Veterans seeking veterans through interpersonal communication

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Abstract

Traditionally, United States military veterans seeking help for physical or mental maladies have used, or have been able to use, Veterans Administration Medical Centers or extension clinics provided they were honorably discharged from the Armed Forces. The Veterans Administration is the single largest health care system in the United States, comprising of 1,400 hospitals and clinics around the country (Veterans Administration, 2014). But many veterans of today's wars in Iraq and Afghanistan are choosing alternative routes for care, forgoing established care centers for smaller, more intimate nonprofit veterans' organizations. This article aims at explaining this phenomenon through the eyes of Iraq and Afghanistan veterans who chose this path in a series of in-depth interviews. Responses are presented in thematic subheadings with excerpts from different participants. Three major themes emerged in this research: distrust with the VA, intense combat experiences, and the importance camaraderie plays when making these help-seeking decisions.

Key Words: Posttraumatic Stress Disorder, Traumatic Brain Injury, combat veterans, Iraq, Afghanistan

Introduction

The United States has been at war for more than 13 years, more than any other war in the history of the United States of America. The war in Iraq lasted nearly nine years, from March 2003 to December 2011. The war in Afghanistan is approaching its 14th year, with the vast majority of combat troops pulling out by the end of December 2014. Nearly 7,000 U.S. troops have died since the fighting began, and tens of thousands have been wounded in action (Fischer, 2014). Nearly 2 and a half million United States military troops have deployed to Iraq and Afghanistan since 2001 (Military One Source, 2012). Tens of thousands of troops are expected to return from Afghanistan by the end of 2014, and many will separate from service and seek treatment at Department of Veterans Affairs Medical Centers (VAMC) and clinics around the country. Many of those facilities are backlogged because of the sheer number of combat veterans returning from deployments. This large influx of returning troops can make it difficult to receive timely medical care at Veterans Administration facilities (Chokshi, 2014). Dozens of small, nonprofit veterans organizations have popped up around the United States, both at the national and local level, and more and more veterans are turning to them for help, forgoing traditional channels (e.g. VAMC) (Carter, 2013). It is worth noting that the Veterans Affairs hospital system is the largest in the United States and is the single largest provider of medical care for combat veterans (Department of Veterans Affairs, 2014).

This paper aims to explain why veterans are seeking out smaller organizations for mental and physical care. The researcher conducted a qualitative study of 10 United States military veterans of the wars in Iraq and Afghanistan through in-depth interviews in Columbia and Charleston, South Carolina. Participants described various reasons for their choices to seek alternative ways of care: long patient wait times, lack of understanding, compassion fatigue, and allegations of overmedicating practices at Veterans Administration health centers were the most common reasons. The findings show that, within this group of interviewees, there is an overarching distrust of Veterans Administration practices. All of the veterans interviewed in this study said they find comfort among other veterans. All participants said they prefer the more personal, intimate experiences of smaller nonprofit organizations where they can communicate with other veterans who have shared similar experiences during military service. All of the veterans interviewed have been diagnosed with Posttraumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI) or, in some cases, both PTSD and TBI. Nearly all branches of the military are represented in this study: Army, Air Force and the Marine Corps, and all the participants were involved in frontline combat in Iraq or Afghanistan, which yielded a wide variety of experiences.

According to the interviewees, all were engaged in small arms firefights and exposed to Improvised Explosive Devices (IED's) in either Iraq or Afghanistan on more than one occasion. It is important to point out that all participants were enlisted members of the military, which means they could enter the Armed Forces with a only a high school diploma or the equivalent. The researcher elaborates on this in the *Implications for Future Research* section at the end of this paper.

Literature Review

This topic draws heavily from psychological research with much of the emphasis on the concept of identification. Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Veterans are veterans of the Armed forces of the United States that served in combat, or in support of combat operations, in Iraq or Afghanistan since 2001 (US Department of Veterans Affairs, 2008). More than one-third of OIF/OEF veterans have served two tours in a combat zone (Kang, 2006). This current generation of veterans is the largest group of veterans to return from combat since the Vietnam War (Hoge et al., 2004).

Reintegration into society is a major barrier for many Iraq and Afghanistan veterans. Due to the urbanized nature of these modern combat theaters, particularly in Iraq, veterans may have difficulty discerning differences between urbanized combat zones, civilian life and a sense of safety (Jacupake, Luterek, Hunt, Conbeare & McFall, 2008). Approximately 41% of the veterans returning from combat have been diagnosed with a mental illness, most commonly Posttraumatic Stress Disorder (PTSD) or substance abuse (Sontag & Alvarez, 2008). Tanielian and Jaycox (2008) estimated that 300,000, or 14%, of service members returning from the wars in Iraq and Afghanistan have PTSD or depression, but just over half of seeks psychological help (Tanielian & Jaycox, 2008).

