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Promoting posttraumatic growth among OIF/OEF veterans : a theoretical exploration of the challenges of reintegration

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ABSTRACT

Approximately 2.2 million men and women have been deployed in service of the wars in Iraq

and Afghanistan. And veterans are returning to their communities in large numbers, many of

them with a range of visible and invisible medical and psychological injuries and needs

(Tanielian & Jaycox, 2008; Hoge et al., 2004; Hoge, Auchterloni, & Milliken, 2006). The

process of veterans re-entering civilian society following a deployment is known as reintegration

(Demers, 2011). While the mental health issues and needs of returning OIF/OEF veterans have

been widely studied (Tanielian & Jaycox, 2008) their experiences and struggles related to

reintegration remain largely unexplored by researchers (Institute of Medicine; 2010; Doyle &

Peterson. 2005). In this paper I explore the reintegration challenges that veterans face from both

a micro and a macro perspective. I first use trauma theories as a way to understand the

intrapersonal challenges that veterans may face during reintegration. I then use the framework of

the military-civilian cultural gap to explore some of the macro level challenges facing OIF/OEF

veterans as they reintegrate into their larger civilian communities. Finally, I focus on

posttraumatic growth as a potential outcome of both combat-related trauma and reintegration. I

present Tedeschi's (2011) model for facilitating posttraumatic growth on a micro-level through

individual therapy and discuss ways in which that model may be enacted within the broader

civilian community to construct a more conducive civilian arena for posttraumatic growth.

PROMOTING POSTTRAUMATIC GROWTH AMONG OIF/OEF VETERANS: A

THEORETICAL EXPLORATION OF THE CHALLENGES OF REINTEGRATION

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CHAPTER I

Introduction to the Wars in Iraq and Afghanistan

The Global War on Terror began in October 2001 as a response to the terrorist attacks of September 11. The war in Afghanistan, known as Operation Enduring Freedom (OEF) began in October 2001. Later, the war in Iraq, known as Operation Iraqi Freedom (OIF) began in March 2003. Approximately 2.2 million men and women have been deployed in service of the wars in Iraq and Afghanistan (Institute of Medicine, 2010). Active duty and Reserve/National Guard troops have served 3 million unique deployments (Institute of Medicine, 2010). Approximately 2.3 million Americans are currently serving in the military, including National Guard and Reserve components (Pew Research Center, 2011). In total, 6,725 OIF/OEF/OND troops have been killed overseas and more than 50,000 have been physically wounded in action (http://www.defense.gov/news/casualty.pdf). With the combat operations in Iraq officially ended since December 2011[1] and the scheduled ending of combat operations in Afghanistan by 2014,

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[1]In September 2010 operations in Iraq were officially renamed Operation New Dawn to reflect the end of the U.S. combat mission there. By December 2011, the majority of U.S troops were withdrawn from Iraq (http://www.operation-new-dawn.com). The U.S. military currently maintains a supportive force of 50, 000 soldiers in Iraq tasked with "conduct[ing] stability operations [and] advising, assisting and training Iraqi Security Forces (ISF)." Despite the non-combat role that U.S. troops have assumed in Iraq, persistent political and social instability create dangerous conditions for U.S. troops deployed there. 38 U.S troops have been killed in action and an additional 36 have died as result of "non-hostile" circumstances. http://www.defense.gov/news/casualty.pdf. OND troops have not been widely included in OIF/OEF studies and OND has not been a frequent topic of reporting in the popular press. While OND troops are likely exposed to many of the same deployment stressors as OIF/OEF veterans, the non-combat centered mission of OND distinguishes it from OIF. Therefore, research regarding the mental health outcomes of OIF/OEF deployments may not generalize to OND. Because the after-affects of OND for veterans have not been explicitly described in the research, OIF/OEF veterans are the focus of this paper. The 10-year anniversary of the start of U.S. operations in Iraq was in March of this year (2013).

veterans will be returning to their communities in large numbers, many of them with a range of visible and invisible medical and psychological injuries and needs (Tanielian & Jaycox, 2008; Hoge et al., 2004; Hoge, Auchterloni, & Milliken, 2006).

The wars in Iraq and Afghanistan represent the longest period of combat operations by the U.S. since the Vietnam War. OIF/OEF are unlike any other U.S combat operations in many ways and U.S troops have faced a number challenges and stressors unique to modern warfare. The number of active military members is the smallest in U.S history. Fewer volunteer service members plus the unprecedented demands of sustained modern warfare mean longer and more frequent deployments, multiple deployments, and shorter respite periods between deployments for U.S. troops (Institute of Medicine, 2010; Tanielian & Jaycox, 2008). Approximately 40% of OIF/OEF service members have experienced more than one deployment (Institute of Medicine, 2010). For the purposes of this project, the term "veteran" is used colloquially throughout to refer to any current or former member of the military who has deployed in service of OIF/OEF (Hoge, 2010) except when otherwise specified. While the term "veteran" officially refers to service members who have discharged from the military, service members who have deployed in OIF/OEF may maintain active duty or reserve status between or following an OIF/OEF deployment.

Troop Demographics

As the dynamics of modern combat have changed dramatically since the United States' last combat engagement, so has the demographic profile of the modern soldier. Current forces represent the most diverse in U.S history with more women and people of color serving in the

military than ever before (Institute of Medicine, 2010; Tanielian & Jaycox, 2008). Of those who have deployed to OIF/OEF, 11% have been women. (Institute of Medicine, 2010) and women currently make up 14% of active duty forces (Pew Research Center, 2011). Among all service members deployed in service of OIF/OEF about 66% were White, 16% black, 10% Hispanic, 4% Asian, and 4% are identified as "other race." (Armed Forces Health Surveillance Center, 2009). The average service member in today's military is likely to be older than in previous conflicts and more likely to be married (Institute of Medicine, 2010, Pew Research Center, 2011). Reserve members have been older than their active duty counterparts – approximately 45% of enlisted reservists are over the age of 30, while the vast majority of active duty enlisted members (73%) are age 30 or younger. Approximately half (47%) of all active duty enlisted members of the armed forces (across all branches) are between the ages of 20-24 (Institute of Medicine, 2010).

Active duty service members are more likely to be married than their civilian same-age counterparts (58.8% of service members vs. 47.4% of civilians age 45 or younger). (Pew Research Center, 2011). And, approximately 14% of service members have a spouse who is also a service member. However, rates of divorce are higher among enlisted service members than among comparable civilian counterparts. Approximately 43.7% of active-duty service members have children, about half of whom are under the age of 8 (Pew Research Center, 2011). While almost all enlisted service members have completed a high school education, only about 4% are college graduates. Officers are much more likely to have college degrees and post-graduate degrees than enlisted soldiers (Pew Research Center, 2011).

Approximately 49% of service members deployed in OIF/OEF were in the Army (including Reserve and National Guard), 19% in the Air Force, 18% in the Navy, and 13% in the Marine Corps (all include Reserve members) (Institute of Medicine, 2010). Members of the

Army and the Marine Corps have comprised the majority of ground forces in Iraq and

Afghanistan, are more likely to have been involved in combat situations, and have suffered the

highest numbers of wounded in action and causalities. (Tanielian & Jaycox, 2008)

Modern Warfare

Heavy combat operations take place largely on urban streets throughout Iraq and

Afghanistan and insurgent enemy combatants look like and live among local civilians,

complicating the ability to distinguish between innocent civilians and combatants. There are no

clearly defined front lines and any excursion "outside the wire" can be potentially life

threatening. Even within the "safe" boundaries of U.S. bases in Iraq and Afghanistan, the danger

of mortar attacks is ever-present, causing troops to remain on high alert at all times. Deployed

service members with non-combat-related military roles, such as administrative staff, find

themselves in the midst of combat operations with little combat training or preparedness.

(Thomas, Wilk, Riviere, McGurk, Castro & Hoge, 2010).

Because of the nature of the conflicts in Iraq and Afghanistan many troops are

commonly exposed to traumatic stressors like being shot at by an enemy, witnessing fellow

soldiers wounded or killed, handling dead bodies and body parts and encountering improvised

explosive devices (IEDs) (Hoge, Castro, Messer, Mcgurk, Cotting & Koffman, 2004; Tanielian

& Jaycox, 2008). Among a representative sample (n= 1,965) of OIF/OEF veterans within a

population-based survey, researchers with the RAND Corporation found that around 50% of

participants had a friend who was seriously wounded or killed in combat, 45% had seen dead or

seriously injured noncombatants and 45% had witnessed an accident that resulted in serious

injury or death. Other traumatic stressors less commonly reported were: smelling the odor of decomposing bodies, experiencing an explosion, head injury, engaging in hand-hand combat, and killing civilians (Tanielian & Jaycox, 2008, p. 97). In a similar study, other commonly reported stressors were: "being attacked or ambushed," "receiving incoming artillery, rocket or mortar fire" "being shot at or receiving small arms fire" and "seeing seriously ill or injured women and children whom you were unable to help." (Hoge, Castro, Messer, Mcgurk, Cotting & Koffman, 2004). The high tempo of combat operations combined with the highly volatile combat environment increases troops' vulnerability to physical and psychological injury.

Improvised explosive devices (IEDs) have been widely used by enemy combatants and have been devastating to U.S forces overseas. IED explosions often cause multiple and severe injuries – limb loss and head injuries are common. IEDs may be responsible for up to 50 % of battlefield wounds (Fischer, 2009) and up to 40% of U.S troop causalities (Tanielian & Jaycox, 2008, p. 26). If IEDs are the signature weapons of OIF/OEF, traumatic brain injuries (TBI) are the signature injuries (Tanielian & Jaycox, 2008). TBIs result from closed head injuries that cause loss of consciousness and can be mild to severe in nature. TBIs can result in significant cognitive and physical impairment and can also affect psychological functioning. Service members with traumatic brain injuries may present with symptoms consistent with other diagnoses such as PTSD, depression, or anxiety and establishing differential diagnostic criteria for TBI has been a unique challenge for researchers, physicians and mental health professionals. Though more research is needed to understand the long-term consequences of TBI, documented outcomes have included decline in cognitive functioning, seizures, dementia, depression, excessive aggressive behaviors, impaired social functioning including loss of employment and

social relationships and increased risk for suicide (Institute of Medicine, 2010; Tanielian & Jaycox, 2008).

Fortunately, major advances in armor and weapons technologies and in the medical field have prevented countless deaths among U.S. service members. The use of improved body and vehicle armor was implemented in response to the frequency and severity of IED attacks on U.S forces early in the beginning of armed conflict. Emergency medical services are available in theater and can be delivered at the site of the injured service member. Improved evacuation procedures to world-class trauma care facilities in Europe and the U.S for service members injured during battle have saved the lives of thousands of injured troops who would have died in previous conflicts (Tanielian & Jaycox, 2008).

Although advances in medical technology and armor protections have saved thousands of lives, the short and long-term physical, psychological and emotional costs of OIF/OEF deployments to service members are significant. Posttraumatic stress disorder (PTSD), TBI, depression, anxiety disorders, substance abuse and physical injuries are prevalent among OIF/OEF veterans (Tanielian & Jaycox, 2008). In the RAND survey mentioned earlier, researchers found that 31% of OIF/OEF veteran participants met criteria for either PTSD, major depression or TBI (Tanielian & Jaycox, 2008). These researchers also found that vulnerability to these psychological injuries increased with the number of traumatic events experienced during deployment, suggesting that veterans who have served multiple deployments are at an increased risk for developing PTSD, major depression and/or TBI. In a pioneering cross-sectional study of Army and Marine veterans surveyed 3-4 months after a deployment from Iraq or Afghanistan, researchers found that 12% of Army veterans returning from Afghanistan and 18% returning from Iraq met criteria for PTSD (Hoge, Castro, Messer, Mcgurk, Cotting, & Koffman, 2004).

20% of Marines, all returning from Iraq also met criteria for PTSD. RAND researchers estimated that, based on their analysis of available research studies and data, between 5-15 % of returning veterans can be expected to develop PTSD as a result of their service in OIF/OEF. (Tanielian & Jaycox, 2008)

Special Considerations for Female Service Members

Although women are serving in the military in record numbers, little research has been done to understand the particular challenges faced by female OIF/OEF service members and veterans. Female combat veterans are largely invisible in the narrative of the Global War on Terror yet women are a necessary and integral part of OIF/OEF forces. Until January 2013 when it was rescinded by Defense Secretary Leon Panetta, the Department of Defense held a specific policy that expressly forbid women from serving in any position or assignment for which the primary mission is to engage in direct combat on the ground (Bumiller & Shanker, 2013). However, given the characteristics of OIF/OEF: high operational tempo, urban guerilla fighting, and the absence of definitive front lines, the distinction between combat and non-combat positions is tenuous at best. Women commonly serve in positions in which they risk exposure to direct combat (Mulhall, 2009; Street, Vogt & Dutra, 2009). More than 100 women have been killed in battle and more than 600 have been wounded in action (Mulhall, 2009). Despite gains that women have made through military service, researchers have found that female service members are underrepresented in high-ranking positions and have lower rates of promotion than male service members (Mulhall, 2009). Gender discrimination may be a common experience for women in the military, mirroring patterns of gender-based discrimination of women in the

civilian sector (Street, Vogt & Dutra, 2009). The chronic and persistent threat of gender-based harassment by male counterparts may compound negative mental health outcomes for female OIF/OEF veterans, particularly given that cohesive relationships with fellow soldiers are necessary for survival in a combat zone (Street, Vogt & Dutra, 2009).

Discriminatory attitudes towards women-specific health care during deployment are another unique source of stress for deployed female service members. Female veterans have reported experiencing lack of access to resources such as hygiene products, birth control, specialized health care and facilities affording appropriate privacy (Mulhall, 2009). Mulhall reports that women may avoid disclosing physical injuries or seeking medical assistance for fear of being viewed as weak by fellow male service members. Injuries left untreated in theater may negatively impact a woman's long-term health and the ease of reintegration.

A critical unique stressor for female OIF/OEF service members is sexual harassment and/or assault while in the military. The threat of military sexual trauma (MST) is pervasive for female service members. Among veterans screened as part of a universal screening protocol for veterans seeking outpatient care from the Veteran's Healthcare Administration (VHA), 21.5% percent of women and (and 1.1% of men) reported an attempted or completed rape while in the military (Hyun, Pavao, & Kimerling, 2009). Due to the prevalence of prior sexual trauma among women who join the military, some researchers estimate that as many as 1 out of every 3 female service members has survived a rape in her lifetime (Women's Bureau of the U.S. Department of Labor, 2011). The prevalence of MST and sexual harassment among service members can have significant mental and physical health consequences. Female survivors of MST are at an increased risk of PTSD, anxiety disorders, substance use disorders, and depression (Institute of Medicine, 2010; Street, Vogt, & Dutra, 2009; Women's Bureau of the U.S. Department of

Labor, 2011). They also report more medical issues and chronic health problems as well as increased social, financial and occupational difficulties during reintegration (Institute of Medicine, 2010; Street, Vogt & Dutra, 2009).

