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Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral study by

Cynthia Wilson

has been found to be complete and satisfactory in all respects,
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the review committee have been made.

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The Office of the Provost

Walden University
2019

Abstract

Social Workers' Perceptions of the Effects on United States Soldiers of Multiple Deployments

by

Cynthia L. Wilson

MSW, University of Washington, 2002

BSW, Pacific Lutheran University, 1999

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Social Work

Walden University

August 2019

Abstract

Military personnel who have served during Operation Iraqi Freedom, Operation Enduring Freedom, and Operation New Dawn have experienced longer and more frequent deployments than U.S. personnel involved in any previous conflict. These multiple tours in combat zones have resulted in complex psychosocial needs for military personnel. The goal of this action research study was to understand social workers' perceptions and experiences of military personnel who experienced 3 or more deployments in a combat zone. The theoretical foundation for the study was narrative theory. Research questions sought to understand the social workers' perceptions of the psychosocial treatment needs of these veterans, to understand the social workers' experiences in providing services to address their needs, and whether participants perceived that the services provided were enhancing the mental and social well-being of the veterans. Data were collected from a focus group of 8 master's-degree-level social workers who worked with veterans with multiple deployments. Data were analyzed using descriptive coding to determine categories and themes. Findings included increased incidents of posttraumatic stress disorder and complex psychosocial needs, the importance of evidence-based practice and successful reintegration, clinical considerations, and potential barriers to effective service. Findings also focused on the importance of organizational support and continuing education for social workers providing these services. The findings of this study might be used to promote positive social change by highlighting the need for ongoing education for social workers, organizations, and society to provide informed evidence-based treatment for veterans who have experienced multiple deployments.

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Dedication

In dedication to the men and women who have served in the U.S. military and the social workers who tirelessly provide them services.

Acknowledgments

I would like to thank the many professors who have been involved in my professional development. I thank my family for the years of support they have provided me during my academic journey; they have been my research assistants, proofreaders, and cheering section. Without them, this journey would have been much harder.

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Section 1: Foundation of the Study and Literature Review

Introduction

For over 200 years, the United States has been involved in formal wars and military actions. The unintended consequences for the veterans who served during war and military actions have been long-term impacts on their mental health and social functioning after returning to civilian life. There have been five formally declared wars, and the United States has been a participant in numerous military conflicts including the current wars in Iraq since 2001 and Afghanistan since 2003 (Sadeh, Lusk, & Marx, 2017). Social workers face unique challenges when working with those who have served in combat zones. Service members who have served in the current wars in Iraq and Afghanistan have served multiple deployments. This action research study will incorporate the experiences of those who have served in the current wars in Iraq and Afghanistan from the perspective of the social workers serving them.

The precursor to the wars in Iraq and Afghanistan was September 11, 2001, the terrorist attack on the United States. After the events of September 11, 2001, the United States embarked on the Global War on Terror. These efforts have been named Operation Iraqi Freedom (OIF) was the name for the war in Iraq that began in 2001, Operation Enduring Freedom (OEF) was the name given to the war in Afghanistan in 2003, and Operation New Dawn (OND) was the transition name signifying the troop drawdown in 2010 (Strong et al., 2014). These actions will be referred to collectively as OIF/OEF/OND. Sadeh et al. (2017) observed that without an enforced draft process to designate who participated in these wars and due to the shortage of military personnel,

the same men and women were deployed to combat situations repeatedly throughout the war. The impact on military personnel who have served during OIF/OEF/OND has been compounded by repeated deployments. Interian, Kline, Janal, Glynn, and Losonczy (2014) reported that in 2008, 46.5% of active duty personnel had experienced multiple deployments.

It is important to understand the correlation between multiple deployments and the psychosocial needs of the service members who have served in combat zones. Per Bentley (2005), the first case of PTSD was documented by the Swiss military physician Johannes Hofer in 1688 (Diego & Ots, 2014). Hofer used the term *nostalgia* to describe a series of symptoms that included anhedonia, anxiety, insomnia, and loss of appetite (Fox & Pease, 2012). Huang and Kashubeck-West (2015) found that military posttraumatic stress disorder (PTSD) has undergone many name changes since 1678: nostalgia, shell shock, and battle fatigue. The overall impression based on empirical and anecdotal evidence suggests that serving in a combat zone can cause individuals to experience symptoms of PTSD and social dysfunction (Smith & True, 2014). Military personnel have reported symptoms of PTSD after a single episode of combat (Kline et al., 2010). This action research study will help to understand social workers' perceptions and experiences working with military personnel involved in multiple deployments during OIF/OEF/OND.