The second most common diagnoses among veterans with physical maladies are musculoskeletal-related diagnoses, which includes Traumatic Brain Injury (TBI). Traumatic Brain Injury is thought to impact nearly 30% of the veterans returning from Iraq and Afghanistan (Tanielian et al., 2008). Traumatic Brain Injury and Posttraumatic Stress Disorder often go hand-in-hand (Fischer, 2014). Posttraumatic Stress Disorder is an anxiety disorder caused by exposure to life-threatening experiences like war, sexual trauma, murder, accidents and natural disasters (Sayer et al., 2009), and is the most common psychiatric disorder among veterans returning from Iraq and Afghanistan (Sayer et al., 2010). Some of the symptoms include recurrent and unpredictable bad memories (flashbacks) associated with a traumatic event, avoidance, withdrawal, depression, sleep disturbance and hypervigilance (American Psychological Association, 1994). Symptoms of Traumatic Brain Injury include mood changes, depression, anxiety, impulsiveness and difficulty with concentration and memory (Bowling & Sherman, 2008). Depression and sleep problems, including nightmares, are also common symptoms affecting combat veterans. Hypervigilance, or a heightened sense of arousal, and high levels of anxiety associated with these problems often leads to social withdrawal and reclusive behavior (Bowling & Sherman, 2008).

Rosebush (1998) suggested that 'soldiers' are at a greater risk of developing Posttraumatic Stress Disorder if they were fired upon, physically injured, or saw people killed in combat (Rosebush, 1998). However, it is important to note, you cannot classify all combatants as 'soldiers' in the context of the U.S. Armed Forces. It is more appropriate to use the umbrella term 'troops' when writing about Marines, soldiers, airmen or sailors. Many journalists and scholars use incorrect terminology when referring to all service members as 'soldiers.' In the context of this research, a 'Soldier' refers to a member of the United States Army, whether officer or enlisted[1]. The same goes for a 'Marine', which applies to the singular form of an officer or enlisted Marine Corps personnel; and 'Sailor' and 'Airman' for Navy and Air Force personnel, respectively. The umbrella term, 'troops' is much more appropriate when referring to a mixed group of United States military personnel. All participants in this study were either fired upon, physically injured, witnessed someone die in combat; both friendly and enemy; under constant threat of IED attacks; in danger of 'green on blue' killings, where their Afghan counterparts whom they were training turned on them; and myriad physical and psychological threats and events that could be potentially harmful. Other incidents included constant threats of direct and indirect fire from enemy combatants, including mortar and rocket attacks, unexploded ordinance, and murder and intimidation campaigns waged by enemy combatants.

Fairbanks et al. (1991) found that Prisoners of War (POWs) with Posttraumatic Stress Disorder were more likely to use social support than those without PTSD. Horowitz and Stinson (1994) discovered that social support helped sustain a person through

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[1] An officer is typically an individual with a college degree who is 'commissioned' upon entering the military. Enlisted troops gain entry with a high school diploma or equivalent degree. More details are in the *Implications and Future Research* section of this study.

emotional turbulence following a traumatic event. When an individual has interpersonal resources available to them, the individual tends to live a less turbulent life after experiencing a traumatic event than those who do not have those resources available (Hunt & Robbins, 2001).

It became apparent early on in this research that the veterans interviewed for this study found comfort in camaraderie. Camaraderie is defined as 'Mutual trust and friendship among people who spend a lot of time together' (Oxford Dictionary, 2014). While this is certainly true among combat veterans who spend months or even years deployed overseas, I argue that the 'experience' is a missing component to the definition. Camaraderie, in the context of this research, is defined as a bond between one or more persons who have shared, or lived through, a common 'experience' (e.g. combat). Thus, camaraderie differs from friendship in that friendship does not necessarily constitute a shared experience. Being around other veterans who shared similar experiences allowed them to quickly assimilate and identify with both members and administrators at Hidden Wounds. Nationalism is also an important part of these veterans' lives, and perhaps another belief where they identify with one another. All participants said that they were proud to serve their country and did not have any regrets about what they had done.

