 585-7950
F (413) 585-7994

November 19, 2009

Andrea Mitchell

Dear Andrea,

Your materials have been reviewed by the Human Subjects Review Committee and we are delighted to approve this interesting and relevant study. You have done an outstanding job of pulling together and presenting all of the needed information and have developed a study that is clear, consistent, well written, and meets all of the requirements of human subject protection. It was a pleasure to review.

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 fine project.

Sincerely,

A handwritten signature in cursive script that reads "Ann Hartman".

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

CC: Fred Newdom, Research Advisor

APPENDIX B
CONSENT FORM

Informed Consent

Dear Participant,

My name is Andrea Mitchell. I am a graduate student at Smith College School for Social Work, and I am writing to ask for your participation in my study, which is to examine both resiliency and risks factors and coping strategies utilized by your Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Combat Veteran clients during the post deployment reintegration process. The study will aim to explore your perspectives and personal insight on veterans' coping mechanisms when faced with factors that make the transition a challenge such as: combat experiences, multiple deployments, mental health symptoms, medical issues, psychosocial stressors, stigma and perceived and actual barriers to resources and care. The population under investigation will be both male and female combat veterans and active duty service members who have been deployed to Iraq and/or Afghanistan. I am interested in what has helped and not helped, what has been a struggle, and what has been successful during re-entry into civilian life. The data from my survey will be used for my thesis, part of the requirements for the masters of social work degree at Smith College, and possibly for future publications and presentations.

I am inviting mental health clinicians who hold one of the following degrees: MSW, RN, MFT, MA in Psychology or Counseling, PsyD, MD in Psychiatry or PhD, and have worked with veterans for a minimum of two years and maintain a current case load that consists primarily of OEF/OIF Veterans. Questions I am asking will focus on demographic/personal information about you (gender, race, educational degree, if you have served in the military, a brief description of your agency (i.e. VA, Vet Center, NGO) and number of years and type of clinical work conducted with veterans. I ask these questions so that I will be able to describe my participants accurately. The interview will be conducted either face-to-face in a public area (i.e. coffee shop, or library) or over the

phone, and will take approximately one to one and a half hours depending on your answers. The interview will be audio recorded with your permission. I will ask a number of open-ended questions about your OEF/OIF client's experiences, and your perspective on how your clients have coped during reintegration into civilian life. At your request, I can provide you the interview guide in advance.

The potential risks of participation in the study are that you may feel emotional distress or discomfort when recalling your clients' stories and their reintegration struggles.

Unfortunately, I am unable to provide financial compensation for your time. Although you may not benefit directly from participating, aside from sharing your stories, your participation could provide assistance and insight regarding the reintegration process for Veterans that could potentially assist other social workers, mental health clinicians and community members better understand how to meet OEF/OIF Veteran's needs. Your insight could assist clinicians, individuals and agencies that work with this population in developing and implementing improved resources, wrap-a-round services and treatment interventions.

Participation is voluntary and you are free to refuse to answer any questions and withdraw from the study at any time prior to March 30th, 2010. If you decide to withdraw, I will immediately remove and destroy all data pertaining to your participation. If you agree to participate, all of your information, as required by Federal Guidelines, will be kept securely locked in a file for three years after I complete my thesis. After that time, provided I do not need access to the information, all data and audio recordings will be destroyed. My thesis advisor will have access to the data after I have coded all the narrative data and disguised all identifying information.

If you have additional questions or are concerned about your rights or any aspect of this study please contact me at aemitche@smith.edu or the Chair of Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

Thank you for your time and consideration.

YOUR SIGNATURE 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, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATION IN THE STUDY

Participant's Signature:

Date:

Researcher's Signature:

Date:

APPENDIX C
INTERVIEW GUIDE

Demographics of Clinicians

Gender: _____

Race: _____

Clinical Degree (circle one) MSW RN MFT Psychology Psychiatry PhD other:

Have you served in the military? Yes No

If you have served, what branch and what was your military occupational specialty?

Number of years and brief description of work that you done with Veterans:

Number of years working with OEF/OIF: _____

Number of OEF/OIF clients you currently serve: _____

Interview Questions about your OEF/OIF clients

1. How do your clients describe their combat experience in Iraq and/or Afghanistan?
What do women warriors report about their experience and how does it differ from what the male warriors report?
2. Can you describe resiliency (protective) factors that your clients have shared with you about their experience in Iraq and/or Afghanistan?
What coping strategies have your clients utilized during their tour of duty?
3. Have your clients described their experience as changing them?
If yes, how have they changed?
4. What are your clients' primary psychosocial stressors during re-entry into civilian life?
How do they cope with these stressors?
In what ways, if any, are the challenges different in the case of multiple deployments?

5. How do your clients cope with their mental health symptoms (i.e. depression, anxiety) and emotional/behavioral responses (i.e. anger, violence, avoidance, hyper-vigilance, high risk behaviors)?
6. Do your clients discuss if and how they have grieved—coped with the loss of buddy, civilian casualties, etc.?
7. What are the challenges and coping strategies for women veterans during reentry and how do they differ from those of male veterans?
8. Who do your clients identify as their primary support system(s)?
9. Can you describe what you perceive as barriers to mental health care and resources for returning veterans?
What changes do you believe need to be made/implemented in order to better serve our returning service members?
10. Are there any questions that I should have asked you or topics that I missed that you would like to address?