Treating Young Veterans

Promoting Resilience Through Practice and Advocacy
Diann Cameron Kelly, PhD, is an Associate Professor at Adelphi University, School of Social Work, Garden City, New York. Dr. Kelly is an editorial board member for Youth & Society, a former Fahs-Beck Fellow (2007–2008), and consults with various organizations to inform and evaluate service delivery within sustainable communities.

Sydney Howe-Barksdale, PhD, JD, is the Director of the Public Interest Resource Center and a Professor of Legal Methods at Widener University School of Law in Wilmington, Delaware. Dr. Howe-Barksdale is a Legal Anthropologist and examines the impact of legal systems on individual rights and local cultures. Dr. Howe-Barksdale is admitted to practice in the State of Maryland, and is a member of the ABA, NBA, and Philadelphia Bar Association.

David Gitelson, DSW, LCSW, is Director, Social Work Department, VA Hudson Valley Health Care System, Montrose, NY, Fellow of the New York Academy of Medicine, and Senior Adjunct Professor, Adelphi University, School of Social Work. He also teaches Social Welfare Policy at New York University Graduate School of Social Work, and Mercy College, BSW Program, Dobbs Ferry, New York.
Treating Young Veterans
Promoting Resilience Through Practice
and Advocacy

Diann Cameron Kelly, PhD
Sydney Howe-Barksdale, PhD, JD
David Gitelson, DSW, LCSW
Editors

SPRINGER PUBLISHING COMPANY
NEW YORK
We dedicate this body of work to all who have silently cried, ached, lost, and felt lost . . . on the field of battle during war and peace . . . and to your loved ones who have yet to breathe deeply and exhale.

We, the Editors and Contributors, salute you.

A Special Mention to

In Memoria

Commander Charles Keith Springle

Lieutenant Colonel Juanita Warman, NP
U.S. Army Reserve, Maryland Army National Guard Yellow Ribbon Faculty Member. Felled by assailant’s gunfire at Fort Hood on 11/5/2009 while assisting fellow soldiers to safety.

John M. Kelly
U.S. Air Force

In Honor

Harry S. Cameron, Sr.
Master Sergeant, U.S. Army, 82nd Infantry (1945–1963)

Christopher S. Cameron

JoAnn Kelly
Captain, U.S. Army (Reserves & Operation Desert Storm)

Mark & Mimi Branker
U.S. Air Force

Peter B. Vaughan
Captain, U.S. Army
Active Duty—1966–1968
Reserves—1964–1970

Scott F. Butler

Thomas Reed
2nd Lieutenant, USMC. U.S. Navy ROTC Midshipman; Air Medal received, 1965 Dominican Republic Crisis

1University of North Carolina School of Social Work has set up the Charles Keith Springle, PhD Memorial Scholarship Fund that will support military-dependent students in the Masters of Social Work. Contributions may be made to the UNC School of Social Work (payee) c/o UNC School of Social Work Development Office. Please contact Mary Beth Hernandez, (919) 962-6469, marybeth@email.unc.edu.
As well as dedications to:

My grandfather, Samuel Mallow (WWI), my great uncle, Mitchell “Mike” Feder (U.S. Army, WWII), my uncles, Nathan Carroll Mallow (U.S. Coast Guard, WWII) and Thomas Mallow (Army Air Corp, WWII), and my stepson, Frank DeMonte (U.S. Navy). This chapter is also dedicated to Francis Walsh, an orphan, who in 1941 enlisted in the Navy, leaving behind his fiancée and a chance to build a family for the country he cherished. He perished on the USS Juneau, sunk in the Pacific in 1942.

—Alissa Mallow

All of my uncles, and cousins, the Mitchell and Williams men who served with honor, humor, and strength in Korea, Germany, the Middle East, on ships, abroad, stateside, and places unspoken. To my uncle Cecil Mitchell, Jr, a Navy man whose brilliant mind and sensitive heart helped to heal the broken at Walter Reed Hospital. To Dr. James D. Wilson, Sr, Special Forces, for a lifetime of commitment and honor and in recognition of his sacrifices, to keep us safe, especially after Vietnam. I am honored to recognize the resiliency our veterans, our country’s true unsung heroes for so many generations.

—Brenda Williams-Gray

Chia Hsing Chen, who is presently serving a second tour in Iraq and whose homecoming experiences inspired this work.

—Donna Caplin and Katharine Kranz Lewis

This is dedicated with love, honor, and profound respect to all of the men and women in the Howe, Barksdale, Pease, Vaughan, DeBourg, McCurdy, Dignan, Clarke, and Stell families who have served in every conflict since we came to this country.

—Sydney Howe-Barksdale

On behalf of my family, I personally dedicate this to my dad (U.S. Army), my nephew (OEF), my niece-in-law (OEF), late uncles (WWII, Korea), my grandfather (WWI), and most importantly my great-great grandfather, Burl Isham (Union Army, Civil War), who began our family’s commitment to national service—military and nonmilitary. My brother, our cousins and I, we thank all of you from the bottom of our hearts.