Special Considerations for Service Members of Color

Potential associations between ethnicity and deployment outcomes have not been widely studied among OIF/OEF veterans. However, there is some research, primarily with the Vietnam veterans population, that suggests that historically, veterans of color have been more susceptible to negative mental health outcomes as a result of deployment (La Bash, Vogt, King & King, 2008) as well as inequitable treatment and racially-based discrimination in military service (Gifford, 2005; Institute of Medicine, 2010). In general, most evidence suggests that African American and Latino veterans are at greater risk of stress-related psychiatric illness, particularly PTSD as a result of deployment than White veterans (Institute of Medicine, 2010). Vietnam casualty data have shown that African Americans experienced a disproportionate number of causalities compared to their White counterparts early in the Vietnam War. (Gifford, 2005) Researchers have suggested that this was due largely to inequitable assignment of African American soldiers in units and positions which were most likely to encounter heavy combat activity (Gifford, 2005). Recent figures have shown that the majority of OIF/OEF causalities, approximately 85%, are White; African Americans have the second highest casualty rate at approximately 8% (Fischer, 2013). Gifford (2005) suggests that low causality rates among African American soldiers are due to the fact that African Americans are now less likely to serve in combat units in OIF/OEF than in Vietnam. Data collected via the National Veterans

Readjustment Survey (Institute of Medicine, 2010) showed that African American and Latino Vietnam veterans experienced significantly higher rates of PTSD than White veterans, even 15-20 years after their service in Vietnam. More recent studies have found that prevalence rates of PTSD and other mental health issues related to military service among veterans of color are proportionate to those noted among White OIF/OEF veterans (Frueh, Hamner Elhai & Knapp, 2004). Some researchers speculate that the mental health outcomes of deployment are more dependent on factors such as level of exposure to combat or pre-deployment risk factors such as prior trauma than race/ethnicity. (Frueh, Hamner Elhai & Knapp, 2004; Gifford, 2005; Duke & Moore, 2011) Others have suggested that exposure to race-related injuries and sociocultural prejudices may play a larger role in post-deployment outcomes than has been previously documented (or than the absence of literature on this topic might suggest) (Loo, Scurfield, Ruch, King, Adams & Chemtob, 2001).

In developing a scale instrument to measure race-related stressors for Asian American Vietnam veterans, researchers considered three domains of racial stressors that might impact mental health outcomes for those veterans (Loo, Scurfield, Ruch, King, Adams & Chemtob, 2001). The first was racial prejudice and stigmatization which was defined as " direct, personal experiences in which one perceives that one has been discriminated against or excluded by virtue of race, or subjected to denigration, harassment, dehumanization, or stigmatization on the basis of race (p. 505). The second domain was bicultural identification and conflict which was defined as "the experience of identifying with the Vietnamese people or culture, which is proposed to conflict psychologically with military conditioning to dehumanize the enemy." Finally, the third domain of racially-based stressors was "exposure to a racist environment" which researchers defined as "having witnessed remarks or behaviors by American military personnel that

denigrated, harassed, or dehumanized Asians (p. 506). The researchers who developed and validated the Race-Related Stressor Scale (RRSS) found that among Asian American Vietnam veterans, exposure to racial stressors in these three domains was more predictive of PTSD symptoms than combat exposure. Researchers also suggest that this relationship between these experiences of racism and discrimination and psychiatric symptoms may generalize to other veteran populations of color.

Given that White troops make up 66% of active duty forces and more than 75% of National Guard and Reserve forces and furthermore that more than 80% of military officers are identified as White (http://prhome.defense.gov/rfm/MPP/ACCESSION%20POLICY-/PopRep2008/summary/chap5.pdf), many of the micro and macro level iterations of racism and racial dynamics that negatively impact people of color in civilian society may be present within the military institution as well. Loo, Scurfield, Ruch, King, Adams & Chemtob (2001) suggest that experiences of racism and discrimination in the military may cause troops of color to experience a reduced sense of physical and psychological safety whiled deployed and to be excluded, or withdraw, from protective unit cohesion, ultimately leading to stress reactions such as hypervigilance and hyperarousal in response to the chronic threat of racism. While little research has been done on the issue of racism in the military, the findings of Loo, Scurfield, Ruch, King, Adams & Chemtob (2001) with the RRSS demonstrate a need for more rigorous attention to this issue. For veterans of color, apart from military, the cumulative effects of living in a society in which racially-based injustice and discrimination are a part of the daily experience may greatly impact not only their increased likelihood for deployment related psychiatric symptoms but also their ability to reintegrate into back into civilian communities which may also be racially hostile environments.

Special Considerations for National Guard and Reserve Service Members

National Guard and Reserve troops face a unique set of stressors and challenges that may place them at greater risk for negative mental health outcomes of deployment (Tanielian & Jaycox, 2008). As of 2007, more than 30% of all troops deployed to OIF/OEF were National Guard and Reserves and during periods of heavy conflict earlier in the wars, National Guard and Reserve troops comprised 40-50% of deployed forces (Tanielian & Jaycox, 2008). The National Guard has an Army and an Air Force component and is the only component of the military that may be activated by state governors to respond to domestic matters such as natural disasters. National Guard troops, colloquially called "Weekend Warriors," live most of their daily lives in civilian communities and many work full-time in the civilian sector. Unlike activity duty troops who are stationed on bases nationally and internationally, National Guard troops are usually able to complete training and service requirements in their communities of residence. National Guard troops typically report for military training and drilling one weekend a month and at least two full weeks of every year.

The comparative effects and differences of National Guard/Reserve status on mental health outcomes of deployment have not been widely studied among veterans from conflicts prior to OIF/OEF. However, a recent longitudinal descriptive study of OIF/OEF active duty component and National Guard/Reserve veterans found that National Guard/Reserve veterans

reported substantially more psychiatric and physical symptoms than active duty soldiers six to nine months after a deployment (Hoge, Auchterlonie, Milliken & Charles, 2006). In this study, data from the Post Deployment Health Assessments (completed by all troops immediately following deployment and discussed in detail in chapter II) and Post Deployment Health Reassessments (completed six to 9 months after the PDHA) of active duty and National/Guard Reserve troops following an OIF deployment was obtained and analyzed. Researchers found that in the initial PDHA, reported rates of traumatic combat experiences and mental health concerns were similar among activity duty and National Guard/Reserve troops. However, PDHRA data showed "substantially higher rates of interpersonal conflict, PTSD, depression, and overall mental health risk" among Guard/Reserve troops (Hoge, Auchterlonie, Milliken & Charles, 2006, p. 2143).

Each branch of the military has a Reserve component as well. Like the National Guard, reservists typically remain in their communities of residence and complete once-monthly drilling requirements. The primary difference between National Guard and Reserve troops is that reservists may not be activated for domestic service. The primary military purpose of the National Guard and Reserve troops is to augment active duty units in times of conflict. Given that the U.S. military has the smallest all-volunteer active duty force in U.S history and the high operational tempo of OIF/OEF, the US military has relied heavily on Guard and Reserves troops to meet operational requirements. Historically, the activation and deployment of National Guard and Reserve troops to participate in armed conflict has been considered a last resort. (Tanielian & Jaycox, 2008) and many Guard and Reservists enlist without the expectation that they will be activated and deployed. Because Guard and Reserve troops are used primarily to augment active duty units in OIF/OEF many Guard and Reserve troops are inserted into unfamiliar units as they

are needed. This potentially weakens connectedness and cohesion with fellow soldiers for active

Guard and Reserve troops, an important factor which could impact the battlefield experiences

and post-deployment needs of Guard/Reserve soldiers. A full review of the scope of specific

issues faced by National Guard and Reserve troops is beyond the scope of this paper. However,

National Guard and Reserve troops are noted as a particularly vulnerable population of

servicemembers whose unique challenges in reintegration should be given serious consideration

by clinicians and the civilian public.

In chapter 1, I present an overview of the wars in Iraq and Afghanistan and described the

demographics of the troops serving in these wars. In chapter II, I describe the phenomenon of

reintegration and present research regarding this phenomenon, including some of the most

common psychological injuries among OIF/OEF veterans. I suggest that reintegration may be

complicated by a number of both micro and macro level challenges. In chapter III, I introduce

the concept of posttraumatic growth (Tedeschi & Calhoun, 2004) and suggest that posttraumatic

growth may be a potential outcome of successful reintegration for OIF/OEF veterans. In chapter

IV I discuss some of the micro level challenges that veterans may face during reintegration with

a focus on trauma as an outcome of combat service. I use trauma theories to describe some of the

intrapersonal challenges facing veterans during reintegration and present some of this history of

the development of trauma theories as they have arisen out of the study of military veterans and

service members. In chapter V I discuss the macro level challenges facing OIF/OEF veterans

reintegrating into their civilian communities. I use the theoretical framework of the military-

civilian cultural gap to locate veterans as members of a small, often invisible minority group

joined by shared experiences and aligned by a unique set of values, beliefs and standards of

conduct which are distinct from, and often incongruent with those normatively prescribed by the

dominant group, American civilians. And, I suggest some ways in which these cultural differences may impair a veteran's ability to reintegrate into a civilian community and achieve posttraumatic growth. In chapter VI, I return to the concept of posttraumatic growth and suggest ways in which it may be inhibited or promoted on the individual and community levels. I present Tedeschi's (2011) model for facilitating posttraumatic within the individual clinical setting and then apply this model to the larger civilian community to suggests ways in which civilian communities could be made more conducive to reintegration and posttraumatic growth for OIF/OEF veterans.

CHAPTER II

REINTEGRATION

While the battlefields of Iraq and Afghanistan present numerous threats to the health and

safety of soldiers, the process of returning home from a deployment may be a long, difficult and

sometimes dangerous one for veterans. The process of service members and veterans re-entering

civilian society and reuniting with families and loved ones following a deployment is known as

reintegration or readjustment (Demers, 2011; Tanielian & Jaycox, 2008). Reintegration begins

when a soldier's deployment ends and may continue indefinitely (Hoge, 2010). The duration and

difficulty of the reintegration process is different for each service member and may depend on

any number of factors including length of deployment, number of previous deployments, medical

and/or psychological injuries sustained, intensity, duration and frequency of combat experiences,

ability to stay connected with friends and family during deployment, personal/characterological

resilience and the presence of pre-existing vulnerability factors such as poverty, substance

dependence, poor social support systems, pre-military trauma history, and the accessibility of

medical and mental health care facilities (Hoge, 2010; Slone & Friedman, 2008; Tanielian &

Jaycox, 2008). All returning soldiers confront the dual challenge of intrapersonally processing

deployment experiences while re-entering civilian communities, re-engaging with friends and

family and re-adapting to a civilian lifestyle. And, while the mental health issues and needs of

returning OIF/OEF veterans have been widely studied (Hoge et al., 2004; Milliken, Auchterlonie

& Hoge, 2006; Tanielian & Jaycox, 2008) their experiences and struggles related to reintegration remain largely unexplored by researchers (Doyle & Peterson, 2005; Institute of Medicine, 2010; Sayer et al., 2011).

In one unique study, researchers assessed areas of reintegration difficulty via survey among a nationally stratified random sampling of OIF/OEF combat veterans who had made at least one visit to a U.S. VA healthcare facility between October 2003 and July 2007 (n=754). Approximately 40% of survey respondents reported experiencing "some to extreme difficulties" in reintegration to civilian life in the past 30 days (Sayer et al. 2010, 593). Among the specific community reintegration difficulties in the survey, some of the most frequently endorsed by respondents were "dealing with strangers (43%)," "making new friends (44%)," "keeping up nonmilitary friendships (45%)," "taking part in community activities (49%)," "belonging in "civilian" society (49%)," "enjoying or making good use of free time (47%)," and "finding meaning or purpose in life (42%)." Furthermore, 57% of respondents reported experiencing more problems controlling anger; 31% reported increased drug and alcohol use; 35% reported engaging in dangerous driving behaviors "noticed by others;" and 42% reported losing touch with personal spirituality or religion. All of these reported challenges and problems may negatively affect a veteran's ability to reenter the civilian world. Researchers in this study reported that these issues and problems have high costs for both the individual veterans and communities as a whole. One hopeful outcome of the study was that 96% of respondents reported interest in receiving reintegration assistance and services.

The timeline of reintegration is different for every veteran and may vary widely in the context of the factors and variables discussed above (Hoge, 2010). However, researchers agree that reintegration is neither a quick nor an easy process for many veterans and their families

(Resnik et al., 2012; Sayer et al., 2011). Many veterans may resume pre-deployment functioning and community integration but most experience at least some difficulties in biospyschosocialspiritual functioning in the weeks and months following a deployment. For some veterans, reintegration challenges may arise periodically, or persist throughout the lifespan, particularly in the presence of chronic or life-altering medical and/or mental health injuries (Resnik et al., 2012).

Hoge (2010) advises veterans that reintegration begins from the time of deplaning from a combat deployment and may continue for years. In one important cross-sectional study, researchers compared the prevalence of PTSD symptoms, and comorbidity of alcohol misuse and/or aggressive behaviors among both National Guard Reservists and Active Duty troops at 3 and 12 months following an OIF combat deployment using an anonymous survey. Researchers found that prevalence rates of reported PTSD symptoms and comorbid depression, substance use and aggressive behaviors increased significantly from 3 months to 12 months in both groups, but more dramatically among National Guard Reservists , suggesting that soldiers may experience persistent or emergent mental health symptoms long after their return from deployment and concluding that "12 months appears to be insufficient time to recover" from a combat deployment. (Thomas et al., 2010, p. 621).

When a soldier ends a tour of duty in Iraq or Afghanistan, she or he completes a "demobilization" period, usually at an American military base, prior to returning to his or her hometown (Slone & Friedman, 2008). Demobilization is a critical period lasting usually one to two weeks during which soldiers "reset" (Hoge, 2010) from months of living and working in a war zone. Also during this time, veterans complete necessary administrative out-processing tasks and paperwork and they undergo a medical evaluation. During the demobilization period,

veterans are briefed on their eligibility for services and benefits and begin the process of

enrolling for VA benefits. Veterans also have access to counselors, chaplains and legal

consultation during this time. In addition to the psychological tasks of transitioning out of a

combat zone and the extensive administrative requirements, veterans are also briefed at length

about the reintegration process. During these reintegration briefings, troops are prepared for re-

entry into civilian life. They receive education about the struggles and challenges they might

expect to face during reintegration and learn to identify warning signs for possible PTSD, TBI

and other medical or mental health conditions. Troops are briefed on the range and nature of

reactions they might expect to experience in response to their deployment and they are made

aware of various resources and supports available to veterans and their families following a

deployment. They are also presented with coping strategies for managing combat stress reactions

at home and prepared for the challenges they might face in dealing with these in the context of

their family and/or community. Although every military branch develops and conducts its own

branch-specific demobilization programing, most programs include components for family

training and education about reintegration as well (Slone & Friedman, 2008).

The Army's BATTLEMIND training is the most widely discussed reintegration program

in the literature (Adler, Bliese, McGurk, Hoge & Castro, 2011; Coll, & Weiss, Yarvis, 2011;

Hoge, 2010; Slone & Friedman, 2008). BATTLEMIND training was developed by researchers

at Walter Reed Army Institute of Research and implemented by the Army in 2006.

BATTLEMIND training is now mandatory for all returning U.S. Army troops and its purpose is

to educate returning OIF/OEF veterans and their families on the stresses of reintegration and the

resources and services that are available to them. BATTLEMIND training is now part of the

Army's larger comprehensive resilience programing called Deployment Cycle Support (DCS)

developed to assist the service member and his or her family throughout each phase of a service member's deployment, beginning with pre-deployment and ending with "reconstitution." Reconstitution is the final phase of the deployment cycle and describes the period of time during demobilization in which soldiers receive reintegration education and training. The Army defines BATTLEMIND training as a set of "strength-based, positive psychology tools to aid Soldiers, Leaders and Families in their ability to grow and thrive in the face of challenges and bounce back from adversity." (https://www.resilience.army.mil/index.html). The Army is currently working to develop new resilience programing and training with researchers at the University of Pennsylvania Positive Psychology Center (Reivich, Seligman, & McBride, 2011).

BATTLEMIND training is a didactic, present-oriented, non-exposure based framework for delivering positive cognitive and behavioral skills-based training for making an effective transition from "battle mind" to "civilian mind." Adjustment difficulties are normalized and validated as "being a natural consequence of having developed effective occupational coping skills related to combat (Adler, Bliese, McGurk, Hoge & Castro, 2011, p. 69)." BATTLEMIND training is delivered by commanding officers in the form of scheduled presentations comprised of lectures, PowerPoint presentations, informational brochures and guides, and experiential worksheets and exercises. Each letter in the acronym BATTLEMIND represents a particular skill, mentality or behavior that troops have adapted through military training, conditioning and experience to survive successfully in a combat zone that becomes maladaptive in the context of the civilian environment if it persists beyond the deployment (Slone & Friedman, 2008). A brief explanation of each BATTLEMIND letter is presented to illustrate the scope of behavioral and psychological adjustments veterans must attend to as part of the reintegration process (Adler, Bliese, McGurk, Hoge & Castro, 2011; Slone & Friedman, 2008).

