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Psychosocial Concerns of Veterans of Operation Enduring Freedom/Operation Iraqi Freedom

Jessica Strong, Kathleen Ray, Patricia A. Findley, Rita Torres, Lisa Pickett, and Richard J. Byrne

U.S. veterans present with complex medical and psychosocial concerns postdeployment. Identification of psychosocial concerns is necessary for appropriate and targeted social work interventions to improve delivery and receipt of health care through the U.S. Department of Veterans Affairs. The purpose of this article is to identify specific psychosocial concerns of veterans of Operations Iraqi Freedom and Enduring Freedom (OIF/OEF) presenting at the War Related Illness and Injury Study Center. A retrospective chart review of psychosocial concerns from all OIF/OEF veterans seen from June 2008 to June 2010 provided data for this mixed methods study. Veterans in the sample ($N = 356$) reported an average of 5.2 psychosocial concerns ($SD = 2.32$, range = 0 to 11). The most commonly reported concerns were pain (72 percent), sleep (62 percent), cognition (61 percent), vocational issues (53 percent), education (49 percent), finances (42 percent), relationships (37 percent), anger (30 percent), substance abuse (23 percent), and social support (20 percent), though these categories were not exclusive and many veterans endorsed more than one category. Multiple psychosocial concerns reported by veterans suggest the need for targeted social work intervention.

KEY WORDS: *mental health; psychosocial factors; social work; veterans*

More than 2.4 million veterans have returned from deployment to Iraq or Afghanistan since September 11, 2001 (Spelman, Hunt, Seal, & Burgo-Black, 2012). Veterans returning from service in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) have often faced and lived through dangerous and difficult situations, but many find more challenges when they return home. Instead of folding neatly back into their lives before deployment, these veterans can face multiple physical, mental, and psychosocial issues that hinder their ability to reintegrate successfully into family and community structures.

BACKGROUND

In addition to psychosocial issues, OEF–OIF veterans have significant health and mental health concerns, reports of which have been supported extensively in the literature (Hoerster et al., 2012; Seal, Bertenthal, Miner, Sen, & Marmar, 2007). These include economic problems, relationship problems, employment or education problems, social functioning, productivity, community involvement, self-care, divorce, dangerous driving, increased anger control problems, homelessness, and increased substance use (Elbogen, Johnson, Wagner, Newton, & Beckham, 2012; Hamilton, Poza, Hines, & Washington, 2012; Sayer et al., 2010; Schell et al., 2011; Spelman et al., 2012; U.S. Department of Housing and Urban Development, 2010). The types of psychosocial concerns found in Iraq and Afghanistan veterans were also noted in previous cohorts of veterans: Vietnam veterans reported many of the same problems with marital instability, unemployment or underemployment, financial decline, social isolation, and legal problems (Kulka et al., 1990).

Social workers have been serving military service members and veterans for many years (Daley, 2003). The U.S. Department of Veterans Affairs (VA) has included social work programs since 1926 and is the largest employer of master's-level social workers in the country (VA, 2012a). Social workers consider the whole person in the environment and often serve as guides for navigating social systems, such as the VA (NASW, 2012). This makes them uniquely positioned to serve veterans of Iraq and Afghanistan, who frequently have many physical, mental, and psychosocial concerns and who must navigate the complex social systems of the Veterans Health Administration and the Veteran

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Benefits Administration. Social workers also have a unique flexibility of role and can work within the private sector, nonprofits, and the VA system.

The War Related Illness and Injury Study Center (WRIISC) in East Orange, New Jersey, is a national asset that can help social workers serve returning veterans. The East Orange site is one of three national referral centers that provide comprehensive evaluation services to veterans who have medically unexplained symptoms thought to be related to their military deployment (VA, 2012b). The evaluation team, which includes social workers, makes recommendations for further care for the veterans on the basis of a comprehensive interdisciplinary evaluation. After the evaluation, however, it is the social worker who follows up with the veteran to ensure that the veteran is able to navigate the complex health and social care systems to address these recommendations.