—Diann Cameron Kelly
CONTENTS

Contributors ix
Foreword xiii
Peter B. Vaughan, PhD
Acknowledgments xvii
Introduction xxi
Today's Young Veterans: Serving a Resilient Community
Diann Cameron Kelly

PART I: ASSESSMENT AND PRACTICE APPROACHES TO
PROMOTE RESILIENCE

David Gitelson and William Valente

1. The Contextual Challenges for Young Veterans 3
Diann Cameron Kelly

2. Living Beyond the Intersection of War Theater and Home:
Protective Factors for Healthy Reintegration 13
Alissa Mallow, Brenda Williams-Gray,
Diann Cameron Kelly, and Jonathan Alex

3. Trauma and the Developmental Course of PTSD
Postdeployment 23
Thomas Quinn and Elizabeth Quinn

4. The Burden of Combat: Cognitive Dissonance in
Iraq War Veterans 33
Wayne Klug, Anne O’Dwyer, Deirdre Barry, Leah Dillard,
Haili Polo-Neil, and Megan Warriner

5. Veterans-by-Proxy: Amending Loss of Self Among the Children
of Combat Veterans 81
Diann Cameron Kelly and Shari Ward
PART II: OUTREACH AND PRACTICE WITH SPECIALIZED COMMUNITIES

Sydney Howe-Barksdale and William Valente

6. Coming Home: Examining the Homecoming Experiences of Young Veterans 101
   Donna Caplin and Katharine Kranz Lewis

7. Beyond Words: Homeless Veterans Who Served in Iraq and Afghanistan 125
   Wesley Kasprow and Robert Rosenheck

8. Tragedy, Loss, and Triumph After Combat: A Portrait of Young Women Veteran Survivors of Sexual and Combat Trauma 135
   Godfrey Gregg and Jamila S. Miah

9. Living in Transition: Young Veterans’ Health and the Postdeployment Shift to Family Life 153
   Kristy Straits-Tröster, Jennifer M. Gierisch, Patrick S. Calhoun, Jennifer L. Strauss, Corrine Voils, and Harold Kudler

PART III: ADVOCACY PRACTICE TO PROMOTE YOUNG VETERANS’ WELL-BEING

David Gitelson and William Valente

10. Ensuring Equality After the War for the National Guard and Reserve Forces: Revisiting the Yellow Ribbon Initiative 175
    Christina Harnett and Lieutenant Colonel Michael Gafney

11. Managing the Return to the Workplace: Reservists Navigating the Stormy Seas of the Homeland 219
    Christina Harnett and Joan DeSimone

12. Veterans’ Courts and Criminal Responsibility: A Problem-Solving History and Approach to the Liminality of Combat Trauma 259
    Justin Holbrook

13. The First Responders’ Bridge to Protecting Veterans: A Social Worker’s Design on Street Reach 301
    Elizabeth Rahilly, Kristen Tuttle, and David Gitelson

    Thomas Reed

Epilogue: Meeting the Need and Respecting the Voice:
   Our Final Words 341
   Diann Cameron Kelly, David Gitelson, Sydney Howe-Barksdale, and William Valente

Index 347
CONTRIBUTORS

Jonathan Alex, LCSW  Assistant Professor, Department of Social Work, Lehman College/CUNY, Bronx, NY.

Deirdre Barry  Alumna of Berkshire Community College and Westfield State College, and member of a military family.

Patrick S. Calhoun, PhD  Associate Director, VA Mid-Atlantic MIRECC; Research Associate, VA Center for Health Services Research in Primary Care; and Assistant Professor, Department of Psychiatry and Behavioral Sciences, Duke University, Durham, NC.

Donna Caplin, RN, MSN  Completed this study as a graduate student at the University of Hartford, West Hartford, CT; currently Adjunct Faculty, University of Connecticut, School of Nursing.

Joan DeSimone, PhD  Instructor, Johns Hopkins University, Division of Public Safety Leadership, Baltimore, MD.

Leah Dillard  Alumna of Berkshire Community College and Elms College, and member of a military family.

Lieutenant Colonel Michael Gafney  Maryland Army National Guard Director of Reintegration Programs, and Officer-in-Charge (OIC), Maryland National Guard Deployment Cycle Support Program; presently assigned to the 29th Combat Aviation Brigade.

Jennifer M. Gierisch, PhD, MPH  AHRQ Fellow in Health Services Research, Durham VAMC, Center for Health Services Research in Primary Care and Department of Medicine, Duke University Medical Center, Durham, NC.

Godfrey Gregg, PhD, LCSW  Clinical Assistant Professor, Adelphi University, School of Social Work, Garden City, NY.

Christina Harnett, PhD, MBA  Assistant Professor, Johns Hopkins University, Division of Public Safety Leadership; Faculty, Maryland National Guard, Yellow Ribbon Program; Member, All Services Resiliency Task Force, Department of Defense, Defense Centers of Excellence, Yellow Ribbon Reintegration Program; Major, Maryland Defense Force, 10th Medical Regiment.
Justin Holbrook, JD  Associate Professor of Law and Director of the Veterans Law Clinic at Widener University Law School, Widener University, Delaware campus. Served as an active duty judge advocate in the U.S. Air Force from 2004 to 2010; deployed twice in support of OEF and OIF, and served as Chief of Military Justice and Chief of International Law in Japan.

Wesley Kasprow, PhD, MPH  Associate Research Scientist at Yale Medical School Department of Psychiatry, New Haven, CT, and Associate Director of the Department of Veterans Affairs Northeast Program Evaluation Center (NEPEC), West Haven, CT.

Wayne Klug, PhD  (Boston College), Professor of Psychology, Berkshire Community College; recipient of the Society for the Psychological Study of Social Issues’ 2010 Award for Outstanding Teaching and Mentoring for Community College Faculty.

Katharine Kranz Lewis, PhD, MSN, MPH, RN  Assistant Professor, Department of Nursing, University of Hartford, West Hartford, CT; Executive Director, Connecticut Public Health Policy Institute.

Harold Kudler, MD  Associate Director, VA Mid-Atlantic MIRECC and Associate Clinical Professor, Department of Psychiatry and Behavioral Sciences, Duke University, Durham, NC.

Alissa Mallow, DSW, LCSW  Vice President for Quality Improvement Systems, Basics/Promesa, Bronx, NY. Formally, Assistant Professor, Department of Social Work, Lehman College/Bronx, NY. Associate Editor, End Page for the Journal of Social Work Practice in the Addictions.