Buddies. While deployed, soldiers operate as part of a unit which provides a built-in support system of peers with a shared set of values, experiences and challenges. Following deployment, veterans separate from their units and may feel the absence of cohesion and bonding they shared with their battle buddies. Veterans are encouraged to re-engage in civilian relationships and avoid social isolation.

Accountability. Soldiers are cautioned that while military values emphasize the importance of personal accountability, standards of accountability may be lower in a civilian context in which most circumstances are not "life or death." Veterans are also cautioned to regulate controlling impulses and to "let things go" when "it doesn't really matter." (Slone & Friedman, 2008).

Targeted Aggression. Military training prescribes the use of aggression, violence and even deadly force when necessary on the battlefield. Veterans are encouraged to identify and regulate inappropriate aggression to avoid negative physical, interpersonal, financial or legal issues in the civilian community.

Tactical Awareness. Soldiers are trained to be on constant alert in an environment in which enemy threats are present around the clock. Following a deployment, behaviors such as hypervigilance or hyperarousal may persisy. Presenters reinforce the fact that soldiers need no longer be alert for battlefield dangers and present skills for managing hypervigilance and hyperarousal.

Lethally Armed. Veterans carry a weapon at all times while deployed and may feel vulnerable or unsafe without a weapon in the civilian environment. Veterans are encouraged to avoid carrying a weapon outside of the home, as carrying a weapon may reinforce thoughts and behaviors that are no longer required for the veteran's safety and survival.

Emotional control. Veterans learn that emotional detachment is an essential survival skill on the battlefield and soldiers are trained to avoid emotional expression and reactivity. Emotional numbness and detachment may damage civilian relationships and increase social isolation and withdrawal. Veterans are encouraged to be emotionally open and expressive with trusted loved ones and to engage in pleasurable leisure activities.

Mission Security. Secrecy around missions and military operations is crucial for mission success for active-duty troops. However, veterans are encouraged to talk about their (non-classified) deployment experiences and advised that secrecy may create conflict and alienation in civilian relationships.

Individual Responsibility. Like accountability, soldiers are trained to uphold a high-level of individual responsibility. Persistent feelings of individual responsibility may manifest negatively as survivor's guilt and emotional detachment. Veterans are encouraged to practice self-forgiveness for battlefield actions they may regret. Additionally, veterans may feel uneasy about asking others for help. Veterans are encouraged to reach out to others for emotional and psychological support following a deployment.

Non-Defensive Driving. Driving in Iraq and Afghanistan is an intense and dangerous experience for service members who must be constantly alert for IEDs. Driving as though in a combat zone while in a civilian environment is dangerous for veterans, their passengers, and other motorists. Veterans are encouraged to prevent aggressive and dangerous driving by avoiding driving for the first few weeks of reintegration until appropriate coping strategies for managing hyperarousal, aggression and control have been adapted.

Discipline. Rigid structure, hierarchy and routine are integral parts of military life, but the civilian environment is far less predictable, structured, or disciplined. Veterans are encouraged to become comfortable with greater flexibility and lack of structure to avoid interpersonal conflicts.

Unfortunately, the efficacy and longitudinal outcomes of BATTLEMIND debriefings and other similar interventions have not been widely researched (Institute of Medicine, 2010). Researchers in one study compared BATTLEMIND training interventions to the Army's former traditional post-deployment stress education intervention administered to veterans returning from a 12-month combat deployment in Iraq. The veterans were screened via survey for a number of mental health concerns including PTSD, depression, and sleep problems. Veterans were screened again via survey 4 months after receiving the intervention. Researchers concluded that BATTLEMIND training "can lead to a reduction in mental health problems and stigma concerns months later compared to stress education." While longitudinal data regarding the long-term effects and outcomes of such interventions is largely unavailable, researchers agree that the military has made important progress in implementing structured debriefing programs for all returning troops since the beginning of the Global War on Terror (Hoge, 2010; Tanielian & Jaycox, 2008).

In addition to the education and debriefing provided during the demobilization period, all soldiers returning from a combat deployment are required to complete the Post Deployment Health Assessment (PDHA). The PDHA is a self-administered survey consisting of about 50 questions pertaining to the veteran's deployment experiences including level of exposure to combat, and his or her physical and mental well-being. The PDHA functions as a screening and

assessment tool for potential medical or mental health concerns or risk factors. Following

completion of the PDHA, veterans are interviewed in person by a health care professional who

may discuss the results of the PDHA with the veteran and present recommendations based on

her/his clinical assessment. If concerns are identified, veterans are referred to the appropriate

service providers, and may even be detained beyond the demobilization period to receive needed

care and rehabilitation on site (Milliken, Auchterlonie & Hoge, 2006). Veterans endorsing non-

acute concerns on the PDHA may also be referred to providers in their home areas. Veterans are

required to complete the Post Deployment Health Reassessment (PDHRA) 3 to 6 months after

the end of their deployment. The PDHRA was instituted in 2005 and is similar to the PDHA in

scope and content. (http://www.pdhealth.mil/dcs/pdhra.asp). Veterans complete a compulsory

second course of BATTLEMIND training at the time of the PDHRA; a second voluntary

BATTLEMIND training course is made available for family members at this time as well.

Researchers have questioned the effectiveness of the PDHA in screening for and

identifying potential PTSD, TBI and other mental health issues resulting from a war-zone

deployment. Milliken, Auchterlonie & Hoge (2006) conducted a population-based descriptive

analysis of all PDHAs completed by OIF/OEF Army soldiers and Marines (n= 424,451)

following deployments between May 2003 and April 2004. Of those, 10,519 (2.5%) individuals

received a mental health referral on the basis of their PHDA data. In comparing their PDHA data

to follow-up surveys pertaining to healthcare utilization 1 year after completing the PDHA,

Milliken, Auchterlonie & Hoge (2006) found that approximately half of their study participants

who received a mental health referral from the PDHA utilized mental health services at least

once on the basis of a PDHA referral (Milliken, Auchterlonie & Hoge, 2006; Tanielian &

Jaycox, 2008). Among all participants who completed the PDHA and post-PDHA survey

(including those referred for mental health care) 88,975 individuals (21%) received some form of mental health care in the year following deployment.

The researchers concluded that the screening criteria for PTSD and other mental health issues used in the PDHA are not sufficiently sensitive to the highly individualized circumstances impacting the physical and mental health needs of each veteran and are not adequate in predicting or facilitating mental health service utilization among returning veterans who might need it. Their findings suggest the PDHA misses critical opportunities to correctly identify and address many of the biospyschosocial stressors and needs of returning veterans. Veterans complete the PDHA during the demobilization period, a time during which they complete hours of paperwork, debriefing, education and assessment. Veterans may underreport mental and medical health concerns out of fear that doing so would delay their homecoming even further (Slone & Friedman, 2008). Finally, researchers have shown that medical and mental health issues related to deployment may emerge many weeks or months following a deployment, outside of the time frame in which veterans are monitored through the PHDA and PDHRA. (Institute of Medicine, 2010; Milliken, Auchterlonie & Hoge, 2006; Tanielian & Jaycox, 2008).

Once veterans complete the demobilization process, they return home to begin the process of rejoining civilian society and re-entering family and social systems. Most veterans and their families experience an initial "honeymoon" period following the veteran's return in the which the anticipation and joy of seeing loved ones for the first time in many months and the relief of being in a safe environment overshadow the impending reality of bills, domestic chores, employment, and other personal responsibilities. After the Welcome Home parties are all over, the realities of functioning in civilian society come to the forefront and the real challenges of reintegration may begin (Hoge, 2010; Slone & Friedman, 2008).

Reintegration is fraught with challenges for both the returning veteran or service member and his/her family, friends, and community. Potential challenges include adjusting to a non-combat environment, reengaging in relationships with civilian family members, loved ones and community members following an extended absence, obtaining or resuming employment or education and possible medical and/or mental health issues such as PTSD, increased substance use and/or serious injuries such as traumatic brain injury (TBI) or loss of limbs and related medical and psychological sequelae (Institute of Medicine, 2010; Slone & Friedman, 2008; Tanielian & Jaycox, 2008). This paper is a theoretical examination of the challenges of reintegration for OIF/OEF veterans as they present in both the micro-level and macro-level domains of personal and interpersonal functioning within the context of a civilian environment. Social work recognizes and embraces a "person-in-environment" perspective with the understanding that "every human life is shaped by the interplay of forces that arise from both within and without (Basham, 2010, p. 3)." In this paper, a micro level analysis of some of the intrapersonal and intrapsychic difficulties facing reintegrating veterans is presented in parallel to a theoretical examination of some of the macro dynamics that arise between veterans and civilian communities that complicate or inhibit reintegration. The micro-level of analysis of reintegration focuses on the trauma-related outcomes of deployment, specifically PTSD and the ways in which those impact a veteran's psychological well-being and ability to reintegrate into the civilian community. The macro-level of analysis centers on the ways in which cultural differences between veterans and civilians, and other environmental factors of the community, complicate reintegration for OIF/OEF veterans. Although the micro and macro level challenges of reintegration are explored separately, a foundational assumption of this paper is that these two arenas are not mutually exclusive. In fact, a complete perspective on the phenomenon of

reintegration challenges facing veterans requires equal attention to both micro and macro issues

as well as the interplay of the two. A thorough assessment of the challenges present in both

arenas can be useful in guiding the development and implementation of social work interventions

to support and facilitate posttraumatic growth with veterans on both the individual and

community levels.

CHAPTER III

An Introduction to the Concept of Posttraumatic Growth

Before moving to a theoretical discussion of the micro and macro challenges facing reintegrating OIF/OEF veterans, a brief introduction to the concept of posttraumatic growth is necessary. I will to elaborate on the theoretical and empirical foundations of the concept of posttraumatic growth in chapters VI and I will suggest that posttraumatic growth is a possible and desirable outcome of reintegration for veterans. Throughout this paper reintegration is conceptualized as an opportunity for posttraumatic growth for OIF/OEF veterans. I will also suggest that attention to the potential for posttraumatic growth as an outcome of the reintegration process can guide micro and macro level social work interventions for OIF/OEF veterans.

Clinical psychologists Tedeschi and Calhoun developed the theoretical concept of posttraumatic growth in the early 1990's. They define posttraumatic growth as ""positive psychological change experienced as a result of the struggle with highly challenging life circumstances (Calhoun & Tedeschi, 1999 2001)." (Calhoun & Tedeschi, 2004, p. 2). They also write

> Posttraumatic growth describes the experience of individuals whose development, at least in some areas, has surpassed what was present before the struggle with crises occurred. The individual has not only survived, but has experienced changes that are viewed as important, and that go beyond what was the previous status quo. Posttraumatic growth is

not simply a return to baseline—it is an experience of improvement that for some persons is deeply profound." (p. 4).

Tedeschi & Calhoun emphasize that the conditions for true posttraumatic growth occur only in the aftermath of an event or circumstance in which "a psychologically seismic event" threatens, alters or destroys the individual's fundamental beliefs and schemas related to fairness, safety and predictability in the world. Tedeschi & Calhoun are careful to distinguish traumatic events of this magnitude from minor daily stressors, asserting that the conditions for posttraumatic growth may be present only following a trauma which alters the individual's sense of self and identity and challenges or changes the basic moral, spiritual and philosophical assumptions guiding the individual's ability to find meaning and purpose in life.

The individual's ability to experience posttraumatic growth following a trauma is mediated by a number of personal, social, and environmental factors discussed later in the paper. Most basically, Tedeschi and Calhoun (2004) describe that posttraumatic growth occurs through the process of grappling with the mental, emotional, social and spiritual consequences of a traumatic event. They theorize that posttraumatic growth occurs through the tasks of cognitive and emotional processing of the event, rebuilding a stable sense of self and reformulating assumptive worldviews that are integrative of the traumatic event. Posttraumatic growth is not a coping mechanism for managing the psychological distress of trauma nor is it a guaranteed outcome for all survivors of a traumatic event. However, in a review of the relevant research and literature, Tedeschi and Calhoun (2004, p. 2004) cite a number of studies in which researchers have identified posttraumatic growth as outcome of a wide variety of major traumatic life events such as "bereavement (Calhoun & Tedeschi, 1989-1990; Edmonds & Hooker, 1992; Hogan,

Morse, & Tason, 1996; Lehman et al., 1993; Miles & Crandall, 1983; Nerken, 1993; Schwab, 1990), rheumatoid arthritis (Tennen, Affleck, Urrows, Higgins, & Mendola, 1992), HIV infection (Bower, Kemeny, Taylor, & Fahey, 1998; Schwartzberg, 1993), cancer (Collins, Taylor, & Skokan, 1990; Cordova, Cunningham, Carlson, & Andrykowski, 2001)…transportation accidents (Joseph, Williams, & Yule, 1993), house fires (Thompson, 1985), sexual assault and sexual abuse (Burt & Katz, 1987; Draucker, 1992; Frazier, Conlon, &Glaser, 2001; McMillen, Zuravin & Rideout, 1995; Silver, Boon, & Stones, 1983; Veronen & Kilpatrick, 1983) … [and] combat (Elder & Clipp, 1989; Sledge, Boydstun & Rabe, 1980)."

Not every soldier who deploys in service of OIF/OEF will experience a "psychologically seismic" event, and not every soldier who experiences a traumatic event will experience negative (or positive) long-term psychological consequences. However, the psychological tasks of healing from trauma theorized by Tedeschi and Calhoun to generate the possibility for PTG, parallel some of the tasks of reintegration following deployment. In this paper I will suggest that opportunities for the promotion and facilitation of posttraumatic growth exist for social workers in both the individual, clinical arena and for all civilians in the arena of the larger civilian community.

Chapter IV

Micro-Level: Trauma Theory

In this chapter, I will explore the phenomena of the reintegration challenges faced by veterans from a micro-level perspective. Trauma theories have arisen largely out of the need to identify and treat the various psychological wounds of warfare among soldiers and warriors throughout history. Though "the existence of psychiatric casualties in war undoubtedly goes back as far as warfare itself." (Tanielian & Jaycox, 2008, p. 4), formal theoretical and diagnostic conceptualizations of combat-related trauma are relatively new. In this chapter, I present a brief history of the trajectory of trauma theories as they have developed through the study and treatment of military service members and veterans. I discuss the development of the diagnosis of posttraumatic stress disorder (PTSD) and describe the prevalence of PTSD and other psychologically traumatic injuries among OIF/OEF veterans. I argue that the diagnostic criteria for PTSD are inadequate as a measure of trauma because they fail to account for the moral, spiritual, existential and sociocultural components of traumatic injury and healing. And, they do not consider salient distinctions between the type, frequency and degree of severity of the trauma or the cultural context in which the traumatic event and trauma survivor are located. Finally, I suggest ways in which traumatic outcomes of military service may complicate reintegration and present opportunities for posttraumatic growth.

Early Greek, Roman and Egyptian descriptions of the symptoms, behaviors and reactions observed among those war veterans are remarkably consistent with the kinds of responses that characterize contemporary theoretical understandings of trauma as a consequence of war (Institute of Medicine, 2010). In 1678, PTSD-like symptoms were first diagnosed among Swiss military veterans under the term "nostalgia." The term "nostalgia" was later used by American physicians to describe the combat stress reactions observed among Civil War soldiers and veterans (Institute of Medicine, 2010; Tick, 2005). Dr. Joseph DeCosta, noting rapid, elevated heartbeat among those reactions, used the phrase "soldier's heart" to describe combat stress reactions commonly observed among Civil War soldiers. Later, Sigmund Freud's formal conceptualization of the causes, consequences, and treatment of trauma catalyzed a new way of understanding the psychological consequences of participating in warfare.