This study was designed to capture and describe the types of psychosocial and health care concerns that are being identified by all OEF–OIF veterans in their initial evaluation at the WRIISC in the VA New Jersey Healthcare System. The goal of this study was to examine the psychosocial concerns that were identified by the veterans themselves rather than by practitioners to provide practitioners with a comprehensive picture, including the patient perspective, of the nature of and multiplicity of concerns faced by each OEF–OIF veteran.

METHOD

This study is a retrospective chart review of psychosocial concerns reported by OEF–OIF veterans seen at the New Jersey WRIISC between June 2008 and June 2010. The institutional review board at the New Jersey VA Health Care System and Rutgers University approved the study.

Demographic data, military information, and mental health status were abstracted from the Initial Health Questionnaire that was completed by each veteran during his or her evaluation. Demographic information included age, years of education, gender, parenting status (currently parenting, not currently parenting), racial background (white, black, or other), marital status (married or living as married, not married), and employment status (working, not working). Military information included service component, branch, and number of deployments at separation from active duty or military service.

To address demographic differences, we examined the sample. Descriptive statistics were used to describe the sample, chi-square analysis was conducted to assess for differences in the categorical variances, and *t*-test analysis was also used to assess for differences in ordinal variables. All analyses were performed with SPSS data analysis software (Version 12.0.1, 2004).

Psychosocial concerns reported by veterans were abstracted from a review of social worker medical record entries. Concerns were defined as difficulties reported by the veteran during the assessment and recorded in the case notes. Staff social workers first reviewed the medical records to identify and define categories and developed a framework for coding. Each staff social worker created an initial list of codes, the code lists were discussed, and then, upon consensus, they were merged into a coding framework. The categories of concerns used in the coding framework are described in Table 1. The social workers then used the framework to code the medical record notes of each veteran's initial assessment. Most of the medical records received multiple codes as veterans described multiple issues or issues that overlapped categories. The research team met regularly to review and address challenges with the coding process. Psychosocial concerns that could not be coded into existing categories were reviewed a second time by three staff social worker coders until consensus was reached.

RESULTS

Most (88 percent) of the sample was male, and veterans had an average of 1.4 deployments (SD = 0.64). The mean age was 34 years old (SD = 10.4), with 14 years of education (SD = 1.7). The majority of the sample was white (58 percent) and had served in the Army (64 percent). Forty-one percent of the sample was married, and 48 percent were currently parenting. The demographic characteristics of the sample are described in Table 2, and the significant differences in demographic characteristics between active duty and reserve component veterans are displayed in Table 3.

Veterans who had served on active duty represented 45 percent of the total sample (N = 159). On average, active duty veterans were 28 years old (SD = 6.83), with 13.2 years of education (SD = 1.39). Fifty-five percent of the sample identified as white, and 25 percent identified as black. One-third of active duty veterans were

Table 1: Descriptions of Coding Categories

Concern	Description
Anger	"Anger issues" or other concerns that veterans attributed to "anger," such as employment, legal, or relationship problems.
Cognition	Concentration and memory issues, as well as mental health concerns, such as depression, anxiety, or posttraumatic stress disorder.
Disability	Challenges applying for social security disability claims or VA compensation and pension applications.
Education	Difficulty using the GI Bill to finance their tuition, entering or maintaining educational programs, or concentrating in school.
Family	Used when veterans indicated a lack of affordable, reliable, or any child care or difficulty making child care arrangements for health care appointments, work, or education. It also included issues with divorce, births or pregnancies, marriage planning, family illness, or a death of a family member.
Finances	Difficulty paying bills, child support, a mortgage, tuition, or loans; facing foreclosure; or difficulty obtaining benefits of the GI Bill or disability claims.
Insurance	Inadequate insurance for medical or dental expenses or no insurance for their family.
Legal	Having child support in arrears, contested child support, incarcerations, or pending lawsuits—applicable to the veterans themselves or to their immediate family members.
Pain	Defined as any physical discomfort, this code was used when veterans described symptoms of physical discomfort as well as difficulties completing work, school, or household tasks because of discomfort.
Relationships	Problems with or isolation from friends, coworkers, family, or significant others.
Sleep	Nightmares, difficulty falling or staying asleep, or insomnia or when these symptoms interfered with other tasks.
Social support	Inadequate or nonexistent social support networks.
Substance abuse	Substance abuse problems or problems related to substance use or abuse, including employment or legal problems stemming from substance use.
Transportation	Driving issues, such as a lack of a vehicle or license, unaffordable fuel costs, distance to health care, or a lack of transportation.
VA system	Difficulties navigating the VA system, including difficulty being seen for their medical concerns, knowing who to talk to, and other barriers.
Vocational issues	Difficulty resulting from unemployment or underemployment, retirement, or disability concerns.