Jamila S. Miah, LCSW, CGP  Doctoral student at NYU Silver School of Social Work, and Clinical Social Worker at the Psychosocial Rehabilitation and Recovery Center, VA Hudson Valley HealthCare System, Montrose, NY.

Anne O’Dwyer, PhD  (Boston College), Dean of Academic Affairs, Bard College at Simon’s Rock; Past President, New England Psychological Association.

Haili Polo-Neil  Alumna of Berkshire Community College and New England Institute of Art; graduate student at Rochester Institute of Technology; and member of a military family.

Elizabeth Quinn, PhD  Associate Professor of Psychology at Marist College, Poughkeepsie, NY; author of The Community Mental Health System: A Navigational Guide for Providers and Community Psychology: A Common Sense Approach to Mental Health. Currently a clinical psychologist working with chemically dependent individuals, many of whom are military veterans.

Thomas Quinn, LCSW  Team Leader for the Danbury Vet Center, a Department of Veterans Affairs counseling center for combat veterans; maintains a private
practice providing mental health services to Vietnam veterans; also an Adjunct Lecturer at Adelphi University, School of Social Work, Hudson Valley Program.

Elizabeth Rahilly, LMSW  Social Worker, VA Hudson Valley Health Care System, Montrose, NY.

Thomas Reed, JD  Taishoff Professor of Law at Widener University School of Law, Wilmington, DE.

Robert Rosenheck, MD  Professor of Psychiatry and Epidemiology and Public Health at Yale Medical School, Department of Psychiatry, and Senior Investigator at the New England Mental Illness, Education and Research Center (MIRECC 151D).

Kristy Straits-Trüster, PhD  Assistant Director, VA Mid-Atlantic Mental Illness Research, Education and Clinical Center (MIRECC); Assistant Professor, Department of Psychiatry and Behavioral Sciences, Duke University, Durham, NC.

Jennifer L. Strauss, PhD  Health Scientist, Center for Health Services Research in Primary Care, Durham VA Medical Center; Research Associate, VA Mid-Atlantic MIRECC and Assistant Professor, Psychiatry & Behavioral Sciences, Duke University Medical Center, Durham, NC.

Kristen Tuttle, LCSW  Clinical Social Worker, VA Hudson Valley Health Care System, Montrose, NY.

William Valente, BA, MFA  MSW student at Hudson Valley Campus, Adelphi University School of Social Work, Garden City, NY.

Peter B. Vaughan, PhD  Dean of the Graduate School of Social Service, Fordham University, New York, NY. Previously, social work officer US Army, Medical Service Corps with the rank of captain who served as the American Division Social Worker, and OIC USARV Stockade in the Republic of Vietnam from July 1967 to June 1968.

Corrine Voils, PhD  Health Scientist, Center for Health Services Research in Primary Care; Associate Professor, Department of Medicine, Duke University Medical Center, Durham, NC.

Shari Ward, MSN, NP-Psychiatry  Director of the Substance Abuse Rehab Facility at Arms Acres, in Carmel, NY; maintains a private practice providing intensive mental health treatment to individuals, couples, and families throughout the Hudson Valley region of New York.

Megan Warriner  Alumna of Berkshire Community College and University of Massachusetts, and member of a military family.

Brenda Williams-Gray, DSW  Assistant Professor, Department of Social Work, Lehman College/CUNY, Bronx, NY.
No one said “Welcome home” when we deplaned at Travis Air Force Base after spending a year in the Republic of Vietnam. The servicemen and servicewomen at U.S. Customs and Immigration, who processed returning military personnel back into the United States, were at best indifferent as they rummaged through and scattered our belongings. At worse they were rude. All of these agents wore Vietnam Campaign Ribbons, indicating that they had completed a tour of duty in there as had we. I suspect they were assigned to in-processing duty because they had themselves experienced it. My sense of their demeanor was that because they had completed a tour of duty in Vietnam, their treatment of returnees could be less than welcoming and was maybe even sanctioned by those in command of that unit. This was yet another example of “suck it up,” which was what all too many men and women in uniform of that era were expected to do without protest when faced with adverse situations.

A number of Vietnam veterans have reported similar or worse experiences when they returned to Reception Centers. Those returning and who were remaining in the service would most likely find the routine of military duty and the familiarity of the military post or base an anchoring point to continuing their lives. In all probability, there would be other Vietnam veterans at those locations with whom they could share their experiences; and if not normalize them, they would at least be able to ventilate and have a sympathetic ear. For many of those veterans who were being separated from the military at their point of return, stateside life would be permanently altered.

Families and communities that were so familiar to them before their Vietnam deployment had become unfamiliar. Warm and open friends with whom they used to be comfortable could no longer be depended on to respond in a way that made them feel welcome to be back in the old fold. “You’ve changed” was a common response to the sadness, anger, isolation, lack of motivation, and search for meaning in life for returning veterans.

Of course they had changed, and little help was available to them as they tried to make sense of their commitment of time and effort to
support what had been sold to them as service in defense of democracy and one’s nation. In addition to suffering physical injury in the course of their service, many veterans sacrificed their physical and psychological well-being, economic stability, and family integrity. Systems of care were not in place to address the needs of these veterans and their families, and well-intentioned professionals who staffed facilities and agencies that offered them care were more often than not ill equipped to understand the depths of anguish and suffering of this group of veterans.

Those close to the veterans felt pain in their relationships with them, because of not knowing how to be supportive as their loved ones struggled to transition from the battlefield to the homeland. Added to these veterans’ problems associated with intimacy, motivation, and future orientation was the response of a number of fellow Americans during that era who expressed openly not only how much they hated the war, but also how much they despised the warriors.