Sigmund Freud famously originated a formal theoretical conceptualization of trauma through his work with female sufferers of "hysteria" in the late 19th century. Freud theorized that symptoms of hysteria were caused by intrapsychic distress often related to traumatic events in childhood and that those symptoms could be alleviated through talking about the memories, thoughts and emotions connected to the event. Freud's investigations of hysteria formed the foundation for his later work in psychoanalysis and "the talking cure" was developed as the first formal treatment for psychological trauma.

During World War I, British psychologist Charles Myers coined the term "shell shock" to describe the symptoms of psychological distress he observed among British veterans. Myers initially theorized that combat stress reaction symptoms were the result of concussive injuries caused by exposure to exploding artillery. Eventually, psychologists and psychiatrists acknowledged that combat stress reactions were equally observed among veterans who had not

been exposed to exploding artillery and/or sustained a physical injury (Herman, 1997) By World War II, largely on the basis of Freud's conceptualization of intrapsychic dynamics, psychologists acknowledged that combat –related stress symptoms were the result of psychological, not physical injuries and renamed them "battle fatigue" or "combat exhaustion" At that time, a rapidly expanding body of psychological research documented the nature and prevalence of combat-stress related symptoms among WWII soldiers during the war and in veterans after its end. Prior to this era of study, it was widely believed that only those soldiers suffering from fundamental characterological flaws or constitutional inferiority were susceptible to combat stress reactions (Herman, 1997; Institute of Medicine, 2010). During WWII a new paradigm for thinking about combat trauma was established, supported by empirical data, which was characterized by the understanding that " any soldier could be made behaviorally dysfunctional as well as physically symptomatic by the stresses, anxieties, and strains affecting him in the war zone environment" (Marlowe, 2001). (Institute of Medicine, 2010, p. 42)."

The Vietnam War "was a turning point in the assessment and treatment of combat-related psychological distress." (Tanielian & Jaycox, 2008). As thousands of American soldiers returned home from the brutal battlefields of Vietnam bearing the physical and psychological wounds of combat, the readjustment difficulties facing returning veterans became an issue of national concern (Tanielian & Jaycox, 2008). Vietnam veterans organized to advocate for the development of formal diagnostic categorization and treatments for the psychological injuries of warfare. In response to their call, the Veterans Administration commissioned a number of systematic large-scale studies investigating the ways in which wartime experiences impacted the lives of Vietnam Veterans. The results of these investigations "delineated the syndrome of posttraumatic stress disorder and demonstrated beyond any reasonable doubt its direct

relationships to combat exposure (Herman, 1997, p. 27). In 1980 the American Psychiatric Association included Posttraumatic Stress Disorder as an official diagnosis in the DSM-III, largely in response to the veterans' self-advocacy.

Any human who participates in warfare is subject to moral, psychological, spiritual and emotional injury. The commonly used phrase "No one leaves unchanged" accurately describes the vulnerability of all participants of war to these kinds of injuries. Veterans may experience a broad range of behaviors, reactions and symptoms related to their service in a war zone. The kinds of behaviors, reactions and symptoms that are commonly experienced by most veterans as a result of participation in war are broadly referred to as "acute combat stress" or "acute stress reactions." Symptoms of acute stress reaction may include sleep disturbances, hypervigilance, intrusive memories, exaggerated startle responses, feelings of anger, sadness, guilt, loneliness or numbness, withdrawal from family and friends, disturbances in interpersonal relationships and increased use of substances (Slone and Friedman, 2008). Symptoms of acute stress reactions typically emerge in the weeks following a veteran's return and are a normal and expected part of the reintegration process. For most veterans symptoms of acute stress reaction will subside over time without significant intervention.

However, many veterans will develop posttraumatic stress disorder as a result of exposure to warzone stressors. Though symptoms of acute stress reaction are often similar to those of PTSD, PTSD differs from acute stress reaction in severity, chronicity, and level of functional impairment. Even with treatment, symptoms of PTSD may persist years, even decades after the traumatic event and create pervasive disturbances in many areas of a person's life. Posttraumatic stress disorder is one the "signature wounds" of the wars in Iraq and Afghanistan. Researchers have typically focused on PTSD as a way to measure and characterize combat-

related trauma outcomes among OIF/OEF veterans and its prevalence has been well documented among OIF/OEF veterans (Tanielian & Jaycox, 2008; Milliken, Auchterlonie, Hoge, 2007). In an analysis of 22 studies that researched PTSD as a possible outcome of deployment among OIF/OEF veterans, Tanielian and Jaycox (2008) found that documented prevalence rates of PTSD ranged from 5% -15% among OIF/OEF veterans. For soldiers, risk factors for developing PTSD include high levels of exposure to combat events, multiple deployments, history of trauma prior to deployment, other pre-existing mental illnesses, being physically wounded while deployed (Hoge & et al, 2004) and of lack social support before/after deployment (Bash, LaVogt, King, King, 2009).

PTSD develops in response to a traumatic event or events in which "the person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to physical integrity of self or others and the person's response [to the event(s) involved intense fear, helplessness, or horror." (APA, 2000, p. 467). In accordance with this definition, the day-to-day lives of many OIF/OEF soldiers in the theater of combat could be characterized as traumatic events. There are three symptom clusters that characterize the primary diagnostic features of PTSD from the DSM-IV. The first cluster is re-experiencing symptoms. Re-experiencing symptoms include things like flashbacks to the traumatic event, nightmares, and intrusive memories of the event and psychological/physiological arousal in response to reminders of the event. The second set of criteria pertain to avoidance. Symptoms of avoidance arise out an effort to avoid painful aspects of remembering the trauma and include restricted range of affect, emotional numbing, foreshortened sense of future and making significant efforts to avoid potential triggers. Finally, PTSD is characterized by hyperarousal. Hyperarousal symptoms include difficulty sleeping,

increased irritability, difficulty concentrating and hypervigilance. A person qualifies for a diagnosis of PTSD when several symptoms from each symptom cluster have been present for more than 1 month. The onset of trauma symptomology or PTSD may be acute, immediately following the trauma or delayed months or even years after the traumatic event. If symptoms persist for more than 3 months, as they often do for OIF/OEF veterans (Institute of Medicine, 2010), the diagnosis of PTSD is characterized as "chronic." Symptoms may also be characterized as recurrent or in remission and many veterans with PTSD will experience fluctuations in symptomology over the course of their lives (Tanielian & Jaycox, 2008; Tick, 2005). A discussion of PTSD is important because researchers studying OIF/OEF veterans have largely relied on the diagnostic criteria of PTSD to measure the trauma-related outcomes of war (Hoge, Auchterlonie & Milliken, 2007; Tanielian & Jaycox, 2008).

PTSD and other trauma-related outcomes of combat deployment may negatively impact a number of areas of functioning in a veteran's life, particularly during the reintegration process. Researchers have shown that "symptoms of combat-related trauma and posttraumatic stress are inversely associated with service members' relationship quality and stability (Institute of Medicine, 2010, p. 68)" Rates of divorce are also higher among veterans with combat-resultant trauma (Institute of Medicine, 2010). PTSD has also been associated with relational disturbances in parent/child relationships and friendships (Institute of Medicine, 2010). Combat-related trauma has also been associated with higher levels of substance abuse and other co-morbid mental illnesses such as depression and anxiety. Trauma symptomology and related sequelae have been linked to occupational impairment and unemployment, higher likelihood of homelessness, increased risky behaviors and related negative legal and health consequences, increased risk for suicide, increased incidents of domestic violence and poor physical health.

(Tanielian & Jaycox, 2008). Many of these impairments occur co-morbidly among OIF/OEF veterans (Institute of Medicine, 2010; Tanielian & Jaycox, 2008) further complicating reintegration.

Judith Herman (1997) and other contemporary trauma theorists (Tick, 2005; Briere & Scott, 2013) have suggested that the diagnostic criteria for PTSD are inadequate as a measure of trauma because they fail to account for the moral, spiritual, existential and sociocultural components of traumatic injury and healing. Furthermore, the diagnostic criteria for PTSD do not consider salient distinctions between the type, frequency and degree of severity of the trauma and they ignore the cultural context in which the traumatic event and trauma survivor are located. These factors, she argues, are especially relevant in considering the trauma survivor's ability to heal from the trauma. Herman and Tick argue that formal diagnostic criteria for PTSD are most accurate in considering the effects of a discreet traumatic event, but fail to capture the complexity of prolonged or chronic exposure to trauma as in warfare. Because of the particular nature of the wars in Iraq and Afghanistan, as described above, Judith Herman's conceptualization of "complex post-traumatic stress disorder" may be a more useful and holistic way to assess the nature of the traumatic impacts of participation in the wars in Iraq and Afghanistan. In addition to many of the symptoms that characterize PTSD, Herman includes novel diagnostic criteria addressing dimensions such as alterations in perception of self, others and the world, and the capacity for meaning making in the wake of trauma.

In the warzones of Iraq and Afghanistan there is little chance for reprieve or protection from the threat of attack or injury. Many servicemembers will have experienced multiple traumatic events or stressors in the course of their OIF/OEF service (Hoge, 2004) and many soldiers will deploy for several months to a year. Chronic or repeated exposure to warzone

stressors over the course of many months may cause profound disturbances in personality

structure and relational capacities. Herman summarizes the experience of traumatized people:

"Traumatized people feel utterly abandoned, utterly alone, cast out of the human and divine

systems of care and protection that sustain life. Thereafter, a sense of alienation, of

disconnection, pervades every relationship, from the most intimate familial bonds to the most

abstract affiliations of community and religion." (1997, p. 52).

Edward Tick presents a similar critique of the inability of the diagnostic criteria for PTSD

to fully describe the nature of the traumatic impacts of war. He further problematizes these

criteria given that they guide and dictate methods of treatment that "commonly alienate or fail

survivors." (2005, p. 102). Tick describes PTSD or combat-related trauma experiences as "soul

injuries" and names a number of dimensions of vulnerability for combat participants that are not

explicit in the DSM-IV criteria. These include: "[the] drive to preserve life and to persevere in

our own existence; self-awareness as autonomous and effective agents creating our

destinies…the functioning of [the] imagination; and [the] capacity to function in society." (p.

109). He argues that moral or spiritual traumatic injuries from war are as pervasive and

damaging as those designated by the diagnostic criteria of PTSD and should be addressed

explicitly in the treatment combat veterans.

Most narratives around the experience and treatment of trauma center around deficits,

pathologies and illness that may occur as a result of trauma. However, more recently, as

discussed above, researchers have suggested growth as a possible outcome of trauma (Briere &

Scott, 2013; Herman, 1997). Posttraumatic growth arises out of the transformative struggle to re-

establish safety, control, connectedness, spiritual meaning and existential direction in the wake

of a traumatic event. For veterans, this process of transformative struggle also characterizes the

reintegration process. For OEF/OIF veterans, the reintegration process may represent an opportunity to catalyze posttraumatic growth and therapists, clinicians, and others working with veterans from a micro-perspective should be aware of this opportunity.

Contemporary trauma theorists such as Tick and Herman argue that the ways in which trauma is experienced, interpreted and treated are culture-bound. That is, the process of healing from trauma is an individual one that occurs within a larger cultural context and furthermore that cultural beliefs about the nature of the traumatic event as well as the trauma survivor have broad implications for the survivor's ability to reintegrate back into the larger community following a traumatic experience. The spiritual, emotional, psychological crises that characterize the traumatic experience may be exacerbated by the ways in which society may reject, ignore, stigmatize or devalue both the trauma survivor and the nature of the traumatic event (Herman 1997; Tick, 2005; Shay, 1995). A brief history of the etiology of the diagnosis of PTSD is presented here to demonstrate the ways in which the issues of veterans in war have driven Western conceptualizations of trauma throughout American history. In general, trauma theories have provided the dominant framework for understanding the effects of participating in warfare and for treating the psychological wounds of war. And, the ways in which trauma may negatively impact the ease of reintegration for OIF/OEF veterans have been discussed above. I suggest that a more complete understanding of the reintegration challenges facing veterans requires attention to both the micro-level (such as PTSD) and macro-level forces (such as culture) that impact veterans during reintegration. Edwards Tick suggests "We could significantly alleviate the suffering of our veterans and minimize their disabilities by attending to the societal dimensions of PTSD." (p. 244). In the following chapter, I will attend to some of the

salient sociocultural factors that may impair a veteran's ability to reintegrate successfully into

civilian society.

Chapter V

Macro-Level: The Military-Civilian Cultural Gap

In this chapter, I will examine the reintegration difficulties that veterans experience from a broader perspective. Veterans grapple with the intrapersonal difficulties that arise as a result of a deployment within the context of civilian communities. A comprehensive understanding of the phenomena of reintegration difficulties facing OIF/OEF veterans necessitates an exploration of the larger civilian communities to which veterans return. Within those communities, a number of social, cultural, political, ideological, institutional and interpersonal dynamics and forces impact a veteran's reintegration process. Problematically, many of these forces function to impair rather than support veterans' abilities to achieve or exceed pre-deployment levels of biospyschosocial well being. The interactions of these forces create and sustain what I name the military-civilian cultural gap. In this paper, the military-civilian cultural gap is used as a theoretical framework which locates veterans as members of a small, often invisible minority group joined by shared experiences and aligned by a unique set of values, beliefs and standards of conduct which are distinct from, and often incongruent with those normatively prescribed by the dominant group, American civilians.

The conceptualization of "the military" as an entity that both cultivates and transmits a particular and unique culture has origins in antiquity (Shay, 1995) and is widely accepted within the literature (Shay, 1995; Tanielian & Jaycox, 2008; Luby, 2012). Below I provide a brief

history of the military-civilian cultural gap and compare and contrast contemporary American

military and civilian cultures as a way to establish the nature of the cultural "gap" I describe.

The processes by which military initiates are emotionally, psychologically and physically

separated from civilian culture and assimilated into military culture are described. The totality of

this separation and assimilation, necessitated by the extreme demands of participation in warfare,

render service members permanently "othered" or estranged from civilian culture in problematic

ways that are described using the framework of the military-civilian cultural gap. The theoretical

application of the military-civilian cultural gap proves useful both as a way to conceptualize the

macro-level reintegration challenges discussed throughout this chapter and as a way to

understand the ways in which civilian communities might become positive spaces for healing

and growth. In the final chapter of this paper I suggest some macro-level interventions that might

function to bridge the military-civilian cultural gap and facilitate posttraumatic growth within

civilian communities.

Military-Civilian Cultural Gap

Researchers and journalists have identified a disconnect between soldiers and civilians

and have described this disconnect as "the military-civilian gap." (Doyle & Peterson, 2005; Pew

Research Center, 2011; Thompson, 2011). The psychosociocultural distance between military

members and civilian society was most famously described by political scientist Sam Huntington

in his book *The Soldier and the State: The Theory and Politics of Civil-Military Relation*s

(1957). In it, he describes a discrepancy between military and civilian values that renders

veterans in civilian society "an estranged minority" and creates tension, even hostility, in

military-civilian relationships. Though his work is foundational in the study of military-civilian relations, Huntington's perspective on the military-civilian gap was largely focused on the political and institutional implications of such a gap on America's military power and structure, not the well-being of veterans. More recently, researchers have suggested that the concept of "military-civilian gap" has not been effectively defined by scholars across the literature and is used interchangeably to describe multiple different relational, structural, political, professional, cultural and institutional phenomena between the U.S military and American civilians (Rahbek-Clemmensen et al., 2012).

Clemensen et al. (2012) describe four distinct iterations of what they call "civil-military gaps." Those are (1) cultural; (2) demographic; (3) policy preference; and (4) institutional. The civil-military cultural gap generally refers to the differences in attitude and values between service members and civilians. The demographic civilian-military gap describes the representativeness of U.S service members relative to the whole population of the United States. Because service members now self-select for military service, the representativeness of the armed forces has declined since the Vietnam War. Service members tend to be more politically conservative and less educated than their civilian counterparts. A wide majority of service members are White males. A disproportionate number of veterans come from Southern and politically conservative states and are more likely to come from military families than civilians (Rahbek-Clemmensen et al., 2012). In short, the Armed Forces are no longer broadly representative of the population of the U.S. The civil-military policy preference gap arises from the fact that the military operates largely on the policies and mandates of civilian government officials, most of whom have no prior military service or background. Rahbek-Clemmensen et al. (2012) suggest an individual's military experience is likely to color his/her policy preferences in

ways that are sometimes in opposition to those widely espoused by non-military members and by the larger civilian population. Finally, the civil-military institutional gap is defined as the relationship between the military/service members and American civil institutions such as courts, education systems, and the media.