Identification

The concept of *identification* is rooted in psychoanalytic theory. Identification has been defined in a number of ways by social science researchers, primarily in psychology, but has been used in a wide range of disciplines – including mass communication. Lasswell (1965) suggests that groups identify with one another because they share a common belief or goal (Lasswell, 1965). Freud stated that identification is "the earliest expressions of an emotional tie with another person" (Freud, 1922 p. 29). Reciprocal identification is closely related to camaraderie, whereby people must have mutual expectations in order to maintain a reciprocal relationship (Kelman, 1961).

There are a lot of studies about veterans of Iraq and Afghanistan, but few, if any, that focus on why Iraq and Afghanistan veterans are choosing to go to smaller nonprofit organizations for help in lieu of traditional places where veterans are seen for care – especially in the communications discipline.

Theoretical Framework

This research employed Grounded Theory, which gets its roots from Pragmatism (Dewey, 1925). Data from Grounded Theory can come from a variety of sources such as interviews, observations and documents, and then coded using a systematic method with numbers or symbols (Glaser & Strauss, 1967). What separates grounded theory from many other theories is that the researcher begins analyzing data as soon as data is collected (Corbin & Strauss, 1990). Grounded Theory is a discovery process. The purpose of such a method is to guide future inquiry and provides ways for the researcher to pivot in order to gather rich data from participants. Corbin and Strauss (1990) suggest searching for cues in the initial data collection, which will serve as a guide in subsequent interviews.

For this study, exploratory informal interviews were first conducted to determine what issues were plaguing the participants in this study. This technique facilitated a better understanding of how to formulate interview questions during the study. Thus, I propose the following research question:

RQ – *Why are some United States veterans of the wars in Iraq and Afghanistan seeking help – for both mental and physical afflictions – at smaller, local organizations in lieu of traditional channels like the Department of Veterans Affairs medical centers?*

Method

To develop the sample frame for this study, the researcher contacted Hidden Wounds, a Columbia, South Carolina-based nonprofit veterans organization. Proximity was key in this study because the researcher had to develop a great deal of rapport with the participants, which helped during the interview process. The contact at Hidden Wounds sent out e-mails, social media messages, made phone calls and sent text messages asking veterans to participate in the study. From this pool, 10 veterans agreed to participate in the interviews (Table 1). All of the participants were combat veterans, having served in the combat theater in Iraq or Afghanistan. The majority of the participants were interviewed in person; only one interview was conducted over the phone.

The author conducted in-depth interviews for this study, both face-to-face and over the phone. Open-ended questions were used during the interviews, which some scholars suggest is the best approach to avoid 'yes or no' answers (Legard, Keegan & Ward, 2003, p. 139), and ended with a follow-up question asking if the participants wanted to add anything else that was not discussed. Given the sensitive nature of the interviews, the researcher employed the technique of achieving empathy without becoming too involved in the process (Rubin & Rubin, 1995). This technique was hard to use based on some of the vivid, detailed accounts of war that some of the participants gave.

The interviews were recorded using an iPhone application and/or digital recorder, then subsequently transcribed, with participant permission, by the author.

The question topics included military background and occupational specialty, number of combat deployments, injuries sustained during combat operations, disability and compensation benefits, residual effects and/or ailments, day-to-day life, and family life and employment status.

Each participant was informed of the purpose of the research and gave verbal consent to be recorded for the study. All participants were aware that they would remain anonymous and that the researcher would be using the findings in an academic setting. All were told the researcher would refer to the interviewees as 'participants or veterans', not their real names. Four of the participants requested the recordings and notes be destroyed upon completion of this study, for which the researcher obliged.

The data were analyzed using First Cycle and Second Cycle coding (Saldana, 2013), looking first at large chunks of data, then making multiple passes to ensure a thorough coding process. The researcher used multiple colors to code the data, which included a legend on the first page of the transcripts as a reference point. One of the codes that was not initially included in the first round of coding was for emotion coding (Miles, Huberman & Saldana, 2014). The researcher thought this information was pertinent to the study so it was included. Lincoln and Guba (1985) suggest that trustworthiness of qualitative research is judged by its credibility, dependability, whether or not it can be confirmed, and its transferability (Lincoln & Guba, 1985, p. 213).

Table 1 *Breakdown of the United States military branches represented in this study*

Army	Air Force	Marines
4	1	5

Total (All Branches) 10

Results

Three main themes emerged after the interviews were coded: VA-related discrepancies and trust issues with care at VA facilities, intense combat experiences and traumatic events with lingering effects, and the importance of camaraderie when seeking help with problems.