As problems continued to be manifested by many veterans of the Vietnam War, such as bizarre public behavior, homelessness, chronic substance abuse, and criminality that persisted long after many service people returned home and several years after the end of the war, researchers began to ask the difficult question of how this group of women and men could be helped. Researchers began to ask questions about the link between veterans’ behaviors and certain types of war activities, behaviors and exposure to certain stressors. Also, researchers explored the links of toxic substances used in fighting the war that may have been associated with certain physical and mental conditions of those veterans. Given the broken bodies of many returning Vietnam veterans, by the early to mid-1980s there was a growing awareness that perhaps something was also broken in the minds, spirits, and social experiences of Vietnam veterans.

This brokenness was different from that of veterans of World War II and the Korean War, and family members, service providers, the uniformed services, and the veterans themselves began to recognize this difference. In response to some new information, the diagnosis of post-traumatic stress disorder was added to the Diagnostic and Statistical Manual of Mental Disorders. This was in large measure because the behaviors that were exhibited by Vietnam veterans did not neatly fit other psychiatric diagnostic categories that were being ascribed. Vet Centers came into existence, VA hospitals tried to devise new treatment modalities, and teams of researchers studied the physical, psychological, and spiritual effects of the war on Vietnam veterans. Troubled
warriors of the Vietnam War, at last, no longer were being told to “suck it up.”

Unlike the Vietnam War, in subsequent wars and U.S. military operations against hostile forces, there has been at least a recognition that war causes many continuing adverse effects for the individuals who are called on to fight them and for the families and communities to which they return. Deployments to the Iraq War and the war in Afghanistan have been different from other wars. Persons may be deployed multiple times, and along with regular military personnel we have seen the deployment of many Reserve Units and National Guard Units which, heretofore, focused on domestic issues. Women now constitute a sizeable portion of military personnel being deployed to those theaters. Additionally, there has been the deployment of husbands and wives, with children being left behind sometimes and with insufficient care arrangements having been made for them. Not only are the dynamics of deployment to military service overseas very different from previous wars, overseas military engagements and the readjustment needs and patterns for those returning are different as well.

For many of us who were mental health professionals during the Vietnam War, we relied on knowledge gained during our formal education. But we quickly recognized that much of what we knew was not easily applied to soldiers in combat situations where the beginning, middle, and end of a mental health intervention or encounter may last for only minutes. After serving as a social work officer in the Republic of Vietnam, first as a division social worker and then heading a mental hygiene operation in the United States Army Vietnam Stockade, I felt at the end of the tour of duty that I had mastered the knowledge and skills to provide well-targeted mental health services to members of the military and to veterans of that war. Other mental health professionals who served in Vietnam returned stateside and were able to provide effective treatment and interventions with veterans of that war because of their own experiences in the combat theater of operations. Learning-by-doing characterized our work in Vietnam. It was in the theater of combat operations where much of our learning about how to treat combatants came about as we were doing it.

Fortunately, there has been a new awareness on the part of governmental departments and agencies that serve the Veteran population. Public and private social service agencies, police and sheriff departments, and faith communities also seek to respond to the needs of returning veterans, and the families and communities to which they return. Many have vowed that never again will we endure the
disrespect for our servicemen and servicewomen, which was accepted and even promoted when the Vietnam veterans returned and tried to begin their lives anew.

The editors of *Treating Young Veterans* and the authors of the individual chapters have taken the approach that by providing practitioners with essential information about the needs, desires, and possibilities for veterans of the wars of Iraq and Afghanistan, those veterans and their families will be able to achieve wholeness in their interpersonal relationships and in their communities. In addition, the larger society will be able to benefit from the training and knowledge, discipline, teamwork, and patriotism that characterized their military service as they are helped to reestablish themselves. This book represents a thoughtful, sensitive, and sensible approach to working with military personnel and veterans who have been deployed to wars in the Persian Gulf, Iraq, and Afghanistan.

It is remarkable that *Treating Young Veterans* considers the multiple diversities of servicemen and servicewomen and veterans and their families. It offers ways in which professionals in helping professions can intervene with and on behalf of returning veterans and their families at an individual and family level, and at community and organizational levels. The combined efforts of these professionals and veterans will bring about social change, which will promote the health and well-being of veterans of recent wars as they return to the multiple roles they performed prior to deployment.

Peter B. Vaughan, PhD
Dean, Graduate School of Social Service
Fordham University
Every large endeavor stands on the broad shoulders of supporters, leaders, and advisers. The same is true for this two-year trek to produce *Treating Young Veterans*.

First, we thank each contributor to this body of work. From the beginning, each of you demonstrated a commitment to the men and women in our Armed Forces, and a strong desire to see their well-being improved. No matter the varied challenges that arose for all of us as we developed this body of work for the public, you remained steadfast in contributing to a text that is a service to one of our nation’s treasures—our veterans. For your diligence, insight, empirical data, and your wonderful humor, we thank you!

In addition to our contributors, we could not have completed this body of work if it were not for the external reviewers. These reviewers did not just review manuscripts. At times, they gave critical insight into terminology, existing services, and practice implications. But most importantly, they took a great deal of time out of their schedules to make certain we achieved our goal of providing a literary service to veterans. These reviewers were

Katherine Bent, RN, PhD, CNS  
Chief, Healthcare Delivery & Methodologies  
NIH-Center for Scientific Review  
Division of AIDS, Behavioral & Population Sciences  
Bethesda, MD

Roni Berger, PhD, LCSW  
Professor, Adelphi University, School of Social Work, Garden City, NY

Elaine P. Congress, DSW  
Professor & Associate Dean, Fordham University Graduate School of Social Service  
New York, NY

Christopher R. Erbes, PhD, LP  
Assistant Professor and Program Manager  
Minneapolis Veterans Affairs Medical Center
We owe them a debt of gratitude. In addition to these reviewers, we also thank the cadre of military officers/retired military officers and veterans who reviewed portions of this work to ensure accuracy and relevancy. In particular, we are deeply grateful for the guidance, direction, and support of Col. Will Barnes, Col. Dick Schnell (Ret.), and Lieutenant Colonel Michael Gafney.