In this paper, the military-civilian gap I describe is most consistent with the civil-military cultural gap described by Rahbek-Clemmensen et al. (2012).The military-civilian *cultural* gap as it exists in post 9/11 America has not been subject to thorough re-examination and/or re-conceptualization among researchers in the context of the wars in OIF/OEF and social, cultural, and political climates have changed enormously since Huntingdon's 1957 publication. The historical etiology of the military-civilian gap in America is well documented and a full review of its origins is beyond the scope this paper. Furthermore, the impact of the end of conscription, the historical legacy of the Vietnam War and the uniqueness of the OIF/OEF conflicts in conjunction with drastic shifts in social, political, and economic climates over the previous 50 years may not be reflected in pre-Vietnam-era conceptualizations of the military-civilian cultural gap limiting the relevancy and applicability of those conceptualizations for the current circumstances. The aims of this paper necessitate an updated theoretical conceptualization of the military-civilian cultural gap which considers both the national history of American military-civilian relations as well as the current realities of military service and the civilian environment of post 9/11 America. That this particular conceptualization of the military-civilian cultural gap is not well established within the literature is noted as a limitation of this paper. However, I highlight the findings of several studies that substantiate my conceptualization of the military-civilian cultural gap (Demers, 2011; Pew Research Center, 2011) and call attention to the need for more research in this area. This work may provide fresh conceptual and theoretical insights

into the state of the military-civilian cultural gap as it persists in the unique circumstances of post 9/11 America.

In this paper, the military-civilian cultural gap is used as a theoretical framework which locates veterans as members of a small, often invisible, minority group joined by shared experiences and aligned by a unique set of values, beliefs and standards of conduct which are distinct from, and often incongruent with, those normatively prescribed by the dominant group, American civilians. The military-civilian cultural gap is basically defined as the differences in ideology, experience and attitude that create and reinforce mutual mistrust, apathy, avoidance, even hostility between veterans and civilians. The concept of the military-civilian cultural gap encompasses the variety of macro-level social, cultural, political, ideological, institutional and interpersonal dynamics and forces that impact a veteran's reintegration process.

The conceptualization of "the military" as an entity that both cultivates and transmits a particular and unique culture dates back to antiquity and is widely accepted within the literature (Institute of Medicine, 2010; Shay, 1995). That the military and civilian society represent separate and unique cultural groups whose values, priorities and standards of conduct are often at odds is similarly well established (Reger, Etheridge, Reger & Gahm, 2008). There is also a substantial body of literature prescribing military cultural competency as an ethical imperative for civilian clinicians working with veterans which substantiates the conceptualization of the military as a distinct cultural entity here (Franklin, 2009; Manderscheid, 2007; Reger, Etheridge, Reger & Gahm, 2008). The military forms a unique cultural group in that there exists a persistent and "shared set of beliefs that affect the thinking and behavior" of service members in the military (Reger, Etherage, Reger & Gahm, 2008). As with any cultural group, the military's norms, values, standards and beliefs dictate the ways in which group members communicate,

think, and behave both within and outside of the group (Rubin, Weiss & Coll, 2012 p. 23). When

a service member joins the military, his or her civilian sense of self and identity is systematically

deconstructed and replaced by military ideals, values, norms and standards of conduct (Demers,

2011; Halvorson, 2010). Military cultural values are habituated through extensive training and

become integrated into the service member's core-sense of self and persist long after discharge

from the military (Rubin, Weiss & Coll, 2012; Halvorson, 2010).

The military cultural identity is characterized by duty to country, obedience to authority,

self-sacrifice, physical strength and the valuing of group cohesion and team success over

individualism and personal agency (Rubin, Weiss & Coll, 2012). Conversely, civilian identities

privilege individualism, materialism and the pursuit of personal gratification (Collins, 1998;

Demers, 2011). Each individual's adherence to military cultural norms is demanded as the

effectiveness and cohesiveness of the military unit has direct implications for the survival of

individual soldiers and the success of missions. Since the primary function of the U.S. military

is to fight and win American wars, the military culture espouses values that enhance a soldier's

physical, intellectual and psychological abilities to fight and survive in a combat zone.

Military Training

Military cultural values are committed to memory by new recruits beginning at basic

training. Each military service branch espouses its own core values. For example, the Army's

core values are: loyalty, duty, respect, selfless service, honor, integrity, and personal courage

(SAMHSA, 2010). These values guide a service member's conduct and decision-making both in

executing missions on the battlefield, and often at home as well. (Slone & Friedman, 2008) New

recruits are introduced to collective living and surviving as they eat, sleep and train together for

up to 3 months during basic training, a transformational period of intense emotional, physical and psychological challenges. Service members learn that the sometimes-brutal requirements of war supersede allegiance to pre-existing moral, spiritual, political or even legal standards of behavior and etiquette (Hoge, 2012; Tick, 2005; Grossman, 2005).

Grossman describes the initiate's boot camp training as an "inoculation" against the stress of participating in war for new recruits, describing the experience as one of "sadistic abuse" and "overt physical [and interpersonal] hostility." Researchers have found that in U.S combat conflicts prior to Vietnam, even as early as the Civil War, a solid majority of American soldiers (75 – 85%) never fired their weapon at an enemy (Grossman, 1995) indicating in those soldiers an innate (conscious or unconscious) resistance to participating in the death or injury of another human being (and/or more simply a lack of rigorous weapons training). Changes in military training and psychological conditioning reduced that percentage down to only around 5% (Grossman, 1995) in Vietnam indicating, on some level, the voracity and totality with which military training may alter or replace innate or pre-existing personally held values, morals and ethics. Grossman also describes that military training relies heavily on Pavlovian classical conditioning and Skinnerian operant conditioning techniques, which may also explain why many veterans continue to operate compulsively on military training and skills even after returning to a civilian environment (for example, defensive driving) (Grossman, 1995). New recruits receive extensive weapons and self-defense training and learn to carry out orders from authority figures quickly, efficiently, and without question. They condition for warfare in realistically simulated environments and scenarios. They are praised and rewarded for success and subject to harsh punishment for failure. The mechanics of battle must become second nature for trainees even before they ever experience an actual combat scenario because in a real combat scenario, even

minor errors could have major consequences including injury and death. Because military cultural values become deeply, perhaps permanently, internalized in ways that are sometimes problematic within the context of a civilian environment, BATTLEMIND and other similar programs have been developed to assist veterans in modifying military cultural values and skills for the civilian environment.

The OIF/OEF Military-Civilian Cultural Gap

Research from the Pew Research Center supports the theoretical conceptualization of the military-civilian cultural gap as a macro-level barrier to reintegration and establishes the nature and the significance of this gap in the context of the wars in Iraq and Afghanistan. Their report entitled *The Military-Civilian Gap War and Sacrifice in the Post-9/11Era (*2011) represents the most substantial effort to date to quantitatively define the military-civilian gap within the context of the wars in Iraq and Afghanistan. I present some specific findings from this study that reveal areas of similarity and difference between veterans and civilians in beliefs and attitudes on a number of issues which are relevant to the military-civilian cultural gap. An analysis of these areas of difference/similarity from the theoretical perspective of the military-civilian cultural gap defined earlier in this paper will lead to a greater understanding the nature of the dynamics that arise between veterans and civilians in society and the ways in which those dynamics may inhibit reintegration for OIF/OEF veterans.

Researchers with the Pew Research Center (2011) published the results of two large surveys in which researchers surveyed a nationally representative sample of 1,853 American military veterans and 2,003 American civilians via telephone or Internet to investigate "the military-civilian gap." Pew researchers describe that their report

compares and contrasts the attitudes of post-9/11 veterans, pre-9/11 veterans and the

general public on a wide range of matters, including sacrifice; burden sharing; patriotism;

the worth of the wars in Afghanistan and Iraq…the nature of America's place in the

world; and the gaps in understanding between the military and civilians. (Pew Research

Center, p. 3).

In the study, 51% of combat and 34% of non-combat OIF/OEF veterans described

readjustment to civilian life as "difficult" or "very difficult." Pew researchers note a number of

endogenous and exogenous factors that may contribute to these difficulties including mental and

physical health issues, length and number of deployments, poor economic climate, and declining

public interest in/approval of the wars in Iraq and Afghanistan. The Pew Center research

revealed important ideological, philosophical and political differences between civilians and

veterans that may be useful in understanding the nature of the post 9/11 military-civilian cultural

gap as defined in this paper and the ways in which this gap contributes to the reintegration

difficulties of OIF/OEF veterans.

The military-civilian cultural gap reinforces and is reinforced by the physical,

experiential, metaphorical and cultural distance between OIF/OEF veterans and members of

civilian society. First, given that veterans comprise a very small, often invisible, minority of

Americans, it would be reasonable to assume that many civilian Americans are not intimately or

directly acquainted with a veteran or service member. In the absence of actual meaningful

relationships with service members and/or veterans, Grossman (1995) suggests that civilians'

perceptions of veterans may be distorted by the unflattering ways in which veterans and soldiers

are often (inaccurately) depicted in popular media and film. Surprisingly, almost 60% of

American civilians surveyed by Pew researchers reported having a close friend or family members who served in either Iraq or Afghanistan. And, more than 60% of all survey respondents said they have at least one immediate family member (a parent, child or spouse) who has served in the Armed Forces at some point. Such statistics stand in stark and telling contrast to the experiences and feelings of social isolation and relational distance often described by veterans in civilian society (Demers, 2011; Grossman, 1995; Shay, 1995). The military civilian cultural gap may create a distance and disconnect between service members and civilians that persists even within the context of "close" friendships or family relationships.

Despite findings that 60% of civilians surveyed reported a close relationship with an OIF/OEF veteran, half of civilians surveyed also indicated "the wars in Iraq and Afghanistan have had little impact on their own lives." That a majority of civilians surveyed both intimately know a veteran and do not feel that the wars in Iraq and Afghanistan affect them (civilians) personally indicates a perception among civilians that issues affecting service members and veterans do not necessarily affect them. This dissonance functions to preserve the military civilian cultural gap and provides civilians with justification to maintain distance from veterans and their struggles. It also speaks to the tendency towards individualism and self-reliance central in American civilian culture. While Pew researchers suggest that the impact of the wars in Iraq and Afghanistan has not been deeply or directly felt by many civilians the financial, political and social costs of these wars to civilian society are actually far-reaching and well-documented (Tanielian & Jaycox, 2008).

While civilians seem not to view the needs and interests of returning veterans as interconnected with their own lives and interests, Pew researches found that civilians do acknowledge the burden of military service for veterans and their families. Eighty-three percent

of civilian respondents endorsed agreement with the statement "military personnel and their families have had to make a lot of sacrifices since the Sept. 11, 2001, attacks." However, a majority of American civilians surveyed (70%) also indicated that the sacrifices made by veterans and their families are "just part of being in the military" while only 26% indicated that they felt these sacrifices were "unfair."[2] Eighty-four percent of post 9/11 veterans surveyed endorsed the belief that "the public does not understand the problems faced by those in the military or their families." Pew researchers describe these data as representing a "gap in burden-sharing" and suggest that both civilian and military Americans readily acknowledge the existence of this gap. Pew researchers concluded that American civilians do not hold a personal sense of responsibility in addressing the reintegration challenges experienced by veterans and their families. The extent to which civilians might reasonably be expected to hold a personal sense of responsibility for "sharing the burden" of military sacrifice and addressing the reintegration concerns of OIF/OEF veterans is debatable. Many theorists have discussed the ways in which civilians consciously and unconsciously avoid, ignore or deny the fact of their implicit participation in the armed conflicts of the nations in which they reside (Herman, 1997; Shay, 1995; Tick, 2005) and others have suggested that civilians of nations at war should and must be open to receiving and holding some of the trauma and suffering of returning veterans. It is reasonable to assume that an increased sense of responsibility, as well as a better understanding of the ways in which the wars impact civilian communities, might motivate civilian communities to be more proactive in addressing the reintegration needs of recent veterans.

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[2]The question was "Do you think it is unfair that those in the military and their families have made more sacrifices during this time, or is it just part of being in the military?" Possible responses were: Unfair; Part of Being in the Military; Both; Neither; Don't Know.

With public support for the wars in Iraq and Afghanistan at an all time low and the presence of more immediate economic, social and political concerns, the civilian stance towards OIF/OEF veterans is characterized by apathy and disinterest. According to Pew researchers public interest in the wars in Iraq and Afghanistan has declined markedly since the early years of OIF/OEF - only 25% of civilians surveyed reported that they were "closely following" the wars in Iraq and Afghanistan. Pew researchers attribute this choice to disengage from coverage of the wars to "national war fatigue" as a result of nearly a decade of fighting as civilians direct their energies and attention to issues of greater immediacy and those that more directly impact them.

Pew researchers presented several findings, which further illuminate some of the differences between service members and civilians that characterize the military-civilian cultural gap. For example, perceived levels of patriotism was another area of cultural difference revealed in the study. Sixty-one percent of post 9/11 veterans indicated that they considered themselves to be "more patriotic than most other Americans." Veterans were also more likely to identify politically as "Republican" while civilians were more likely to identify as "Democrat." Overall, half of veterans surveyed identified as "politically conservative" compared to 37% of civilians. Partisan political differences between veterans and civilians may further dichotomize veterans and civilians, particularly within highly politically polarized civilian communities. However, while the majority of civilian respondents in the Pew research study expressed disapproval of the wars in Iraq and Afghanistan, they reported a largely favorable view of veterans and service members. For example, although 91% of civilian respondents indicated that they had "felt proud of the soldiers" engaged in OIF/OEF, more than one third of civilian respondents (34%) indicated that they had "felt ashamed of something the military had done in Afghanistan or Iraq." Pew researchers concluded that in general, more post 9/11 veterans than civilians hold the view

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that one or both wars has been "worth it" with nearly 50 % of civilians surveyed indicating the belief that neither war has been "worth it."

Pew researchers also asked veterans to indicate their reasons for joining the military. The most popular reason, endorsed by 88% of post 9/11 service members in the survey was "To serve my country." The degree of sacrifice that service members have been willing to make in service of OIF/OEF has not been reciprocated by the larger civilian public. The personal, emotional, social and political distance that many civilian Americans have been able to maintain throughout the wars in Iraq and Afghanistan is largely a result of civilian privilege. Paulson and Krippner (2010) indict this civilian privilege saying that "[civilians] nurture the notion that the poor, unskilled, and those not bound for college join the military and that this does not apply to them or their children." In a public that reports shame, apathy, disinterest, and opposition around America's engagement in the wars in Iraq and Afghanistan, those who served in support of those wars may be subject to similar sentiments. In short, veterans return to a civilian public which does not value their service in the context of an unpopular war and which sees itself as fundamentally apart from those who do chose to serve (Herman, 1997; Shay, 1995; Tick, 2005).