Action research is a qualitative methodology that allows researchers to focus on specific situations to develop an understanding and focus on solutions (Dilshad & Latif, 2013; Thiollent, 2011). Focus groups provided a venue for participants to share their

experiences and perspectives on social research issues (Stringer, 2007). This action research study explored social workers' experiences when providing services to veterans who have served multiple deployments and reported experiencing symptoms of PTSD, mental health symptoms, drug or alcohol use, and interpersonal relationship issues. Data obtained add to the body of knowledge social workers use in working with veterans who are experiencing PTSD, mental illness, and addiction.

To understand the purpose of the study and the social work problem of understanding the care needs of veterans who have served multiple deployments in combat zones, I asked social workers questions to better understand their experiences and perspectives of these veterans' treatment needs, which were determined through questions, data collection, and data analysis. Social work ethics and values, as defined by the National Association of Social Workers' (NASW) Code of Ethics (2017), guided this study to ensure that ethical research practices were upheld. The significance of the study provided an increased understanding of the treatment needs of veterans. The study was based in narrative theory, which provided a lens for understanding social workers' perspectives about how multiple deployments in combat zones affect veterans' mental health and social functioning. I conducted a comprehensive literature review to further define the relevance of the research and the issues around veterans who have served in multiple combat deployments.

Problem Statement

OIF/OEF/OND tours of duty have had a profound impact on today's military. The conclusion of the Vietnam conflict in 1973 saw the end of the draft (Parenti, 2006). More

recent wars have been fought by voluntary military forces. Unit cohesion has been implemented to increase participation and retention, resulting in a larger number of veterans being deployed multiple times to combat (Parenti, 2006). Interian et al. (2014) indicated that military members serving in OIF and OEF are experiencing multiple deployments in combat zones, which can have severe impacts on their psychological and physical well-being. Owens et al. (2014) and Smith and True (2014) reported that consequences of multiple deployments include an increased incidence of PTSD, depression, addiction, traumatic brain injury (TBI), and increased divorce rates. Prior to receiving treatment for symptoms related to PTSD, mental health issues, or drug and alcohol use, military personnel were redeployed to combat.

Previous research studies support the negative compound effects multiple deployments have on military personnel (Moore et al., 2017). Deployed service members have experienced repeated combat missions, which increase exposure to traumatic events and thereby enhances their risk of developing symptoms of PTSD (Huang & Kashubeck-West, 2015; Interian et al., 2014). Smith and True (2014) noted that OIF/OEF/OND service members are experiencing PTSD at a rate 13–20% higher than previous wars. These findings in both past and present studies support an increase in reported symptoms of PTSD in those who served in combat zones (Hines, Sundin, Rona, Wessely, & Fear, 2014).

Fragedakis and Toriello (2014) reported between 12% and 30% of the active duty military personnel who served in combat zones during OIF/OEF/OND experience combat-related PTSD. Fischer et al. (2015) reported that 30% of the veterans receiving

healthcare through the Veterans Health Administration were also treated for PTSD in the mental health clinic (Finley et al., 2015). Those diagnosed with PTSD are at a higher risk of also having a co-occurring disorder, such as mental illness and substance use (Heltemes et al., 2014). Owens et al. (2014) found that, of the OIF/OEF veterans receiving treatment for PTSD, 10% have a co-occurring alcohol use disorder, and 5% have a co-occurring drug use disorder.

Research has suggested this correlation may be due to veterans using substances to self-medicate postwar pain and distress experienced in civilian life (Kline et al., 2010). McDevitt-Murphy, Fields, Monahan, and Bracken (2015) found the comorbidity of mental illness diagnosis and addiction has been noted to be more severe and persistent in OIF/OEF/OND veterans than in any previous military action. It would appear a correlation exists between multiple deployments and the diagnosis of mental illness and substance use because of the OIF/OEF/OND wars. A study conducted by Sadeh et al. (2017) found that of the 2.5 million troops deployed during OIF/OEF, 70% reported having at least one combat exposure during deployment. Many of the veterans who served during OIF/OEF have had multiple deployments, with those serving two or more combat deployments showing an increased risk of PTSD (Kline et al., 2010). Kline et al. (2010) went on to report that military personnel with three or four deployments are 27.2% more likely to have comorbid mental health problems and engage in substance abuse and suicide attempts. Research studies and findings have documented the effects of military service in combat zones, but there is minimal research on the social workers' experience of providing post deployment care to veterans. This study sought to

understand the social workers' experiences in providing services to veterans who have served multiple deployments in combat zones.