We are indebted to Peter B. Vaughan, Dean, Fordham University, Graduate School of Social Service, and a veteran, for contributing his voice to this body of work in the Foreword. But also, we thank him for his mentorship and direction in the early and final days of this project. Before this project commenced, Councilwoman Suzanna Sullivan Keith, Rye, New York, inspired conversations and connections with everyone she knew to help complete a body of work for United States veterans. She brought two of the editors together, and connected two of the reviewers/contributors to the project. *Treating Young Veterans* owes a debt of gratitude to this wonderful businesswoman and public servant who remains a humble benefactor. Thank you Suzanne.

Edited compilations too often forget the tireless, diligent work of editorial assistants and coordinators. Our editorial coordinator is William “Bill” Valente, an MSW student at Adelphi University, School of Social Work. He also serves as the graduate research assistant for
Diann Kelly. Prior to attending Adelphi University and working on this project, Bill worked as a daily news reporter with outlets such as the Poughkeepsie Journal. He was also an English teacher in Spain, and Community Program Manager for the Mediation Center of Dutchess County. Our work could not have been completed without him, and thus we humbly thank him for all of his work. In addition to Bill, we want to acknowledge two other former graduate students who worked on the project during its early days—Scott Butler (also a veteran) and Jeanette Corrow. We thank them for their efforts as well.

David Gitelson expressed specific thanks to the veterans with whom he directly works, who teach him every day about courage and resilience. In addition, “I’d like to thank my colleagues, who teach me … about commitment, and my family, who teach me everything that’s important.”

The authors Kristy Straits-Tröster, Jennifer Gierisch, Patrick Calhoun, Jennifer Strauss, Corrine Voils, and Harold Kudler would also like to thank the veterans and their families who volunteered their time for their project. In addition, they acknowledge Patricia Vanderwolf and Stephen Dienstfrey of abt SRBI for their partnership in this effort and their dedication to veterans’ health and well-being. “We [also] credit our late friend and colleague, Dr. Mimi Butterfield for her early vision, encouragement and contribution to this project.”

At the time of these analyses, Dr. Gierisch was funded by a fellowship from the Agency for Healthcare Research and Quality (grant 2-T32-HS000079). Dr. Strauss was funded by a Department of Veterans Affairs Research Career Development Award (RCD-06-020).

Christy Harnett and Lieutenant Colonel Michael Gafney express sincere gratitude to members of the National Guard and the Army Reserve, who contributed to the development of their chapter. “Thank you for your assistance and for your services to our country.” Further, Alissa Mallow acknowledged the contributions of veterans and noted, “I am humbled by the strength, resiliency, and valor of not only the men in my family but for all the service men and women who have served, are serving, and will serve in the armed forces. Thank you for protecting and defending the freedoms, liberties, and rights I cherish as an American.”

Donna Caplin and Katharine Kranz Lewis note that their study would not have been possible without the veteran volunteers who generously agreed to participate in this important study. They give “[s]pecial thanks to the Hartford Hospital School of Nursing Alumnae Association who supplied funding for the research study.
‘The homecoming experiences of Connecticut veterans of Iraq (OIF) and Afghanistan (OEF).’”

In the end, there are three key groups that are the most important as we offer our gratitude. First, we are especially thankful to Springer Publishing for acknowledging this work and choosing to bring it to fruition. More importantly, we thank Jennifer Perillo who remains a phenomenal editor. Thank you, Jennifer!

Further, we thank all veterans, active duty personnel, and veteran families for inspiring our body of work. What you endure, during peace time and during war, remains unfathomable. We hope our contribution to your community enhances services and outreach programs to positively impact quality of life for today’s veterans . . . and those tomorrow.

Finally, we thank our families, our children, and our spouses for their enormous support throughout this journey. We could not have achieved this if it were not for you. Thank you for allowing us to be of service to others.

Perhaps on earth I never shall behold,
With eye of sense, your outward form and semblance;
Therefore to me ye never will grow old,
But live forever young in my remembrance!

—Dedication, The Seaside and the Fireside, 1850
Henry Wadsworth Longfellow
Introduction

TODAY’S YOUNG VETERANS: SERVING A RESILIENT COMMUNITY

Diann Cameron Kelly

... let us strive on to finish the work we are in; to bind up the nation’s wounds; to care for him who shall have borne the battle, and for his widow, and his orphan—to do all which may achieve and cherish a just, and a lasting peace, among ourselves, and with all nations.

—PRESIDENT ABRAHAM LINCOLN, 2ND INAUGURAL ADDRESS, 1865

The strength of our veterans is not just embodied in their erect carriage, confident walk, or firm resolve which defines their presence. Their strength is in their resilience, which overcomes adversity in the face of insurmountable odds. This resilience is demonstrated by the veteran’s quiet tenacity to face the diagnosis of posttraumatic stress disorder (PTSD) or traumatic brain injury (TBI); or the hopeful smile on the mask of a stoic face of grief and depression; or a caring, empathetic heart deeply camouflaged by the wounds of isolation and rage.

Treating Young Veterans captures the strengths, needs, and concerns of young servicemen and women making the transition from active combat duty to veteran status and a return to civilian life. This text reexamines the human costs and sacrifices attached to combat. Veterans’ experiences with loss, extensive physical and emotional separations, along with lasting visible and nonvisible wounds appear normal in the combat arena. However, when servicemen and women transition home and attempt to reintegrate into civilian society, they find that the skills, coping mechanisms, beliefs, and social mores which allowed them to survive in combat make it harder to return to civilian life (Jarrett, 2008; Vogt, Samper, King, King, & Martin, 2008; Wheeler & Bragin, 2007). All of these put them at increased risk for the following: PTSD, TBI, chronic health issues, substance abuse, domestic violence, homelessness, unemployment, divorce, and overall social and emotional instability (Erbes et al., 2007; Frisman & Griffin-Fennell, 2009; Jarrett, 2008; Vogt et al., 2008).