As veterans reenter civilian society, they also struggle to reassume their civilian identities. However, given the nature of the military-civilian gap and some of the issues discussed above, accessing a civilian identity, and therefore acceptance, within larger civilian communities may be difficult. During a wartime era, both service members and American civilians must learn to navigate relationships and social interactions with one another, which are complicated by stigma associated with mental illness, myths and misconceptions about veterans, civilian opposition to war, and military/civilian cultural differences (Tanielian & Jaycox, 2008). Though few studies exist that explore the role of the military-civil cultural gap in reintegration

from a veteran's perspective, researchers have used veterans focus groups to explore the community reintegration process with some success (Demers, 2011; Tanielian & Jaycox, 2008). Demers (2011) completed a unique qualitative study of OIF/OEF service members and synthesized some of the primary challenges veterans reported that they faced in reintegrating back into the civilian environment. She found that veterans perceived a low level of respect from civilians in comparison to the level of respect they perceived from fellow service members during their military service. Veterans felt a distinct lack of purpose in civilian lifestyles. One veteran voiced frustration about constantly overhearing "petty conversations about shit that means nothing." (Demers, 2011, p. 171). And veterans reported a general sense that they did not fit into the civilian world. No female participants were included in Demers' research and a small sample size limited the generalizability of her findings. It should be noted that in general women and persons of color are largely underrepresented in the research and literature regarding veterans and in particular OIF/OEF veterans. This underrepresentation enforces both the invisibility and vulnerability of these populations and fails to accurately represent the diversity within the military.

The feeling of "not fitting in" is commonly reported by veterans (Demers, 2011; Herman, 1997; Tick, 2005) as one of the major challenges in reintegrating back into a civilian society. Many of the ways in which veterans do not "fit in" have been described above. Judith Herman (1997) describes the most basic difference separating veterans and most civilians: "The veteran is isolated not only by the images of the horror that he has witnessed and perpetuated but also by his special status as an initiate in the cult of war." (p. 66). Although soldiers have traditionally enjoyed a status as "idealized and valued member[s] of society" (Herman, 1997) their status as "initiate[s] in the cult of war" may further alienate them from civilians, most of whom have

never encountered a warzone environment. Larner and Blow (2011) explain that " during the reintegration process the necessarily changed worldview of the combat veteran comes into conflict with the surrounding social worldview that is dissociated from any adequate understanding of their combat experience." (p. 193). The ways in which civilians respond or do not respond to returning veterans have implications for veterans' abilities to reassume their civilian identities and become accepted and valuable members of their communities.

Throughout history, societies have acknowledged the need to create public space for the healing of war trauma among soldiers by devising rites, rituals and memorials to facilitate the reintegration of veterans into society (Herman, 1997; Shay, 1995; Tick, 2005). Such rituals promote public awareness of and acknowledgement for the sacrifices and struggles that war participants have endured in the course of their service and aid veterans in making the sociocultural, emotional and psychological identity shift from "warrior" to "civilian." In America, holidays such as Veterans Day, and memorials such as the Vietnam War Memorial have been created in part to make the public arena a more amenable space for veterans to receive (and provide) acknowledgement, social support and healing. Rituals, rites and memorials that foster a mutual sense of connection and belonging between veterans and their civilian communities have been largely absent throughout the wars in Iraq and Afghanistan. This is noted as an important deficit that may have far-reaching implications for OIF/OEF veterans' abilities to both heal from the trauma of war and to be welcomed back into the larger civilian community. For example, negative homecoming experiences and perceptions of low social support are among the many predictive factors of chronic PTSD among veterans (King, King, Fairbank, Keane & Adams, 1998; Yarvis, 2011;). The impacts of trauma are often described as "invisible wounds." In general, the military-civilian cultural gap is a way to understand the macro-level

forces that enforce and maintain the invisibility of veterans and their needs. Rites, rituals and memorials that promote the visibility of veterans and create empathic spaces for civilians to engage with the burdens of military service and warfare may also function to enhance a community's capacity to provide healing and protective social support and to be a space for posttraumatic growth for veterans.

Chapter VI

Micro And Macro Models Of Posttraumatic Growth

Throughout the centuries, the psychological, emotional and spiritual consequences of

participating in warfare have been evident among soldiers who have gone off to war and returned

home to their communities. And, while the traumatic effects of participation in combat have been

well-documented, the process through which veterans transition from "soldier" to "civilian" after

leaving the battlefield, known as reintegration, has not been widely studied. Because "no one

leaves unchanged" from a warzone, reintegration can be a challenging process for all returning

troops. Because of the high intensity of contemporary warfare and the current social, political

and economic climates of American civilian society, the 2.2 million veterans of the recent wars

in Iraq and Afghanistan face many unique challenges during reintegration. In this paper, I

examined those challenges from two different yet equally salient perspectives.

From a micro-level perspective I used trauma theory to discuss some of the ways in

which the experience of trauma, and particularly PTSD, may complicate reintegration for

veterans. I also explained that contemporary trauma theorists have critiqued the use of the

diagnostic criteria of PTSD as a measure of trauma because they fail to account for the type and

severity of the traumatic experience and do not include considerations for the moral, spiritual and

existential injuries that may result from trauma. I also argued that the process of reintegration is

both an intrapersonal and interpersonal one. That is, the process of reintegration occurs within a

social and cultural context and a complete understanding of the reintegration challenges facing veterans requires attention to these contexts as well as the intrapersonal or trauma-related difficulties that arise as a result of combat. Using a macro-level framework which I call "the military-civilian cultural gap" I discussed some of the unique sociocultural differences between veterans and civilians that may complicate reintegration and hinder posttraumatic growth for veterans. Throughout this paper I have suggested that reintegration may present opportunities for posttraumatic growth for veterans who have experienced trauma. In this final chapter, I will discuss some of the ways in which the possibility for posttraumatic growth may exist for veterans on the micro and macro-levels.

As discussed in chapter III, the term "posttraumatic growth" was originally coined by psychologists Tedeschi and Calhoun (1996) in response to a burgeoning body of clinical and empirical research demonstrating positive psychological and socioemotional changes in response to a traumatic event among a wide range of populations and traumatic circumstances. They define posttraumatic growth as the experience of "positive psychological change experienced as a result of the struggle with highly challenging life circumstances." (2004, p.1). They define "challenging circumstances" to mean those "that represent significant challenges to the adaptive resources of the individual, and that represent significant challenges to the individual's way of understanding the world and their place in it." (2004, p. 1). The experience of deploying to a combat zone undoubtedly qualifies as a "highly challenging life circumstance." Certainly, most individuals lack the appropriate internal and external "resources" to manage the experience of war effectively. And, while the process of military training and acculturation described in chapter V attempts to endow servicemembers with such adaptive resources in preparation for the inevitable trauma of participating in war, most servicemembers will have experiences that

challenge the ways in which they view themselves, others and the world around them during the course of their service (Tedeschi & McNally, 2011).

Through empirical research, Tedeschi and Calhoun (1996) developed an instrument for measuring posttraumatic growth among trauma survivors called the Posttraumatic Growth Inventory (PTGI). Through extensive quantitative and qualitative research, Tedeschi and Calhoun identified five major areas of posttraumatic growth commonly reported by survivors of trauma. THE PTGI quantifies and measures these 5 domains of growth for empirical research purposes. The domains of growth are: "greater appreciation of life and changed sense of priorities; warmer, more intimate relationships with others; a greater sense of personal strength; recognition of new possibilities or path's for one's life; and spiritual development." (Tedeschi & Calhoun, 2004, p.6). Only one study has been conducted using the PTGI to measure posttraumatic growth among OIF/OEF veterans (Pietrzak et al., 2010). In that study, researchers used anonymous surveys to assess for levels of combat exposure, psychopathology, psychosocial functioning, social support and posttraumatic growth among 272 predominately White male National Guard/Reserve OIF/OEF veterans 2 years after their most recent deployment. In the study, 72% of veterans surveyed endorsed experiencing growth in at least one of the five domains following deployment. The most commonly experienced area of growth endorsed was "greater appreciation of life and changed sense of priorities." This finding is consistent with studies of posttraumatic growth in other veterans populations wherein "greater appreciation of life and changed sense of priorities" is the most commonly endorsed domain of growth among veterans (Tedeschi, 2011).

Posttraumatic growth is not a direct, immediate, or guaranteed outcome of a traumatic event. Rather posttraumatic growth "occurs concomitantly with the attempts to adapt to highly

negative sets of circumstances that can engender high levels of psychological distress (2004, p. 2)." From this explanation, the reasons why reintegration represents an opportunity for posttraumatic growth become clearer. The process of reintegration, particularly for veterans suffering from PTSD, is in and of itself "an attempt to adapt to highly negative sets of circumstances that can engender high levels of psychological distress" for many of the reasons I discussed in chapters II, IV and V. Opportunities for posttraumatic growth may be enhanced or limited by various micro and macro level forces. In particular, Tedeschi and McNally (2011) describe seven variables that "increase the possibility of psychological growth in the aftermath of trauma"

> (a) cognitive processing, engagement, or rumination; (b) disclosure of concerns surrounding traumatic events; (c) the reactions of others to self-disclosures; (d) the sociocultural context in which traumas occur and attempts to process, disclose and resolve trauma; (e) the personal dispositions of the survivor and the degree to which they are resilient; and (f) the degree to which events either permit or suppress the aforementioned processes." (p. 19).

These seven variables will serve as a framework for understanding the ways in which posttraumatic growth may be promoted by clinicians working from a micro perspective and by and within larger civilian communities welcoming returning veterans.

On an individual level, the opportunity for posttraumatic growth arises through the intrapsychic struggle to process the traumatic circumstance. Within the context of trauma theory, this process typically occurs through individual psychotherapy. Psychologist Richard Tedeschi

(2011) recently published a model for facilitating posttraumatic growth among veterans within the context of psychotherapy. I will describe the model he presents as a way to explore posttraumatic growth in the context of trauma theory. On a broader environmental level, opportunities for posttraumatic growth may arise out of, or through, the process of reintegrating back into the civilian community. Using the framework of the military-civilian cultural gap, I will explore some of the ways in which posttraumatic growth might be enhanced or inhibited with attention to the five domains of growth and the seven variables that promote growth described by Tedeschi and Calhoun (2004).

Micro-Level Model of Posttraumatic Growth

Trauma theories were originally developed largely out of the need to identify and treat the negative psychological outcomes of combat observed among soldiers and veterans. In particular, the diagnosis of PTSD was eventually identified and defined to describe the nature of the combat-related psychological injuries incurred by war veterans. The diagnosis of PTSD describes a particular set of persistent pathologies that may arise as a result of participating in warfare and treatments for trauma-related symptoms of combat are structured largely around eliminating or reducing those pathologies. Tedeschi and Calhoun (2011, p. 2) describe that the "the main focus of work in psychology, medicine, and related disciplines, has traditionally been on the ways in which traumatic events are precursors to highly distressing and sometimes severe sets of psychological and physical problems." They further explain that the notion of posttraumatic growth, although "not prevalent in either clinical or research settings" comes from a "very long tradition of viewing human suffering as offering the possibility for the origin of

significant good." (2004, p. 2). In this paper, I argue that contemporary theoretical understandings of, and treatments for, the negative consequences of trauma should be augmented to include clinical considerations for the potential for posttraumatic growth (Tedeschi and Calhoun, 2004).

As discussed above, the combat-related trauma symptoms may first emerge weeks or even months after returning from deployment. Every veteran who has participated in warfare will engage in the task of processing those traumatic experiences intrapsychically. As I described in chapter IV veterans begin to process those experiences within the context of reintegration and the inability to process those events may impair the reintegration process. Many OIF/OEF veterans seek mental health care services, including individual psychotherapy, in the weeks, months and years following a deployment. Tedeschi (2011) suggests that individual psychotherapy may provide the most appropriate, or pragmatic, context for facilitating posttraumatic growth for veterans. I present Tedeschi's model for promoting posttraumatic growth within the individual therapeutic setting as a way to describe some of the micro-level interventions that social workers and other mental health clinicians working with OIF/OEF veterans might consider. Later I will apply some of these micro-level considerations in an exploration of some of the ways in which the larger civilian community can assist veterans in achieving posttraumatic growth.

Tedeschi and Calhoun (2004) have suggested that a combination of elements from theoretical models of psychotherapy such as cognitive, existential, humanistic and narrative therapies may be usefully employed to promote posttraumatic growth in veterans in a clinical setting. Drawing on each of those models, Tedeschi and McNally (2011) developed the "Comprehensive Soldier Fitness" program described in chapter IV as "a pathway towards posttraumatic growth." (p. 139). Components developed for this program form the basis for

Tedeschi's conceptualization of promoting posttraumatic growth in individual psychotherapy.

Within a psychotherapeutic setting, cognitive processing provides the primary mechanism for posttraumatic growth. Survivors of trauma narrate the events of their trauma as means of cognitive processing and begin to develop a full view of the ways in which the trauma has impacted their relational, spiritual, existential, psychological and physical well-being. They must also assess the ways in which their beliefs about themselves and their world have been altered due to trauma. Through cognitive processing, survivors identify these alterations and address them by developing new beliefs, schemas and principles that are integrative of the traumatic event. Through cognitive processing, a survivor may begin to answer such questions as "Who am I?" and "What will become of my life?" (Tedeschi & Calhoun, 2004, p. 10). Many trauma survivors engage in cognitive processing inherently through the process of grappling with traumatic outcomes intrapersonally outside of the context of individual therapy (Tedeschi & Calhoun, 2004). However, many survivors of trauma struggle to find spaces and relationships within which they can safely and productively process their traumatic event. Therefore, Tedeschi recommends that for the individual survivor, the psychotherapeutic setting may provide the best opportunity for cognitive processing and therefore posttraumatic growth.

Within the context of individual psychotherapy, the nature of the relationship between the clinician and the veteran forms the basis for the promotion of posttraumatic growth. As in most theoretical models of clinical work with trauma survivors (Briere & Scott, 2013) Tedeschi and Calhoun emphasize the importance of a strong therapeutic alliance between clinician and survivor as a necessary and foundational element of therapy. Tedeschi and Calhoun (2004) coined the term "expert companionship" to describe the relational stance of the therapist in facilitating posttraumatic growth. The basic principles of expert companionship include:

respect for survivors; being the humble learner rather than the expert; highlighting how aspects of post-trauma experiences reported indicate developing areas of posttraumatic growth; fashioning a narrative together with the trauma survivor that respects the horror of trauma while at the same time opening areas of change and development; and encouraging an appreciation for the paradoxical in the trauma experience, so that vulnerability can be strength…(Tedeschi, 2011, p. 139.).

Clinicians who are unable to establish a strong therapeutic alliance may be unable to facilitate relational healing and posttraumatic growth. Civilian clinicians should be aware of their own implicit or explicit biases or knowledge deficits that would impair their ability to have respect for the survivor, to hold the survivor's story in the interest of developing a coherent narrative, and to identify areas of progress towards posttraumatic in veteran clients.

Secondly, Tedeschi suggests that emotion regulation and affect management techniques should be employed with veterans. Disturbances in affect regulation are common among trauma survivors. Intrusive thoughts and memories may cause emotional dysregulation in survivors of trauma. Because emotional dysregulation impairs a survivor's ability to engage in constructive cognitive processing, Tedeschi (2011) suggests that therapists should teach anxiety reduction techniques and affect regulation skills as an integral part of therapy with veterans. Third, Tedeschi (2011) emphasizes the importance of "constructive self-disclosure." Constructive self-disclosure is an integral part of any trauma-focused therapy (Briere & Scott, 2013). Constructive self-disclosure describes the process through which survivors begin to talk about their trauma in a safe setting and with a compassionate, validating "other," usually, the therapist. Having an experience in which the disclosure of traumatic events is met with understanding and

compassion by a responsive other helps to "introduce trauma survivors to new schemas that can form the basis for a changed view of self, others, and how to live life…and can also allow for the development of emotionally significant relationships." (Tedeschi, 2011, p. 139). For many veterans, the experience of having killed or injured other human beings is part of their narrative. If therapists or clinicians working with veterans are unable to respond with compassion and sensitivity to the horror stories that veterans need to disclose as part of the healing process, they may (inadvertently) silence the veteran's narrative and therefore impair the process of posttraumatic growth.