Purpose Statement and Research Questions

The purpose of this qualitative research study was to understand social workers' perceptions and experiences regarding multiple deployments, operationalized as three or more tours in a combat zone, during OIF/OEF/OND, which have had cumulative effects on the mental health and social functioning of veterans who receive care through veteran services in Western Washington. Through this action research study, I developed an understanding of the social workers' evaluations of the cumulative mental health and social effects of multiple deployments on their veteran clients. There are were two primary research questions and one subquestion guiding this study. The questions were specific to social workers who provide services to veterans who have served multiple deployments.

RQ1: What are the perceptions of social workers in Western Washington regarding the psychosocial treatment needs of veterans who experienced three or more tours in a combat zone during Operation Iraqi Freedom/Operation Enduring Freedom/Operation New Dawn?

RQ2: What are the experiences of social workers in Western Washington providing services to address the psychosocial treatment needs of veterans who experienced three or more tours in a combat zone during Operation Iraqi Freedom/Operation Enduring Freedom/Operation New Dawn?

SQ1: From social workers' perspectives, are the services being provided enhancing the mental and social well-being of veterans?

Definitions

I have provided definitions for key terms that will be used to increase the clarity of this research study.

Interpersonal relationships: A person's relationships with spouses, children, family, and employers. The three components of an interpersonal relationship with a partner are intimacy, shared activities, and responsibilities. Interpersonal relationships involve mutual trust and the sharing of emotions, thoughts, and physical closeness (LaMotte, Taft, Reardon, & Miller, 2015). Returning service personnel are not just reintegrating with spouses but also other interpersonal relationships such as with their children, and parenting relationships depend on a parent's psychological resources and sources of support or stress in the marital relationship (Meis et al., 2017; Mustillo, Xu, & Wadsworth, 2014).

Interpersonal violence: Acts of violence perpetrated against an individual's intimate partner (Scioli, Otis, & Keane, 2015). These acts include psychological abuse and physical aggression (Love et al., 2014).

Mental disorders: The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013) defines them "as clinically significant disturbances in an individual's cognition, emotional regulation or behavior" (p. 20). Mental health issues include emotional disorders, depression, dysthymia, anxiety, adjustment disorders, and psychotic disorders. Mental disorders may cause distress in

social or occupational functioning, as well as other areas of one's life (Gebhardt et al., 2017; Scioli et al., 2009; Wright, Britt, & Moore, 2014).

Multiple deployments in a combat zone: More than one deployment to a combat zone (Interian et al., 2014; MacGregor, Heltemes, Clouser, Han, & Galarneau, 2014; Scioli et al., 2009; Sadeh et al., 2017; Smith & True, 2014).

Posttraumatic stress disorder (PTSD): A disorder that occurs after exposure to a traumatic event, according to *DSM-5* (American Psychiatric Association, 2013). PTSD in veterans is an anxiety disorder that occurs after experiencing war-related trauma. During deployments, military personnel frequently experience life-threatening events during combat, base attacks, injury, and the deaths of others (Dodson & Beck, 2017; Fragedakis & Toriello, 2014; Gebhardt, Alliger-Horn, Mitt, & Glaesmer, 2017).

Psychosocial treatment needs: The treatment necessary for improved functioning in medical, mental health, substance abuse, relationship factors, legal, employment, and housing needs of veterans (Kline et al., 2009).

Substance abuse: Using drugs or alcohol as a coping mechanism to potentially reduce symptoms of distress following deployment. Many returning service members are affected by addiction (Owens et al., 2014). Addiction behaviors include hazardous drinking, heavy drinking, binge drinking, and drug use (McDevitt-Murphy, Fields, Monahan, & Bracken, 2015). Alcohol can provide a tension-reducing effect by reducing anxiety, decreasing psychological defenses, and inhibiting uncomfortable emotions, making it the most frequently abused drug (Owens et al., 2014). Veterans who abuse opiates are enabled to suppress anger, rage, and hostility (Weiss et al., 2011). The use of

stimulants and cocaine enables them to manage symptoms of depression. The use of drugs or alcohol provides a means of numbing emotions and engaging in avoidant coping strategies (McDevitt-Murphy et al., 2015; Owens et al., 2014; Weiss et al., 2011).