Note: VA = U.S. Department of Veterans Affairs.

Table 2: Demographic Characteristics, by Active or Reserve Component Veterans

	Component											
	Active (*n* = 159)				Reserve (*n* = 194)				Total			
Characteristic	***n***	**%**	***M***	***SD***	***n***	**%**	***M***	***SD***	***N***	**%**	***M***	***SD***
Gender												
Male	145	91.2			166	85.6			311	88.10		
Female	14	8.8			28	14.4			42	11.90		
Race												
White	87	56.1			112	58.6			199	57.51		
Black	39	25.2			44	23			83	23.99		
Other/unknown	29	18.7			35	18.3			64	18.50		
Marital status												
Married	52	33.3			92	48.7			144	41.74		
Not married	104	66.7			97	51.3			201	58.26		
Parenting												
Parenting	70	39.1			110	56.4			180	48.13		
Not parenting	109	60.9			85	43.6			194	51.87		
Employment												
Working	54	34.8			95	50.5			149	43.44		
Not working	101	65.2			93	49.5			194	56.56		
Military branch												
Air Force	11	7			7	3.6			18	5.10		
Army	63	39.9			164	84.5			227	64.31		
Coast Guard	1	0.6			0	0			1	0.28		
Marines	60	38			16	8.3			76	21.53		
Navy	23	14.6			7	3.6			31	8.78		
Age			28.36	6.83			35.64	9.95			34	10.4
Education (in years)			13.2	1.39			13.86	1.86			14	1.7
Number of deployments			1.58	0.71			1.26	0.53			1.4	0.64

Table 3: Differences in Characteristics of Active and Reserve Component Veterans

Variable	***n***	***M***	***SD***	***t***	**Value**	***t***	***df***
Gender		353				2.64	
Marital status	385				8.27**		
Parenting	385				11.22**		
Employment	343				8.52**		
Age						–8.12***	340.96
Active duty	159	28.36	6.83				
Res/Nat Guard	194	35.64	9.95				
Education					–3.77***	343.21	
Active duty	158	13.2	1.37				
Res/Nat Guard	191	13.86	1.866				
Number of deployments				4.79***		286.81	
Active duty	159	1.58	0.71				
Res/Nat Guard	194	1.26	0.53				

Note: The *t* and *df* were adjusted because variances were not equal. Res/Nat = Reserve/National.
**$p < .01$. ***$p < .001$.

married, and 40 percent were currently parenting. Ninety-one percent were male, with an average of 1.58 deployments (*SD* = 0.71). Forty percent were in the Army, 38 percent were in the Marines, 15 percent in the Navy, 7 percent in the Air Force, and 1 percent in the Coast Guard.

Veterans of the Reserve and National Guard represented 55 percent of the total sample ($N = 194$). The average age was 36 ($SD = 9.9$), with 14 years of education ($SD = 1.86$). The majority of the sample was male (86 percent) and had served in the Army (85 percent); 58 percent identified as white, and 23 percent identified as black. Almost one-half of the sample was married (49 percent), and 56 percent were parenting. They experienced an average of 1.26 deployments ($SD = 0.53$).