Tedeschi (2011) explains that creating a trauma narrative that includes domains of posttraumatic growth is another way clinicians can facilitate the process of posttraumatic growth in therapy. Tedeschi explains that the dialectic of trauma, of something that is negative but may also create positive change, is difficult for survivors to acknowledge. Tedeschi explains that attending to this paradox within the trauma narrative creates more space to recognize and capitalize on opportunities for growth. Finally, Tedeschi advises clinicians to assist veterans in "developing life principles that enhance resilience." In the aftermath of trauma, using a strengths-based perspective to acknowledge the personal strength the veteran has used to survive a combat deployment may form the foundation for building resilience and thus posttraumatic growth. Traumatic events often present major challenges to previously held schemas, beliefs, and principles and to the survivor's ability to use those principles to guide their way of living in the world. Developing new life principles encompasses the task of identity reformulation for veterans transitioning into the civilian world and defining new existential and spiritual beliefs in the wake of trauma.

Social workers are often in an ideal position to address the challenges of reintegration for

OIF/OEF veterans on the micro-level. Tedeschi's model for facilitating posttraumatic growth within the therapeutic setting represents an augmented view of the ways in which clinicians can conduct therapeutic work with OIF/OEF veterans. Social workers working with veterans in a clinical context should be aware of the concept of posttraumatic growth and familiarize themselves with the literature that I have presented in this paper. They should also actively engage in increasing self-awareness of biases, knowledge deficits, and countertransferential issues that would impair their ability to be responsive to returning OIF/OEF veterans or that would hinder the process of posttraumatic growth in their veteran clients. As a segue to the next section, there are many aspects of the civilian-military cultural gap that could impair the therapeutic relationship between veterans and civilian clinicians. I would encourage clinicians working with veterans to examine the ways in which their personal and political views about the wars in Iraq and Afghanistan, their knowledge, or lack thereof, of military culture and their assumptions and biases about military servicemembers may (inadvertently) impact their ability to facilitate posttraumatic growth among military veterans.

Macro-Level Model of Posttraumatic Growth

Although they do not present specific suggestions for implementing their model of posttraumatic growth on a macro-level, Tedeschi and Calhoun (2004) and Tedeschi (2011) do note some of the ways in which larger social forces, such as stigma and political and social climates, may impair a veteran's ability to achieve posttraumatic growth during reintegration. In the following section I use Tedeschi and Calhoun's (2004) broader model of posttraumatic growth to explore some of ways in which posttraumatic growth may be promoted or inhibited by

the civilian-military cultural gap during reintegration.

The ability to engage in cognitive processing is central in the process of posttraumatic growth. Cognitive processing as Tedeschi and Calhoun (2004) prescribe it, is most effectively enacted through the disclosure of the survivor's narrative in the presence of a supportive other(s). In this section, I argue that if civilian communities are to be spaces that promote posttraumatic growth for military veterans throughout reintegration, they must provide space for veterans to disclose their experiences and present opportunities for veterans to develop new narratives through cognitive processing. And, civilian communities must provide a supportive social environment in which veterans may disclose and process.

Currently, I argue, civilian communities are largely inadequately supportive of veterans, due in large part to the military-civilian cultural gap. Edward Tick argues that "an entire society is afflicted by war and must participate in its warriors' healing." (p. 208). Many authors present evidence that societies throughout history and across the globe have identified the need for, and devised rituals of purification and cleansing for returning warriors (Grossman, 1995; Herman, 1997; Tick, 2005) as a means of welcoming them back into the larger community and initiating healing. One way in which Americans have traditionally initiated the healing of military veterans is simply by acknowledging their return (Tick, 2005). In World War I and II for example, welcome home parades for returning veterans were common within civilian communities. Welcome home parades or rituals may establish a link between veterans and civilians and they may initiate an atmosphere of acknowledgement and acceptance (Grossman, 1995). Positive homecoming responses convey messages of support and availability. Veterans who are not initially welcomed in meaningful ways by their communities may not experience the community as a space that will be willing to engage in the healing process with the veteran or that would

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welcome the veteran's narrative.

Homecoming rituals have been largely absent from the homecoming experiences of OIF/OEF veterans (Rieckhoff, 2012). The lack of public homecoming rituals for OIF/OEF veterans may be attributable to "war fatigue" and record low public support for the wars in Iraq and Afghanistan, both aspects of the military-civilian cultural gap. If veterans do not initially perceive the community as a space that can acknowledge their suffering and celebrate their sacrifice, they may avoid sharing their narratives fearing judgment, shaming, hostility or rejection (Grossman, 1995; Herman, 1997). Therefore, organizing meaningful homecoming rituals may be one way in which communities can promote posttraumatic growth among veterans returning from war.

Another way in which civilians may cultivate an environment amenable to the process of posttraumatic growth is by making the wars in Iraq and Afghanistan and the needs of returning servicemembers more visible. Herman asserts that "returning soldiers look for tangible evidence of public recognition. After every war, soldiers have expressed resentment at the general lack of public awareness, interest and attention; they fear their sacrifices will be forgotten." (p. 70). After nearly a decade of fighting two wars, and in the wake of other more immediate economic and social concerns, coverage of the wars in Iraq and Afghanistan in popular media is sparse. researchers found that most Americans are no longer closely following the wars in Iraq and Afghanistan, as they were earlier in the wars (Pew Research Center, 2011). And, both veterans and civilians in the same survey reported that the civilian public does not understand the problems facing veterans. Many Americans may simply be unaware of, and therefore unable to be responsive to, the needs of returning veterans. The media may represent a space for the narratives of veterans to be heard and supported by civilians. Local media could be used as a

platform for educating the larger civilian public about the wars in Iraq and Afghanistan and engaging the community in the needs of returning veterans. Slone and Friedman (2008) further recommend that civilians use media, such as documentaries about war and military service, to increase their knowledge about veterans' issues and therefore their capacity to be empathic and responsive towards returning veterans.

Homecoming rituals and enhanced public awareness of and engagement in the wars in Iraq and Afghanistan and the reintegration needs of veterans may create space within the community for veterans to feel safe to share their narrative and engage in cognitive processing. Through cognitive processing, survivors of trauma begin to make sense of their experiences by attempting to find meaning in the traumatic circumstance and developing a new sense of identity and new beliefs and schemas which arise out of that meaning. In individual therapy, the therapist helps the veteran construct meaning from the event through cognitive processing. On a macro-level, civilian communities have an opportunity to influence this meaning-making process to promote posttraumatic growth.

Civilian communities may influence the meaning-making process in two important ways. First, veterans may experience a kind of culture shock when returning to the civilian world from deployment (Coll, Weiss & Yarvis, 2011). Apart from their units, Veterans may feel the loss of camaraderie, trust and sense of belonging when they return to civilian society (Coll, Weiss & Yarvis, 2011). Military service provides a built-in source of camaraderie, purpose, and meaning for soldiers, that they may lose following discharge from the military (Burk, 1999). Veterans often experience civilian life as lacking meaning or devoid of a higher purpose (Demers, 2011). Civilian communities should provide opportunities for veterans to reassume meaningful roles in their communities. For example, Slone and Friedman (2008) report that employers may be

hesitant to hire veterans fearing that they may be dealing with combat-stress reactions that would impair their ability to be effective employees. They suggest that civilian employers often under-value the unique set of strengths and skills that are acquired through military service. Veterans who are able to assume meaningful roles in society may be more likely to derive meaning, and growth, from their traumatic experience (Herman, 1997; Tedeschi, 2011).

Second, the civilian social construction of meaning of the events in Iraq and Afghanistan may be drastically different from the ways in which OIF/OEF veterans understand the meaning of their combat service. Larner and Blow (2011) suggest that "Returning combat veterans cannot share important meanings with others who cannot allow themselves to understand or comprehend the actual lived experiences they have faced." The wars in Iraq and Afghanistan have lasted well beyond our national expectations, they have been fought for ambiguous reasons that have been largely unsupported by the American public, and they have had very little visible impact on the day-to-day lives of most civilian Americans. For many civilians, it may be difficult to construct any sense of meaning in regard to the wars in Iraq and Afghanistan. However, in order for communities to promote posttraumatic growth among veterans, they must be able to ascribe positive meaning to the veterans' service and to reflect that back to the veteran. If communities ascribe negative or stigmatized meaning to OIF/OEF veterans' service, they may further marginalize veterans and contribute to the development of new schemas and beliefs that are characterized by shame, regret, guilt and existential emptiness as was the case among many Vietnam veterans (Tick, 2005).

Telling the story of the traumatic event(s) (to a supportive other) is essential for posttraumatic growth. Tick (2005) suggests that many societies have constructed opportunities for returning warriors tell their stories to a listening public He further suggests that veterans are

offered very few platforms from which to tell their stories in contemporary society nor do they have a listening public to tell the stories to. During the Vietnam War era, in response to this lack of space for storytelling, Vietnam veterans developed veteran-exclusive "rap groups" as a way to tell their stories to one another, and to listen to the stories of other veterans. Tick (2005) and Slone and Friedman (2008) implore individual civilians to be willing to listen to the stories of veterans when the opportunity arises, or to invite those opportunities for storytelling when appropriate. Tedeschi and Calhoun suggest that "in telling these stories to others, the emotional aspects of the events and the survivor are usually revealed resulting in an intimacy that may be surprising...The narratives of trauma and growth may also have the effect of spreading the lessons to others…and can challenge whole societies to initiate beneficial changes." (2004, p. 9). Giving veterans platforms to tell their stories within the community may not only promote posttraumatic growth, it may also help to bridge the military-civilian cultural gap.

On the macro-level veterans collectively tell their story through popular media and news outlets (Tick, 2005). Civilian directors, actors, and journalists are largely responsible for interpreting those stories to the civilian public. Civilians who are not well acquainted with any OIF/OEF veterans may derive their knowledge of veterans primarily through popular media. In considering the framework of the military-civilian cultural gap, the ways in which veterans' stories are presented may be influenced by the sociocultural and political biases of those civilians responsible for creating those stories of the larger culture in which they are created. If civilians' form negative opinions about veterans as a result of these media, that would diminish the capacity of the larger civilian public to function as a supportive, empathic other in hearing veterans' narratives in their communities.

Earlier I described that, due to issues highlighted in the framework of the military-civilian

cultural gap, civilian attitudes towards veterans are characterized largely by apathy and disinterest. To promote posttraumatic growth among veterans, popular media should ensure that the nature of the wars in Iraq and Afghanistan as well as the reintegration issues facing veterans are routinely covered and accurately portrayed. For example, the recent documentary "The Invisible War" presented with raw detail the epidemic of sexual assault and rape of female service members in the military. This award-winning documentary sparked a larger social movement to investigate and change the ways the military adjudicates military sexual assault and garnered broader civilian and political attention to this issue. For female survivors of military sexual assault, this documentary may have provided a way to tell the story of their experiences, and the ways in which the civilian community responded supportively to this documentary may have presented these women with a greater opportunity to achieve posttraumatic growth. There are also many excellent autobiographies and oral history collections written by and about OIF/OEF veterans (Kraft, 2007; Powers, 2012; Wood, 2006) that give civilians the opportunity to "hear" the war stories of recent veterans.

Tedeschi and Calhoun (2004, p. 8) argue that "supportive others can aid in posttraumatic growth by providing a way to craft narratives about the changes that have occurred and by offering perspectives that can be integrated into schema change." In considering the ways in which communities may promote posttraumatic growth among veterans, the capacity of the civilian public to act as a supportive other with which veterans may disclose their narratives is impacted by the military-civilian cultural gap. Pew Researchers discussed that public support for the wars in Iraq and Afghanistan are at an all time low. They also found that more than one third of civilian survey respondents (34%) indicated that they had "felt ashamed of something the military had done in Afghanistan or Iraq." Tedeschi and Calhoun (2004) have suggested the

ways in which the narratives of trauma survivors are responded to may greatly impact their ability to achieve posttraumatic growth. Because of the military-civilian cultural gap, I argue that the larger civilian public is currently not functioning as a supportive other for OIF/OEF veterans.

Many researchers, authors, and journalists have suggested ways in which the civilian public may function more supportively for veterans. First, the American civilian public should not conflate their lack of moral and political support for the wars in Iraq and Afghanistan with lack of support for veterans in general. Grossman (1995) and Tick (2005) suggest that this was the case among civilians during the Vietnam War. Pew researchers (2011) did conclude that civilians were able to hold a distinction between the wars in Iraq and Afghanistan, which they do not support, and the veterans of those wars. For example, Pew researchers found that 76% of civilians surveyed said that they had personally thanked someone in the military for their service, and 58% of civilians surveyed said that they had done something to help someone in the military. And, 95% of post 9/11 veterans surveyed reported that a civilian had thanked them for their service since returning home. However, the experiences of Vietnam War veterans created a history of hostility and disconnect between veterans and civilians, and I have argued that that history persists in the military-civilian cultural gap of today. Perceptions of civilian/public support among OIF/OEF veterans have not been explicitly addressed by theorists or researchers and this is noted as an area for further exploration.

Slone and Friedman (2008) suggest several ways in which civilian community members can be supportive of veterans. Examples include learning about resources and services available to veterans in the community, reaching out to assist veterans and their families with household tasks or childcare, thanking service members and their families for their service and sacrifice, providing volunteer or pro-bono professional assistance when possible, and becoming active in

local organizations that serve veterans. I would also suggest that civilians have an opportunity to provide support and allyship by advocating for veterans on social and political platforms. Tick (2005) suggests that in America, national holidays, such as Veterans Day and Memorial Day, were instituted to give the civilian public an opportunity to honor and reflect on the ways in which veterans have served and sacrificed. These opportunities for public observance are ways that the civilian public may provide collective support to servicemembers and veterans. Tick suggests that such veterans' holidays have lost their meanings in recent history and have been co-opted by retailers offering sales and politicians wishing to garner political favor. He suggests that these days could instead be used for public readings of the names of war causalities or public gatherings and vigils that could instill meaning in the service and sacrifice of veterans, give space for veterans' stories and convey authentic public support and gratitude.

Conclusion

As the wars in Iraq and Afghanistan come to a close, the population of OIF/OEF veterans will be rapidly expanding. And, while the number of programs and clinicians specializing in treating veterans expands as well, in this paper I have suggested that the reintegration challenges facing veterans extend well beyond the intrapersonal clinical realm. Many veterans will have experienced a traumatic event during the course of their wartime service, and many will incur "invisible" psychological wounds like PTSD. Trauma theories have been the dominant framework for conceptualizing and addressing the intrapersonal dimensions of traumatic injury among veterans. However, a complete perspective on the phenomenon of reintegration challenges facing veterans requires equal attention to both micro and macro issues as well as the

interconnectedness of the two. A thorough assessment of the challenges present in both arenas can be useful in guiding the development and implementation of social work interventions to support and facilitate posttraumatic growth with veterans on both the individual and community levels.

The concept of posttraumatic growth suggests a constructive, strengths-based way to orient the clinical treatment of trauma among veterans but it also offers a new perspective on the role of the community in addressing the reintegration needs of veterans. Because of the ways in which the military-civilian cultural gap may complicate reintegration for OIF/OEF veterans, and therefore inhibit the potential for posttraumatic growth, I have argued that civilian community members should be more aware of the wartime experiences and reintegration issues facing OIF/OEF veterans and more willing to be responsive to those needs. However, the macro-level reintegration challenges and needs of OIF/OEF veterans have not been widely studied. By framing civilian communities as spaces that might promote healing and posttraumatic growth for veterans, I suggest the importance of understanding the ways in which the larger civilian environment impacts reintegration for returning OIF/OEF veterans and I hope to draw attention to the need for more research in this area.

References

Adler, A. B., Bliese, P. D., McGurk, D., Hoge, C. W., & Castro, C. A. (2011). Battlemind

debriefing and Battlemind training as early interventions with soldiers returning from Iraq:

Randomization by platoon. *Sport, Exercise, and Performance Psychology*, *1*(S), 66–83.

doi:10.1037/2157-3905.1.S.66

Armed Forces Health Surveillance Center. 2009. Background Information on Deployments to

OEF/OIF, June 11, 2009. RETURNING HOME FROM IRAQ AND AFGHANISTAN

American Psychological Association Presidential Task Force on Military Deployment Services

for Youth, Families, and Service members. (2007). The psychological needs of US

military service members and their families: A preliminary report. American

Psychological Association. Retrieved from:

http://www.apa.org/releases/MilitaryDeploymentTaskForceReport.pdf (accessed July 20,

2009).