Treating Young Veterans brings to life the practice, outreach, and advocacy opportunities that facilitate a healthy and socially engaged
reintegration for traditional veterans (i.e., enlisted and career military personnel) and nontraditional veterans (i.e., reservists and national guardsmen and women) between 18 and 40 years. Further, it combines knowledge from across disciplines to promote thoughtful and purposeful interventions and future research aiding reintegration of young, socially developing veterans into civilian communities.

This work comprises nearly 15 chapters divided into three parts: (1) Assessment and Practice Approaches to Promote Resilience; (2) Outreach and Practice With Special Communities; and (3) Advocacy Practice to Promote Young Veterans' Well-Being. Each part is preceded by a summary written by members of the editorial team that details the material to the reader. After these parts, the editors offer an Epilogue summarizing significant steps needed in practice, outreach, and advocacy to improve the quality of living and well-being for veterans, their families, and their communities.

_Treating Young Veterans_ is designed to enhance practice and research to inform services to veterans and their families, and ensure this community is not marginalized again after another war conflict. Currently, of the 23 million U.S. veterans, about 60% are under the age of 65 years (National Center for Veterans Analysis & Statistics, 2010). With approximately 21% of veterans between the ages of 18 and 24 years unemployed compared with 16% of nonveteran young adults in the same age group (Bureau of Labor Statistics, 2010) and many attempting to self-manage their mental health and physical health needs, vigorous outreach and contemporary practice strategies are needed for this community as there are only about 1000 VA Vet Centers (260) and VA community-based outpatient clinics (773) across the nation (National Center for Veterans Analysis & Statistics, 2010).

Our emphasis on trauma, cognitive dissonance, and pathways toward social and emotional triumph is informed by the diverse contributions of many scholars, practitioners, and veterans. This includes the work of Wesley Kasprow and Robert Rosenheck of Yale Medical School’s Department of Psychiatry and the Northeast Program Evaluation Center focusing on veterans dealing with homelessness. In addition, we have scientists and practitioners from Duke University Medical Center and the VA Mid-Atlantic MIRECC who discuss the transition of veterans to civilian life and the effects of transition on families; and law professors Thomas Reed and Justin Holbrook of Widener University Law School who respectively provide information on the VA claims process as well as the nation’s Veteran Courts across the United States that ensures issues related to veterans’ mental health
are not further misconstrued or ignored in a civilian context and costs the veteran his or her freedom postdeployment.

This text answers the call for creative early responses to and comprehensive interventions for our veterans prior to their return from combat and throughout their reintegration into civilian society. Knowing what we know now, veterans should return home with their expectancy of honor . . . expectancy of duty, . . . and expectancy of responsive services being met from the partnerships between their veteran care systems and the civilian community. They should also expect to return to a fully functional life comparable to that which they had before deploying.

_Treating Young Veterans_ is a tribute to the honorable duty these men and women have shown in the face of turmoil and chaos, and is a humble response to their need for services . . . but most of all, their sacrifice.

**REFERENCES**


Treating Young Veterans

Promoting Resilience Through Practice and Advocacy
Part I

Assessment and Practice Approaches to Promote Resilience

David Gitelson and William Valente

Part I of Treating Young Veterans offers a distinct portrait of the assessment, issues and concerns regarding veterans and their families. It immerses the reader in assessment opportunities for working with veterans and recognizing and fostering hallmarks of resiliency in the face of reintegration and through the symptomatic challenges of post-traumatic stress disorder (PTSD).

The clash of war-time demands and home-life expectations overload the psyche of many returning veteran and is a theme throughout the book. Diann Cameron Kelly looks at those identifiers that present challenges to veterans returning from war. This information gives veterans and those who serve them a more profound recognition of their worldview in a moment of crisis while providing tools for helping professionals to improve well-being in the face of reintegration.

Veterans have their own internal tools to cope with life post-combat. Alissa Mallow, Brenda Williams-Gray, and Jonathan Alex, along with Diann Kelly consider five of these protective tools that may foster veterans’ resilience. Utilizing these factors can be an excellent way for veterans and helping professionals to promote post-traumatic growth. Further, PTSD has its own course of development, and Thomas Quinn and Elizabeth Quinn identify the stages of development and how to use this knowledge in flexible, specific, and superior assessment and treatment. Wayne Klug, Anne O’Dwyer, along with alumna from Berkshire Community College offer a comprehensive presentation on cognitive dissonance and its relationship to combat. Finally, Diann Kelly returns with colleague Shari Ward to discuss how the combat trauma experienced by veterans, equally affects their children across the life span. She identifies these individuals, dealing with secondary traumatization, as “veterans-by-proxy”.
The views and research expressed in Part I posit that veterans dealing with trauma, who are attempting to reintegrate into civilian life, face a unique and brutal set of challenges. Assessment of how these challenges manifest in each veteran, followed by appropriate, professional, and consistent responses, is society’s responsibility—a responsibility that is often given to the helping professions.
THE CONTEXTUAL CHALLENGES FOR YOUNG VETERANS

Diann Cameron Kelly

The day soldiers stop bringing you their problems is the day you have stopped leading them. They have either lost confidence that you can help them or concluded that you do not care.