Discrepancies and Trust with the VA

All of the participants in the study had grievances with the Veterans Affairs health care system (Figure 1). In some cases, some were said to be egregious. One particular participant claimed that his medical records from a military doctor would not suffice in the VA health care system, and thought it to be a hostile environment, based on his experiences (Figure 1).

"Basically my entire experience with the VA has been one of almost and antagonism of veterans. They doubt your diagnoses even when they come from military doctors."

This same participant felt as though he was stuck when it came to navigating his way to proper care, hence the reason he turned to Hidden Wounds for help.

"If you say, hey, my provider isn't giving me the support I think I need at the VA they'll tell you – And?"

This participant has been treated at several different VA facilities around the country, two in Ohio (Columbus and Cincinnati) and two in South Carolina (Charleston and Columbia). His experiences were similar at the different VA medical centers. At one point, the participant sought in-patient mental health treatment because his PTSD symptoms flared up being robbed at gunpoint at his apartment in Columbus, Ohio.

"It's a lot of peoples' last stop before they end up in jail or some other state facility. If you have any other option, if you aren't absolutely going to end it, like tomorrow, I would tell everyone to stay away from VA in-patient care. Basically what they're going to do is throw pills at you until it sticks."

Another participant echoed a similar sentiment, claiming that the VA's answer to these problems is to prescribe psychiatric medications.

"You go and you say you can't sleep at night…well, we'll write you a sleeping pill. And all it's doing is masking the symptoms, it's not you know, getting to the root cause and the reasons behind it."

This participant is advocating for medical marijuana use for veterans dealing with Posttraumatic Stress Disorder, and admits to using marijuana in lieu of prescription medications.

He's started a campaign for medical marijuana called 16-20, the military time for 4-20, a code widely known by marijuana users. He has a 100% service-connected disability rating with the VA because of multiple injuries he sustained after his vehicle was hit by a rocket-propelled grenade. This means he receives, and will continue to receive, compensation for the rest of his life (roughly $3,000/month; Department of Veterans Affairs compensations and disability scale, 2014).

Another participant complained of overmedicating practices for physical drugs, claiming he was prescribed medication that would prevent him from functioning normally.

"They hand you a Flexoril, say here, here's your 10 milligram muscle relaxer, take it three times a day. And you tell me if you can function taking just that pill three times a day, you know, on top of the other types of pills? They want to give you a drug regimen. You end up battling the side effects of that regimen more than the actual symptoms or effects that you had from PTSD."

This participant suffers from knee and back injuries, PTSD and TBI, and has been taking numerous medications for the past five years.

Long Wait Times at the VA Medical Centers

All of the veteran participants expressed concerns about wait times at the VA health facilities, especially at the Dorn VA in Columbia, South Carolina. Some backed up this claim citing national media reports of medical malpractice and cover-ups involving patient wait times. These allegations proved to be true, which led to the resignation of the former Secretary of the Veterans Administration, Eric Shinseki. One veteran said that, because of the swell in the number of veterans returning from combat, providers (e.g. doctors, nurses and other hospital staffers) are burnt out (Figure 1).

"It took me two months to be seen by a mental health care professional ... you're the 60th PTSD patient they've seen today and you're just another notch in their compassion fatigue belt."

Multiple participants used the same terminology when describing the VA.

"We don't trust the 'system.' When a veteran says he doesn't trust the VA we're not saying it about the personnel, we're saying it about the system itself."

Two of the other participants referred to the VA as a 'machine' referring to its size, therefore lacking personal connection in the eyes of these participants. There were many references like 'machine' 'it' 'institution' and 'system' throughout the interview process.

Intense Combat Experiences

The participants all had combat experience and exposure to traumatic events. Some had multiple combat tours; others just one. Deployment times ranged from 6 to 18 months, some with consecutive tours with little or no downtime between deployments. As one Marine recounted his worst experience in Afghanistan, he became overwhelmed with grief and began sobbing during the interview.

"I lost my best friend, he was my best friend in the Marine Corps, you know. I saw him get burned alive, and that, you know, it shook me down to the core. I didn't even know what to do when I came back. I would just have crying spells, I would, you know, just lose it because I was so hurt."

This was just one account of many traumatic events this participant experienced. He was wounded in action, receiving two purple hearts between two deployments to Afghanistan. He was part of the surge in Marjah, Afghanistan where Marines were tasked with pushing south in the volatile Helmand province region that had been overrun by Taliban fighters. His unit was under constant attack and sustained heavy casualties during both deployments. There was even a *HBO* documentary about his unit called, "The Battle for Marjah" chronicling the unit's harrowing combat experiences in what, at the time, was the most volatile region in Afghanistan.