Barrett, T. W., & Mizes, J. S. (1988). Combat level and social support in the development of

posttraumatic stress disorder in Vietnam veterans. *Behavior Modification, 12*(1), 100-115.

doi:10.1177/01454455880121005

Bash, H. A. J. La, 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*, *24*(2),

231–258. doi:10.1177/0886260508317177

Basham, K. (2010). Trauma theories. In J. Berzoff, P. Hertz & L. Flanagan (Eds.), *Inside

out/outside in: Psychodynamic clinical theory and practice in contemporary

multicultural context* (revised). Northvale, NJ: Jason Aronson.

Briere, J., & Scott, C. (2013). *Principles of trauma therapy: A guide to symptoms, evaluation,*
    and treatment. Thousand Oaks, Calif.: Sage Publications.

Bulmiller, E. & Shanker, T. (2013, January 23). Pentagon is set to lift combat ban for women.
    The New York Times. Retrieved from http://www.nytimes.com/2013/01/24/us/pentagon-
    says-it-is-lifting-ban-on-women-in-combat.html?pagewanted=all

Catherall, D. R. (1986). The support system and amelioration of PTSD in Vietnam veterans.
    Psychotherapy, *23*(3), 472-482. doi:10.1037/h0085641

Coll, J. E., Weiss, E. L., & Yarvis, J. S. (2011). No one leaves unchanged: Insights for civilian
    mental health care professionals into the military experience and culture. *Social work in*
    Health Care, *50*(7), 487–500. doi:10.1080/00981389.2010.528727

Collins, J. J. (1998). The complex context of American military culture: A practitioner's view.
    Washington Quarterly, 21(4), 213.

Demers, A. (2011). When veterans return: The role of community in reintegration. *Journal of*
    Loss and Trauma, *16*(2), 160–179. doi:10.1080/15325024.2010.519281

Diagnostic and statistical manual of mental disorders: DSM-IV-TR. (4th ed.). (2000).
    Washington, DC: American Psychiatric Association.

Doyle, M. E., & Peterson, K. A. (2005). Re-entry and reintegration: Returning home after
    combat. *Psychiatric Quarterly, 76*(4), 361-370. doi:10.1007/s11126-005-4972-z

Drummet, A. R., Coleman, M., & Cable, S. (2003). Military families under Stress : Implications
    for family life education. *Family Relations*, *52*(3), 279–287.

Duke, M. R., & Moore, R. S. (2011). Ptsd treatment-seeking among rural Latino combat
    veterans: A review of the literature. *Journal of Rural Social Sciences*, *26*(3), 157–180.

Fontana, A., Rosenheck, R., & Desai, R. (2010). Female veterans of Iraq and Afghanistan
seeking care from VA specialized PTSD programs : Comparison with male veterans.
Journal of Women's Health, *19*(4), 751-757. doi:10.1089=jwh.2009.1389

Franklin, E. (2009). The emerging needs of veterans: A call to action for the social work
profession. *Health & Social Work*, *34*(3), 163–167.

Frueh, B. C., Elhai, J. D., Monnier, J., Hamner, M. B., & Knapp, R. G. (2004). Symptom
patterns and service use among African American and Caucasian veterans with combat-
related PTSD. *Psychological Services*, *1*(1), 22–30. doi:10.1037/1541-1559.1.1.22

Gifford, B. (2005). Combat casualties and race: What can we learn from the 2003-2004 Iraq
conflict? *Armed Forces & Society*, *31*(2), 201–225. doi:10.1177/0095327X0503100203

Guay, S., Billette, V., & Marchand, A. (2006). Exploring the links between posttraumatic stress
disorder and social support: Processes and potential research avenues. *Journal of
Traumatic Stress, 19*(3), 327-338. doi:10.1002/jts.20124

Halvorson, A. (2010). *Understanding the military: The institution, the culture and the people*.
Report from the Substance Abuse and Mental Health Administration

Herman, J. L. (1992). *Trauma and recovery*. New York, N.Y.: Basic Books.

Hoge, C., Auchterloni, J., & Milliken, C. (2006). Mental health problems, use of mental health
services, and attrition from military service after returning from deployment to Iraq or
Afghanistan. *The Journal of the American Medical Association*, *295*(*9*), 123-132.

Hoge, C., Castro, C., Messer, S., Mcgurk, D., Cotting, D., & Koffman, R. (2004). Combat Duty
in Iraq and Afghanistan: Mental health problems, and barriers to care. *The New England
Journal of Medicine*, *351*(*1*), 1023-1032.

Hoge, Charles W; McGurk, Dennis; Thomas, Jeffrey; Cox, Anthony; Engel, Charles, C; Castro, Carl, A. ; (2008). Mild traumatic brain injury in U.S. soldiers returning from Iraq. *The New England Journal of Medicine*, *358*(5), 453-463.

Huntington, S. P. (1957). *The soldier and the state; the theory and politics of civil-military relations.*. Cambridge: Belknap Press of Harvard University Press.

Hyun, Jenny, K., Pavao, J., & Kimerling, R. (2009). Military sexual trauma. *PTSD Research Quarterly*, *20*(2), 1–8.

Institute of Medicine: Committee on the Initial Assessment of Readjustment Needs of Military Personnel, Veterans, and their F. (2010). *Returning home from Iraq and Afghanistan: Preliminary assessment of readjustment needs of veterans, service members, and their families*. Retrieved from http://www.nap.edu/catalog.php?record_id=12812

Jakupcak, M., Vannoy, S., Imel, Z., Cook, J. W., Fontana, A., Rosenheck, R., & McFall, M. (2010). Does PTSD moderate the relationship between social support and suicide risk in Iraq and Afghanistan War Veterans seeking mental health treatment? *Depression and anxiety*, *27*(11), 1001-5. doi:10.1002/da.20722

Johnson, D. R., Lubin, H., Rosenheck, R., Fontana, a, Southwick, S., & Charney, D. (1997). The impact of the homecoming reception on the development of posttraumatic stress disorder. The West Haven Homecoming Stress Scale (WHHSS). *Journal of traumatic stress*, *10*(2), 259-77. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/9136091

King, L. A., King, D. W., Fairbank, J. A., Keane, T. M., & Adams, G. A. (1998). Resilience–recovery factors in posttraumatic stress disorder among female and male Vietnam veterans: Hardiness, postwar social support, and additional stressful life events. *Journal of Personality And Social Psychology, 74*(2), 420-434. doi:10.1037/0022-3514.74.2.420

Kraft, H. S. (2007). *Rule number two: lessons I learned in a combat hospital*. New York: Little, Brown and Co..

Larner, B., & Blow, A. (2011). A model of meaning-making coping and growth in combat veterans. *Review of General Psychology*, *15*(3), 187–197. doi:10.1037/a0024810

Lipari, Rachel, N., Cook, Paul, J., Rock, Lindsay, M., & Matos, K. (2008). 2006 Gender relations survey of active duty members. *Defense Manpower Data Center Report*, *2007-022*, 1-185.

Loo, C. M., Fairbank, J. a., Scurfield, R. M., Ruch, L. O., King, D. W., Adams, L. J., & Chemtob, C. M. (2001). Measuring exposure to racism: Development and validation of a Race-Related Stressor Scale (RRSS) for Asian American Vietnam veterans. *Psychological Assessment*, *13*(4), 503–520. doi:10.1037//1040-3590.13.4.503

Luby, C. D. (2012). Promoting military cultural awareness in an off-post community of behavioral health and social support service providers. *Advances in Social Work*, *13*(1), 67–82.

Manderscheid, R. W. (2007). Helping veterans return: Community, family, and job. *Archives of Psychiatric Nursing*, *21*(2), 122–124. doi:10.1016/j.apnu.2006.12.006

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 : the Journal of the American Medical Association*, *298*(18), 2141-8. doi:10.1001/jama.298.18.2141

Mulhall, E. (2009). *Women Warriors: Supporting she "who has borne the battle." Iraq and Afghanistan Veterans of America. IAVA Issue Report.* Retrieved from http://issuu.com/iava/docs/iava_womensreport_2009

National Center for Veterans Analysis and Statistics. (2011). America's Women Veterans: Military Service History and VA Benefit Utilization Statistics. National Center for Veterans Analysis and Statistics, Department of Veterans Affairs, Washington, DC. November 2011

National Research Council. (2010). *Returning Home from Iraq and Afghanistan: Preliminary Assessment of Readjustment Needs of Veterans, Service Members, and Their Families*. Washington, DC: The National Academies Press. Retrieved from: http://www.nap.edu/catalog.php?record_id=12812

Paulson, D. S., & Krippner, S. (2007). *Haunted by combat: Understanding PTSD in war veterans including women, reservists, and those coming back from Iraq*. Westport, Conn: Praeger Security International.

Pew Center for Research. (2011). The military-civilian gap: War and sacrifice in the post 9/11 era. Retrieved from: http://www.pewsocialtrends.org/files/2011/10/veterans-report.pdf

Pietrzak, R. H., Johnson, D. C., Goldstein, M. B., Malley, J. C., & Southwick, S. M. (2009). Psychological resilience and postdeployment social support protect against traumatic stress and depressive symptoms in soldiers returning from Operations Enduring Freedom and Iraqi Freedom. *Depression & Anxiety (1091-4269), 26*(8), 745-751. doi:10.1002/da.20558

Pietrzak, R. H., Goldstein, M. B., Malley, J. C., Rivers, A. J., Johnson, D. C., Morgan, C. a, & Southwick, S. M. (2010). Posttraumatic growth in veterans of Operations Enduring Freedom and Iraqi Freedom. *Journal of Affective Disorders*, *126*(1-2), 230–5. doi:10.1016/j.jad.2010.03.021

Powers, K. (2012). *The yellow birds: A novel*. New York, New York: Little, Brown and Co.

Rahbek-Clemmensen, J., Archer, E. M., Barr, J., Belkin, a., Guerrero, M., Hall, C., & Swain, K.
E. O. (2012). Conceptualizing the Civil-Military Gap: A Research Note. *Armed Forces &
Society*, *38*(4), 669-678. doi:10.1177/0095327X12456509

Reger, M. a., Etherage, J. R., Reger, G. M., & Gahm, G. a. (2007). Civilian Psychologists in an
Army Culture: The Ethical Challenge of Cultural Competence. *Military Psychology*, *20*(1),
21-35. doi:10.1080/08995600701753144

Resnik, L., Bradford, D. W., Glynn, S. M., Jette, A. M., Johnson Hernandez, C., & Wills, S.
(2012). Issues in defining and measuring veteran community reintegration: proceedings of
the Working Group on Community Reintegration, VA Rehabilitation Outcomes
Conference, Miami, Florida. *Journal of Rehabilitation Research and Development*, *49*(1),
87–100. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/22492341

Reivich, K.J., Seligman, M.E.P., & McBride, S. (2011). Master resilience training in the U.S.
Army. *American Psychologist (66)*, 1, 25-34.

Ricks, T., (1997, July). The widening gap between military and society. *The Atlantic Monthly.*
66-78

Rieckhoff, P. (2012, February 3). If the Giants or Pats get a parade, shouldn't Iraq vets?
Retrieved from: http://iava.org/blog/pats-and-giants-get-parade-–-our-iraq-vets-don't

Rubin, A., Weiss, E, L., Coll, J. E. (Eds.). (2012). *Handbook of military social work*. Hoboken,
New Jersey; John Wiley & Sons, Inc.

Samet, E. (2011, August 1). On war, guilt, and "Thank you for your service". Retrieved from:
http://www.bloomberg.com/news/2011-08-02/war-guilt-and-thank-you-for-your-service-
commentary-by-elizabeth-samet.html

Sayer, N. A., Frazier, P., Orazem, R. J., Murdoch, M., Gravely, A., Carlson, K. F., & Hintz, S.

(2011). Military to Civilian Questionnaire : A Measure of Postdeployment Community

Reintegration Difficulty Among Veterans Using Department of Veterans Affairs Medical

Care. *Journal of Traumatic Stress*, *24*(6), 660–670. doi:10.1002/jts.

Sayer, N. a, Noorbaloochi, S., Frazier, P., Carlson, K., Gravely, A., & Murdoch, M. (2010).

Reintegration problems and treatment interests among Iraq and Afghanistan combat

veterans receiving VA medical care. *Psychiatric Services*, *61*(6), 589-97.

doi:10.1176/appi.ps.61.6.589

Sayer, N. a, Friedemann-Sanchez, G., Spoont, M., Murdoch, M., Parker, L. E., Chiros, C., &

Rosenheck, R. (2009). A qualitative study of determinants of PTSD treatment initiation

in veterans. *Psychiatry*, *72*(3), 238-55. doi:10.1521/psyc.2009.72.3.238

Schnurr, P. P., Lunney, C. A., & Sengupta, A. (2004). Risk factors for the development versus

maintenance of posttraumatic stress disorder. *Journal of Traumatic Stress, 17*(2), 85-95.

Shay, J. (1994). *Achilles in Vietnam: Combat trauma and the undoing of character*. New York:

Atheneum

Slone, L. B., & Friedman, M. J. (2008). *After the war zone: a practical guide for returning

troops and their families*. Cambridge, Mass.: Da Capo Lifelong

Street, A. E., Vogt, D., & Dutra, L. (2009). A new generation of women veterans: stressors faced

by women deployed to Iraq and Afghanistan. *Clinical Psychology Review*, *29*(8), 685–94.

doi:10.1016/j.cpr.2009.08.007

Tanielian, T., & Jaycox, L. H. (Eds.). (2008). *Invisible wounds of war: Psychological and

cognitive injuries, their consequences, and services to assist in recovery*. Santa Monica,

CA: Rand Corporation.

Tedeschi, R. G., & Calhoun, L. G. (1996). The Posttraumatic growth inventory: Measuring the positive legacy of trauma. *Journal of traumatic stress*, *9*(3), 455–71. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/8827649

Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic growth : Conceptual foundations and empirical evidence. *Psychological Inquiry*, *15*(1), 1–18.

Tedeschi, R. G., & McNally, R. J. (2011). Can we facilitate posttraumatic growth in combat veterans? *The American Psychologist*, *66*(1), 19–24. doi:10.1037/a0021896

Tick, E. (2005). *War and the soul: Healing our nation's veterans from post-traumatic stress disorder*. Wheaton, Ill.: Quest Books.

Thomas, J. L., Wilk, J. E., Riviere, L. a, McGurk, D., Castro, C. a, & Hoge, C. W. (2010). Prevalence of mental health problems and functional impairment among active component and National Guard soldiers 3 and 12 months following combat in Iraq. *Archives of general psychiatry*, *67*(6), 614-23. doi:10.1001/archgenpsychiatry.2010.54

Thompson, M. (2011, November 10). An army apart: The widening military-civilian gap. *Time*. Retrieved from: http://battleland.blogs.time.com/2011/11/10/an-army-apart-the-widening-military-civilian-gap/

Tsai, J., Harpaz-Rotem, I., Pietrzak, R. H., & Southwick, S. M. (2012). The role of coping, resilience, and social support in mediating the relation between PTSD and social functioning in veterans returning from Iraq and Afghanistan. *Psychiatry: Interpersonal & Biological Processes, 75*(2), 135-149. doi:10.1521/psyc.2012.75.2.135

Wood, T. (2006). *What was asked of us: An oral history of the Iraq War by the soldiers who fought it*. New York, N.Y.: Little, Brown and Co.

Women's Bureau of the U.S. Department of Labor. (2011). *Trauma-informed care for women*

   veterans experiencing homelessness: A guide for service providers (pp. 1–84).

Yarvis, J. S. (2011). A civilian social worker's guide to the treatment of war-induced PTSD.

   Social Work in Health Care, *50(1),* 51-72. doi:

   http://dx.doi.org/10.1080/00981389.2010.518856