Traumatic brain injury (TBI): Trauma caused by exposure to blasts and concussive blasts. Explosive blasts cause a change in atmospheric over pressure and subsequent under pressure (Zuckerman et al., 2017). This sudden change in atmospheric pressure causes a physiological disruption in brain function. The loss of brain function may include a loss of consciousness, loss of memory, or altered mental status. Symptoms of TBI include headache, tinnitus, dizziness, issues with memory and concentration, depression, anxiety, and irritability (Dismuke, Gebregziabher, Yeager, & Egede, 2015; Manners et al., 2016). Functional impairments associated with TBI include loss of executive functioning, memory, decision making, and the ability to focus one’s attention. These symptoms range in severity from mild to moderate and severe (Lopez et al., 2017; Wallace, 2009).

Veterans: Those who served active service and completed a predetermined period of service in the armed forces (Burdett et al., 2012). At the time of separation, the service member must be discharged under any condition other than dishonorable to be considered a veteran (U.S. Department of Veteran Affairs [VA], 2014).

Nature of the Doctoral Project

In this study, I used an action research methodology to collect qualitative data through purposive sampling of social workers who work in primary care, outpatient mental health, inpatient mental health, and the warrior transition unit in Western

Washington. The focus group setting allowed the participants the opportunity to engage with one another through the discussion of their individual experiences when working with veterans. Focus groups are an approach used by researchers for its sensitivity to the human experience, and they provide an opportunity to enhance meaning and reduce uncertainty (Stringer, 2007). Dilshad and Latif (2013) defined focus groups as being communication for a specific purpose on an agreed upon subject.

The focus group met for one 2-hour session. Social workers provided valuable insight into the mental health and social challenges demonstrated by veterans who experienced multiple deployments and the coping strategies they use to deal with combat situations during OIF/OEF/OND (Bradburn, Sudman, & Wansink, 2004; Fenge, 2010; Stringer, 2007). I placed an announcement introducing the study and requesting volunteer participants on Facebook and LinkedIn to recruit social workers for participation in a focus group. I provided social workers who volunteered to participate in the research study with my name and email address. For inclusion in the study, the social worker had to be working with or have recently worked with OIF/OEF/OND veterans.

The format for the focus group was a face-to-face group interview. The interview took place in a conference room at a public library, which provided a safe and confidential environment. With permission from all participants using an informed consent form, the content of the focus group was audio recorded with two audio recordings and transcribed verbatim for data analysis using transcription software called Dragon Dictation. The data was coded and categorized into themes to answer the research questions aimed at understanding social workers' perceptions of and experiences with

veterans who have served multiple deployments in combat zones. All materials were placed in an access restricted office in a locked cabinet to protect participant confidentiality.

Significance of Study

The significance of this study was to increase the understanding of how social workers assist veterans of multiple deployments in the enhancement of their mental and social well-being. The findings from this study may aid social workers, who provide services to veterans, in understanding the impact of multiple deployments on the mental and social well-being of veterans and in designing appropriate services to mitigate the cumulative effects of these deployments. These findings may also help social workers support veterans reintegrate into the community more effectively and efficiently. Service quality awareness may be advanced by the sharing of study findings with the head of social work services and the chief of mental health services at Puget Sound Health Care Systems both at the Seattle and American Lake divisions, and the social workers who participated in the focus groups.

Petrovich (2012) asserted that social workers who understand the military and veteran culture are more successful in providing treatment to veterans with PTSD, mental illness, and addiction issues. The study findings will add to the generic military social work research literature by capturing information about multiple deployments and social workers' perceptions and experiences of the mental and social well-being of veterans. The research will provide insight from social workers who provide case management and

therapy services to veterans with PTSD, mental health issues, and addiction symptomatology.