Veterans who had served in active duty were more likely than their Reserve and National Guard counterparts to be unmarried [$\chi^2(1, N = 385) = 8.27$, $p < .005$]; and unemployed [$\chi^2(1, N = 343) = 8.52$, $p < .004$]. They were significantly younger, with a median age of 28.36 ($p = .001$). The effect size d is approximately .8, which is considered large. Active duty veterans had significantly less education, with a median 13.20 years ($p = .001$); effect size d is .4, considered medium; and they had significantly more deployments, with a median of 1.58 deployments ($p = .001$). The effect size d is .5, also considered medium.

Veterans presented with an average of 5.2 ($SD = 2.32$, range = 0–11) interconnected psychosocial concerns. The psychosocial concerns presented by veterans, ranked by prevalence, are described in Table 4. The interconnected nature of the concerns made coding complex. Vocational issues, for example, frequently were connected with educational concerns and finances. The most commonly reported concerns in this sample were pain (66 percent); sleep (58 percent); and vocational (48 percent), educational (46 percent), and cognitive concerns (43 percent). There were two significant differences in the psychosocial concerns reported by active duty and reserve component veterans. Reserve component veterans were more likely to report difficulties with sleep [$\chi^2(1, N = 202) = 2.98$, $p = .05$], whereas active duty veterans reported more vocational difficulty [$\chi^2(1, N = 173) = 6.68$, $p = .007$].

Employment and education were two of the greatest psychosocial concerns for veterans in the WRIISC. Less than one-half were employed (37.4 percent employed full time, 8.4 percent employed part time). Many veterans were exploring educational options as well. Most veterans were interested in returning to school (50 percent) or were actively enrolled in school (26 percent), whereas almost one-quarter (24 percent) considered their education complete.

DISCUSSION

Veterans in this sample reported a range of zero to 11 psychosocial concerns, with an average of 5.2 ($SD = 2.32$), reinforcing and extending the literature that veterans struggle with issues simultaneously (Sayer et al., 2010). The majority of the veterans in this sample did not have a singular medical concern but rather an array of interconnected medical and psychosocial issues that needed assessment and intervention. It is clear that veterans of OIF–OEF often have complex lives with many responsibilities—working or seeking employment,

Table 4: Frequencies of Psychosocial Concerns of Active and Reserve Veterans, Ranked

	Active ($n = 159$)		Reserve ($n = 194$)		Total ($N = 353$)	
Concern	***n***	**%**	***n***	**%**	***N***	χ^2
Pain	102	64.15	131	67.53	233	
Sleep	83	52.20	119	61.34	202	$\chi^2(1, N = 202) = 2.98$*
Vocational	90	56.60	83	42.78	173	$\chi^2(1, N = 173) = 6.68$**
Educational	57	35.85	86	44.33	143	
Cognitive	60	37.74	76	39.18	136	
Relationships	51	32.08	52	26.80	103	
Financial	38	23.90	41	21.13	79	
Anger	28	17.61	39	20.10	67	
Substance abuse	21	13.21	28	14.43	49	
Social support	15	9.43	25	12.89	40	
Disability application	12	7.55	7	3.61	19	
VA system	6	3.77	7	3.61	13	
Legal	6	3.77	3	1.55	9	
Transportation	2	1.26	3	1.55	5	

Note: VA = Veterans Affairs.
*$p < .05$. **$p < .01$.

attending school or exploring training options, and parenting children, while managing their postdeployment health problems. As noted in the literature review, previous studies have described the existence and extent of many psychosocial issues in the OEF–OIF veteran population, such as financial problems, chronic pain, sleep disturbances, and educational and vocational concerns. This study, however, extends the literature by demonstrating that OEF–OIF veterans must manage several of these concerns simultaneously.