COLIN POWELL (1995)

Coming home from combat is not an easy task for veterans. Soldiers do not get on a plane, leave the war theater, and then disembark in a small town with a myriad of waving flags, grand bandstand music, and deafening cheers from family, friends, and neighbors. Actually, soldiers are informed they are finally leaving the combat environment a short time before departure (often after many weeks, if not months, of uncertainty of when their actual departure may be) (Department of Defense, 2009). They must, then, stay alive to ensure they can get to the safety of the demobilization site—their last step before coming home to the United States.

During their time in demobilization, soldiers go through a myriad of screenings to address any physical and mental health needs before they arrive home. One of the more essential documents is the Post Deployment Health Assessment. This document’s stated purpose is to assess the health of soldiers after their deployment, and identify issues that can “assist military healthcare providers” and other health care providers in providing care to veterans (Department of Defense, 1999). The Health Assessment portion of the form is no more than six questions (Department of Defense, 1999, p. 2):

1. Would you say your health in general is . . . (choices are five indicators ranging from “Excellent” to “Poor” of which only one indicator is chosen).
2. Do you have any unresolved medical or dental problems that
developed during this deployment?
3. Are you currently on a profile or light duty?
4. During this deployment have you sought, or intend to seek,
counseling or care for your mental health?
5. Do you have concerns about possible exposures or events during
this deployment that you may feel may affect your health?
6. Do you have any questions or concerns about your health?

While critical to the Department of Defense as well as the Veterans
Administration, as there is an electronic record of this information fol-
lowing the veteran, there is not one question on this health assessment
that identifies the likelihood or existence of posttraumatic stress dis-
order (PTSD) symptoms, substance use during combat, or stability
factors once state side, including employment prospects and housing.
Stability factors address the quality of life and well-being domains of
overall health for the veteran (Department of Defense, 2009; Fontana
& Rosenheck, 2004; Hoge et al., 2004; Monson, Taft, & Fredman, 2009).

Further, during this transition period, returning soldiers attend a
myriad of briefings, in essence, on how to live state side (Department
of Defense, 2009; Koppes, 2010; Manderscheid, 2007). For some of the
returning soldiers, many of the briefings ask about suicidal ideation,
substance use and dependency, or lack of stability on the home front,
and are likely to occur before tens of peers and commanding officers
(C. Quinn, personal communications, September 12, 2010, October 13,
2010, October 15, 2010). The presence of confidentiality is minimal if
not stifled during this context.

And then they return home.

According to Dr. Constance Quinn (2010), a Social Worker and
Clinical Coordinator of Inpatient Psychiatry at the Hudson Valley
Health Care System of the Veterans Administration, when soldiers
return home “they often go underground.”

They try to regain normalcy. That’s what going underground means.
They rejoin families and friends, and they attempt to reclaim their
civilian jobs or find new employment. Unfortunately, the Post
Deployment Health screening is done in the demobilization [site],
and people tell you what you want to hear just to move on from
[combat]. We [at the VA] may not see them until a year later or
maybe even more when life as a new civilian is just too difficult
to manage.

—Quinn, 2010
CONTEXTUAL CHALLENGES TO MANAGING REINTEGRATION

The presumption that most veterans, returning from combat zones, experience some form of debilitating outcome such as a severe mental illness or incarceration is not sound (Department of Defense, 2009; Fontana & Rosenheck, 2004; Hoge et al., 2008; Jarrett, 2008; Manderscheid, 2007). In fact, a large amount of veterans return to the United States and present as the resilient warrior, one who does well during transition and early reintegration, has a cohesive, supportive social network of family and friends, is able to secure employment, and also has or has access to private insurance beyond the benefits available through the Veterans Administration (Fontana & Rosenheck, 2004; Hoge, Auchterloine, & Milliken, 2006; Jarrett, 2008; Manderscheid, 2007).

In addition, many returning veterans also have the protective factors of living in municipalities or states that overtly support veterans with consumer opportunities (i.e., discounted products) solely for veterans and their families, and communities that are overly supportive of veterans (Quinn, 2010). However, there are many veterans who face significant contextual challenges that increase the likelihood for debilitating outcomes such as severe mental illness, substance abuse, and suicide, among others (Brenda & Belcher, 2006; Friedman, 2006; Hoge et al., 2008; Jones, Young, & Leppma, 2010; Kang & Hyams, 2005; Keuhn, 2009; Meichenbaum, 2009; Pompili et al., 2009). These challenges negatively affect veterans’ transition to civilian status (Lapierre, Schwegler, & LaBauve, 2007; Seal, Bertenthal, Miner, Sen, & Marmar, 2007), becoming public health concerns.

Gehlert et al. (2008) developed a social epidemiological model to facilitate the study of factors that increase the likelihood for socio-behavioral and physical health disparities and rates primarily among individuals confronting significant chronic illnesses. Gehlert et al. (2008) suggested that when we know what environmental and social issues influence public health, and fuel the perpetuation of social and behavioral challenges and maladies, we are better able to address it through early, targeted, and comprehensive intervention.

... social factors represent upstream determinants defined as features of the social environment, such as socioeconomic status and discrimination that influence individual behavior, disease and health status. Viewing health disparities through a lens that incorporate
When looking specifically at the determinants before, during, and after veterans’ deployment, we find a myriad of conditions that may increase the likelihood for public health concerns within and among this community. Given the greater weight to upstream determinants, these conditions are (1) environmental, (2) social, (3) behavioral, and (4) biological (Gehlert et al., 2008) (see Figure 1.1).

Combat exposure is one of the more significant environmental conditions that place veterans at risk for debilitating outcomes postdeployment (Friedman, 2006; Hoge et al., 2004; Lapierre et al., 2007). Long-term and frequent exposure to combat, as well as direct involvement in the causing of casualties of enemy combatants and civilians, imparts a significant level of stress on the individual (Friedman, 2006; Hoge et al., 2004; Kang & Hyams, 2005; Meichenbaum, 2009). The veteran must cognitively detach himself or herself from that stressor in order to complete the military task.