Theoretical Framework

The theoretical framework I used for the study was narrative theory. Narrative theory provides a framework for facilitating the organization and understanding of individual perspectives and experiences. According to Hickson (2015), the use of narrative inquiry allows a researcher to develop an understanding of participants' experiences, interpretations, and perceptions. Hayden, Brown, and Riet (2017) suggest that the use of narratives strengthens knowledge and contributes to practice development. Using a lens of narrative theory allowed me to develop an understanding of the social workers' experiences, interpretations, and perceptions of the treatment needs of veterans who have served multiple deployments (Buettgen et al., 2012; Cihodariu, 2012; Haydon et al., 2017). Haydon et al. (2017) noted that narrative theory provides the foundation for a researcher to understand the experiences and perceptions of social workers' by listening, observing, reading, and interpreting transcripts. Narrative research is a way to collect data to inform future decisions and the development of practice (Hickson, 2016; Payne, 2014). Narrative theory provides a foundation for accessing knowledge, supports an increased awareness among participants, provides the opportunity for increased information sharing, and empowers research participants (Buettgen et al., 2012; Hickson, 2016; Norton, Russell, Wisner, & Uriarte, 2011).

Cihodariu (2012) supports the use of narrative theory in the understanding of social workers' thoughts and experiences. The use of narrative theory supports the

research purpose of understanding the social work perspective and experience regarding how multiple deployments have had cumulative effects on veterans' mental health and social functioning through the telling, recording, documenting, and dissemination of these experiences.

Value and Ethics

NASW provides the framework for ethics in research regarding social workers' experiences and perceptions of working with veterans who have served multiple deployments in combat zones (NASW, 2017). According to Bogolub (2010), ethical principles and social work mandates guide social work research. Social work research seeks to aid research respondents through ethical and fair standards in research and the acquisition of knowledge. NASW's Code of Ethics (2017) provides the values, principles, and standards by which social workers conduct themselves. These guidelines provide the foundation for the decisions social workers make when there are ethical issues in research. The core value of social justice relates to creating social change into the experiences of social workers providing services to veterans who have served multiple deployments. This study embraced the dignity and worth of the person and the importance of human relationships by ensuring a safe environment for the social workers who participated in the study. Integrity was maintained through respectful communication and confidential interactions before, during, and after the research study. NASW's Code of Ethics (2017) outlines social workers' responsibility to contribute to the knowledge base of the profession. The research study will provide data on the experiences of social workers who work with veterans who have served multiple

deployments. All research was conducted with full participant consent to ensure confidentiality. Research data has been reported accurately and was disseminated to the social workers who participated in the study.

The VA is a participant in ongoing research into the treatment of PTSD. The VA seeks to provide evidence-based care to all veterans. Beder and Postiglione (2013) noted that there are 9,000 social workers employed by the VA. These social workers provide a range of services to veterans. Strong et al. (2014) note that social workers employed at the VA provide case management services to complex patients, biopsychosocial assessments, evidence-based therapy, research, and utilization review. Social workers are depended on to provide high-quality care to the veterans who receive services at the VA. The Association of VA Social Workers (2017) supports the development of social work through education, training, research, and the dissemination of information to enhance the effectiveness of social work.

The values, ethics, and standards of the profession served as a guide for this research. This action research study supports social workers' responsibility to the broader society, per Section 6.01 of the NASW Code of Ethics (2017). This study explored the effects of multiple deployments on veterans' mental health and social functioning. These findings will potentially add to the general knowledge base of social work as well as other clinical professionals who provide services to veterans seeking services through the VA.

Review of the Professional and Academic Literature

I completed the literature review over 2 years using the resources of the Walden Library. I used the EBSCOhost search engine, and the SOCindex and PsychInfo databases provided peer-reviewed journal articles, which I reviewed to find literature related to this study. The Veterans Health Administration intranet provided data specific to PTSD. Key search words included *PTSD, military, multiple deployments, social workers, Iraq, Afghanistan,* and *Gulf War*.

Prevalence of Repeated Deployments and Mental Health Conditions

Frey, Collins, Pastoor, and Linde (2014) reported that for over 10 consecutive years, over 1.5 million troops have been deployed to combat zones in Iraq and Afghanistan. Military personnel experience multiple deployments in combat zones with shortened time frames between deployments compared to troops in past conflicts (Lamp, Maieritch, Winer, Hessinger, & Klenk, 2014). Multiple deployments are the result of having an all voluntary military force (Sadeh et al., 2017). Huang and Kashubeck-West (2015) found the OIF/OEF/OND conflicts resulted in military personnel serving multiple deployments in combat zones. During these deployments, they have experienced repeated combat missions, which increases exposure to traumatic events and thereby impacts their psychological and physical well-being (Huang & Kashubeck-West, 2015). Multiple deployments to combat zones may influence the incidence of PTSD in military personnel due to the ongoing stress and state of hyperarousal these service members experience.