Active duty and reserve veterans were similar in most areas but differed demographically and in several key concerns. For example, active duty veterans were more likely than Reserve or National Guard veterans to report vocational concerns. This was not unexpected because active duty veterans who leave the service must begin a new career after military separation, whereas Reserve or National Guard veterans may already have an established career before separating from the military (Burnett-Ziegler et al., 2011). In addition, Reserve or National Guard veterans may receive care within the VA system while still on active reserve duty.

The findings from this study further support and extend the literature that chronic pain and sleep problems are important concerns for returning veterans and can limit functioning in other areas (Evans, Shipton, & Keenan, 2005; Helmer et al., 2009; Leger, Guilleminault, Bader, Levy, & Pallard, 2002; Ouellet, Beaulieu-Bonneau, & Morin, 2006). These were the most commonly listed concerns reported by veterans in this study. Other research has indicated that 47 percent of returning veterans sampled had mild levels of pain, and 28 percent reported moderate to severe pain (Gironda, Clark, Massengale, & Walker, 2006). Issues with sleep, both sleep quality and sleep quantity, have also previously been noted in returning veterans (Capaldi, Guerrero, & Killgore, 2011; C. S. Hoge et al., 2008; C. W. Hoge, Terhakopian, Castro, Messer, & Engel, 2007; Lew et al., 2010; Seelig et al., 2010). Because pain and poor sleep can exacerbate other medical and behavioral health concerns, it is important for medical and behavioral health clinicians working with veterans to assess for pain and sleep disturbances and to ensure that these issues are addressed.

Veterans also reported concerns about employment (53 percent) and education (49 percent), further supporting the literature that vocational concerns remain an important priority for veterans (Bureau of Labor Statistics, 2009; Burnett-Zeigler et al., 2011), and that these concerns are found simultaneously with other health issues (Cohen, Suri, Amick, & Yan, 2013). This finding was also established in veterans of previous conflicts, in which employment problems have also been found to be associated with mental health concerns, with unemployment raising the risk of depression and other mental health disorders decreasing the ability to work (Anderson & Mitchell, 1992; Savoca & Rosenheck, 2000).

IMPLICATIONS FOR SOCIAL WORK

The multiplicity of concerns in this sample is important for social workers to note, because greater psychosocial stress can lead to poorer health outcomes. Adjustment problems have been found to lead to financial problems; conversely, financial problems can also lead to adjustment problems (Elbogen et al., 2012). Previous health research has found that multiple psychosocial stressors (such as education, income, employment, single parenting, marital status, and depressive and anxious symptoms) increase the risk for heart disease, and the greater number of stressors, the higher the risk (Thurston & Kubzansky, 2007). These concerns also have a multiplicative effect, as one concern can exacerbate other concerns, thereby worsening a veteran's situation. It is therefore important for social workers and other health care practitioners to note the presence of multiple psychosocial concerns in OEF–OIF veterans. The multiple and interwoven nature of returning veterans' self-reported concerns requires a multidisciplinary perspective and demonstrates the need for social workers in the medical clinic setting. Social workers should collaborate with medical and mental health professionals to address the veterans' concerns across multiple domains—pain, sleep, education, and employment, relationships, cognitive abilities, and others—and establish a plan for addressing multiple concerns simultaneously.

Beyond the multiplicity of concerns and their interconnection, the specific veteran-reported issues of pain and sleep are interrelated. Veterans in pain have difficulty sleeping, and veterans who cannot sleep get little reprieve from pain. Furthermore, both pain and sleep have an effect on vocational and educational issues, cognitive issues such as memory and concentration, and relationships.

Recent research has noted a connection between relationship, employment, legal, or financial problems (Bush et al., 2013) and sleep disturbance (Tanskanen et al., 2001) and suicide or suicide attempts in a military population. Sleep disturbance is also associated with poor job performance and difficulty performing duties and work-related accidents (Leger et al., 2002; Pilcher & Huffcutt, 1996). Social workers, therefore, can direct interventions toward the improvement of pain symptoms and sleep quality to decrease the impact of the other related psychosocial concerns. HSW

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