Another participant, this time speaking about Iraq, described anxiety-filled accounts of countless convoy security operations on the roads in Iraq.

"I was IED'd once (Improvised Explosive Device), resulting in a Traumatic Brain Injury, on a convoy in Iraq."

This participant also described an assault by a fellow soldier when he was deployed to Somalia who refused to carry out orders on a mission. He said the junior soldier just snapped for reasons he could neither explain nor elaborate on.

"I came around the corner and my subordinate cold-cocked me. He knocked me to the ground on this concrete slab and beat me unconscious until somebody, I guess, pulled him off of me."

The participant said this resulted in his second TBI, which subsequently led to a decline in military performance, resulting in a loss in rank and an 'Other than Honorable (OTH) Discharge' from the Army. He reported that the VA would not recognize his injuries as combat-related, and was unable to receive disability compensation. He says he's currently appealing this decision and has since hired a lawyer.

One participant, a former Marine, was critically injured when his vehicle was hit blown up by an IED. He spent a year and a half recovering from severe physical injuries at Walter Reed Medical Center in Washington, D.C. His injuries included a Traumatic Brain Injury, resulting in several brain surgeries, deep flesh wounds to his legs and arms, and the loss vision in his left eye. He's now permanently disabled and has since been discharged from the Marine Corps. Despite major setbacks, he graduated with a business degree from the University of South Carolina in 2010.

All of the participants suffer from PTSD, TBI or both as result of their combat experiences. Some of the most seriously injured veterans actually seem to be coping with their injuries better than those who did not have noticeable physical wounds. They attribute this to social support from their families and Hidden Wounds.

Camaraderie

Perhaps the most salient theme that emerged from this study was the importance of camaraderie. All of the participants acknowledged the importance of talking to other veterans with similar experiences, pointing out that to understand the experiences, you have to have lived them. One veteran described why he chose to seek help at a smaller, veteran-run organization (Figure 1).

"Veterans are reaching out to organizations like this because veterans trust veterans. We know if a veteran is running an organization, he's going to make sure, you know, we're done right."

Another veteran valued the small, intimate quality of a local organization, comparing Hidden Wounds with larger, national veterans' organizations around the country.

"This is local. This is home. This is where you come back and it's more personal, it's not just someone calling over the phone and asking how you're doing. They'll meet you face-to-face."

Another participant, who lives in Charleston, South Carolina, had a similar response about proximity.

"If you reach out to smaller organizations, there's someone who's next to you there, [and] they're your neighbors. That means a lot versus you just going to a big building where they run people in and out and you're just another number."

The importance of a smaller, veteran-run nonprofit organization was a big factor in the participant's choice to as well.

"I'm not knocking any of the organizations that are helping veterans, but know that some of these nonprofit organizations aren't really helping as much as they can ... the reality is that they spend more money to make more money. You can look up and see how much money for every dollar that you donate to that organization is getting back to the actual veterans, so you know, you got another veteran who's doing it, who's not getting paid to do it, who's doing it on his own – it's looking out for one another."

One participant, who claimed he'd been waitlisted at the VA, lauded the swift actions of Hidden Wounds.

"Literally after a week I was in the office with them at least 2 to 3 times a week. It's been really good. You're not just another number."

During the course of this study, this participant has started volunteering at Hidden Wounds. He added that helping fellow veterans is rewarding and helps him in his coping process.

Figure 1 *Themes that emerged from Interviews*
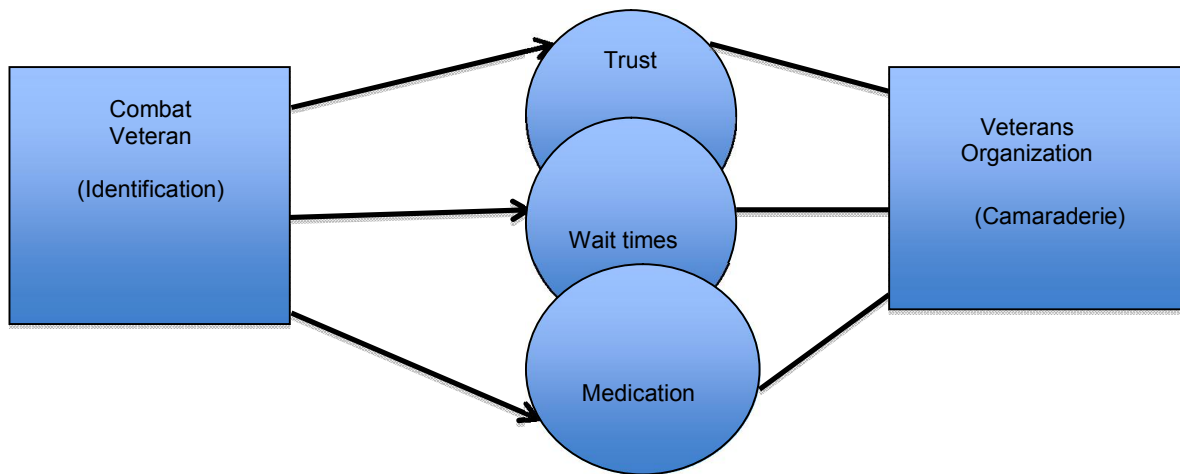
Discussion and Conclusion