In addition, the deployments in the current Global War on Terror (GWOT) are frequent and long (i.e., often 12–18 months) with minimal or infrequent home/base stays away from combat (Felker et al., 2008; Hoge et al., 2004; Lapierre et al., 2007). As such, the soldier attempts to succeed at tasks that remain consistently harmful to his or her own perception of self and interpretation of his or her own actions, amid a tenuous, uncertain environment where fatalities are a daily possibility.

Along with combat exposure, environmental conditions also include a diminished socioeconomic history that decreases social capital prior to deployment and can inform the likelihood of stability during reintegration (Department of Defense, 2009; Manderscheid, 2007). In addition, a history of domestic violence (Monson et al., 2009) along with minimal education and employment options also increase the likelihood of repeating this postdeployment history, especially when combined with combat exposure and other stressors (Manderscheid, 2007).

Social conditions follow environmental conditions, and speak to the factors that enhance or detract from one’s quality of living (Fontana & Rosenheck, 2004; Jarrett, 2008). Key conditions are housing and employment losses as well as low educational attainment
and connections with a supportive social network (Manderscheid, 2007). The behavioral conditions, following the social conditions, involve minimal health care utilization (Hoge et al., 2006), smoking, alcohol, and other drug use (Brenda & Belcher, 2006; Meichenbaum, 2009; Pompili et al., 2009), along with poor anger management and being unable to connect with loved ones or demonstrating empathy to others (Monson et al., 2009).
When combined with the biological conditions, including pre-existing medical or mental health issues (Collins & Kennedy, 2008; Hoge et al., 2008), there is a higher likelihood that veterans will require early and more intensive interventions to secure and stabilize their reintegration into the civilian context. This social epidemiological model facilitates our understanding of the contextual challenges for veterans, and informs a more polytrauma perspective toward intervention.

A POLYTRAUMA PERSPECTIVE TO EARLY INTERVENTION

Combat exposure diminishes a returning soldier’s ability to directly enhance his or her own quality of living when transitioning to civilian society (Koppes, 2010; Manderscheid, 2007). This is not to say that the veteran is unable to accomplish the task of reintegration. However, the task of reintegration is an intergroup and interdisciplinary task that includes the veteran, family, his or her reintegration partner(s) (i.e., Chaplain, veteran mentor, military “buddy,” etc.), as well as interdisciplinary professionals engaged with the veteran to secure his or her transition home and facilitate reintegration into the civilian arena (Jarrett, 2008; Koppes, 2010; Manderscheid, 2007).

Collins and Kennedy (2008) maintain that combat produces such visible and nonvisible injuries that the therapeutic care needs to be multifaceted and polytrauma-focused. A polytrauma model, as emphasized by their “Polytrauma Rehabilitation Centers,” asserts that attending to daily living, cognitive functioning, emotional attunement, and social connectedness ameliorates long-term issues and medical needs (Collins & Kennedy, 2008). The goal is to inform, support, and motivate veterans and their families through a paradigm of “action-oriented, strength-based, and solution-focused ...” service goals (Collins & Kennedy, 2008, p. 994).

Primarily used to address medical issues emerging from traumatic brain injury (TBI), the polytrauma perspective identifies a multitude of stressors that impact the overall well-being and propensity of well-being for the veteran. This includes (1) multiple outcomes of combat exposure, including the consistent uncertainty of death or extensive injury as well as contributing to the harm of another; (2) treatment that is specific to the veteran’s complex issues; (3) presence or lack of family support; (4) social characteristics, including marital status,
employment, or housing; and most importantly, (5) loss of access to “military environment and culture” (Collins & Kennedy, 2008, pp. 995–996). Collins and Kennedy (2008) assert that

> [t]he ultimate goal of [this model] is to optimize quality of life by maximizing independent functioning and community integration. Toward this end, treatment occurs in multiple setting, including the community.

—Collins & Kennedy, 2008, p. 994

Thus, returning soldiers (highly resilient, moderately resilient, and minimally resilient) require a comprehensive, multifaceted approach to support their home-bound efforts as early as possible.

**WHERE DO WE BEGIN?**

Many researchers from within the military and in the veteran/civilian community assert or imply that transition from the combat arena must begin before the demobilization site (Collins & Kennedy, 2008; Felker, Hawkins, Dobie, Gutierrez, & McFall, 2008; Jarrett, 2008; Lapierre et al., 2007; Manderscheid, 2007; Pietrzak et al., 2010; Seal et al., 2007). Their rationale for this belief is that early intervention is the key to better socio-behavioral and physical health outcomes postdeployment. Knowing about addiction, suicidal ideation, along with minimal familial support and lack of housing or unemployment are essential contextual challenges to address in order to achieve strong postcombat health screenings. But more importantly, there is no gestalt or one-size-fits-all strategic plan to reintegrate veterans. Each veteran requires a personalized strategy based on the causal determinants specific to the veteran—their environmental, social, behavioral, and biological determinants (risk and protective factors) that may diminish or enhance the quality of life and well-being for the returning veteran.

With these issues facing today’s young veteran, emerging from GWOT operations, there is a high likelihood that these young veterans can be marginalized, disappear, and embark on a pursuit to reclaim their lives through an existential vacuum. This existential vacuum embodies social alienation and a struggle to find purpose and meaning amid loneliness, despair, apathy, and cynicism that can lead to distress, depression, and aggression (Frankl, 1992; p. 111; Mascaro & Rosen, 2005).
In fact, no veteran should ostensibly disappear from the national landscape. When veterans disappear from the national landscape, it is indicative of the environmental context of our nation—an oppressive contextual challenge of apathy and low regard toward today’s young veteran.

REFERENCES