Using in-depth interviews of Iraq and Afghanistan combat veterans, this research examined the reasons why these veterans opted to go to a small, local nonprofit veteran's organization instead of Veterans Affairs medical centers when seeking help for physical and psychological problems. There is a general consensus amongst the veterans interviewed that trust and camaraderie are important when making these choices. Several key themes emerged from this study, including trust issues with the Veterans Administration, intense combat experiences, and the importance of camaraderie between veterans.

Few studies have conducted research about the choice to forgo traditional veterans' facilities and choose smaller organizations in help-seeking choices. However, it's clear that the social support element is crucial in understanding these choices. Hunt (2001) conducted a similar study of British World War II veterans and found that the veterans think it's important to have of social support and veterans organizations to aid in the coping process (Hunt, 2001). However, this was a much older population than the one in this study. Fairbanks et al. (1991) found that veterans with Posttraumatic Stress Disorder were more likely to benefit from social support than those without it (Fairbanks et al., 1991). Today's veterans, in the context of this study, had a similar sentiment when it came to the interpersonal connections they make with other veterans, emphasizing the difference this has made since returning from war. Many of today's veterans withdraw from society for various reasons, perhaps lending some explanation to the 22 veterans taking their lives every day (Department of Veterans Affairs, 2014). Far more veterans are dying at their own hands than on the battlefields of Iraq and Afghanistan. More studies that help explain behavioral choices and patterns could potentially mitigate these problems.

Implications for Future Research

Employing a quantitative or a mixed-methods approach with a large cohort would be useful in determining if this is a nationwide phenomenon. Studying women, in the same context of this study, would also be interesting to see if there are any gender-based differences. Using experimental research, such as exposure therapy, where the veteran recalls a certain traumatic event would also yield interesting results. Perhaps viewing video of actual war footage in an experimental setting would be useful in future research to see how veterans respond to the stimuli.

All of the veterans in this study were enlisted military personnel. This means, with a few exceptions, that they entered the military after graduating high school or receiving an equivalent degree. However, this varies amongst the different branches of the military. For example, the Army implemented a GED program in 2009 where soldiers could earn a GED and enter the Army upon completion. Some services require a GED plus a certain number of college credits to gain entry into the military. It would be interesting to compare enlisted service members to officers. An officer, again, in most cases with some exceptions, is someone who entered the military with a college degree. This is most commonly done through a college or university's Reserve Officers' Training Corps (ROTC) program, where an individual pledges to serve for an certain length of time in a branch of the military in exchange for a subsidized college education, and participates in mandatory military-related training during their time in

college. Upon graduation from college, a ROTC candidate is commissioned as an officer and is officially in the military, usually sent somewhere for additional training. Some people just decide to join the military after college, having never been a part of ROTC. Officers go through separate training and compete for different military occupational specialties (MOS). Therefore, officers are typically older than enlisted troops and more educated. I believe education and socioeconomic status are two major variables that would have significant effects in a quantitative study related on this topic. Studying college-educated officers would be another way to compare differences between enlisted-officer ranks. I would think there would be marked differences between the two groups.

This research sheds light on important issues Iraq and Afghanistan veterans face after separating from service. There are thousands of U.S. troops still deployed in Afghanistan (USA Today, 2015), which means that they, too, will be returning, and seeking health care. The Veterans Administration currently provides five years of health care coverage from the date of separation from the service (Veterans Administration, 2015). Thus, the backlog and perceived problems will likely persist for an indefinite period of time. Research like this could serve as a starting point to streamline the health care process at veterans' hospitals or, at the very least, provide guidance on what issues need immediate attention.

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