Petrovich (2012) noted that military personnel who serve in war zones are taught to function at a heightened sense of arousal and to suppress their emotions and emotional

reactions while making rapid decisions to survive the combat experience. The military trains soldiers to prepare for combat but does not reorient them for their return to civilian life (Fragedakis & Toriello, 2014). Military personnel returning to their families from combat are still in a state of hyperarousal, which can make the transition back to civilian life difficult. Cigrang et al. (2015) indicated that military personnel were not prepared for the compound effects multiple deployments would have on their physical health, mental health, and relationships. Because OIF/OEF/OND were the first conflicts in which veterans experienced multiple deployments, it is understandable that the effects of multiple deployments are mostly unknown. The literature supports the need for an increased understanding of veterans' mental health treatment needs including depression and PTSD.

Posttraumatic Stress Disorder

Military personnel serving in combat zones are under increased stressors due to the threat of attack, personal injury, or death. According to Franklin and Thompson (2005), PTSD is one of only two diagnoses in the *DSM-5* (American Psychiatric Association, 2013) that require a precipitating event. Roy, Foraker, Girton, and Mansfield (2015) defined this precipitating event as the experience of severe trauma, such as combat-related trauma. Seppala et al. (2014) described PTSD as a stress disorder marked by hyperarousal, difficulties with emotional regulation, and autonomic dysfunction. Veterans who served in combat zones are at an increased risk of developing PTSD due to combat exposure (La Brash et al., 2009). Mott et al. (2014) reported PTSD as the most common diagnosis of OEF/OIF veterans. A diagnosis of PTSD can occur from a single

exposure to a traumatic event according to the *DSM-5* (American Psychiatric Association, 2013).

The *DSM-5* (American Psychiatric Association, 2013) provides the diagnostic criteria for a diagnosis of PTSD, with seven criteria considered when assessing and diagnosing PTSD: (a) exposure to severe trauma or death; (b) presence of intrusive symptoms associated with trauma; (c) avoidance of trauma-related stimuli; (d) negative moods associated with the traumatic event; (e) hyperarousal and reactivity due to the trauma; (f) the duration of symptoms lasts more than 1 month; (g) the trauma causes impairment in social, occupational, or other areas of life; and (h) the trauma is not caused by substances. Wright, Kelsall, Sim, Clarke, and Creamer (2013) reported that studies have shown multiple deployments as having a negative impact on the mental health of service members. Lamp et al. (2014) suggested that service members who served during OIF/OEF/OND may have a prevalence rate for PTSD of up to 41%. Multiple studies have shown rates of PTSD ranging from 14% to 44% (Huang & Kashubeck-West, 2015; Lamp et al., 2014; Quartana et al., 2014; Scioli et al., 2009; Seppala et al., 2014; Sharpless & Barber, 2011; Smith & True, 2014; Wright, Britt, & Moore, 2014). Due to the high rates of PTSD, it is important for social workers to have a comprehensive understanding of the needs of those who have served in combat zones.

Both qualitative and quantitative approaches have been used in research on PTSD, mental health diagnosis, substance abuse, and interpersonal issues for veterans of multiple deployments. Huang and Kashubeck-West (2015) completed a study with 289 Iraq/Afghanistan veterans. The veterans, recruited through veterans' organizations on

Facebook and veteran organizations, were provided online questionnaires to determine the effects of trauma on PTSD. The surveys were collected through SurveyMonkey, and the participants were asked to complete the deployment risk and resilience inventory's 15-item combat experiences subscale and post-battle experiences subscale to assess combat exposure. The 29-item Laufer-Parsons guilt inventory was completed to assess the veterans' level of guilt related to participation in a war zone. The 17-item PTSD checklist was used to assess overall symptoms of PTSD. The researchers found that veterans who held a lower rank reported higher levels of perceived threat than those of a higher rank. Of the 289 participants who completed surveys, 43% scored high enough to be identified as having PTSD. The research finding suggests that combat exposure, guilt, and perceived threat increase the probability of developing PTSD (Huang & Kashubeck-West, 2015). The data from the research study supports a correlation between trauma during combat and the increased probability for developing PTSD.

Military personnel serving in combat zones not only experience the stress and hyperarousal of conflict but also post-combat trauma (events related to combat but not direct threat of harm). Renshaw (2010) defined *combat exposure* as directly experiencing a traumatic event, such as the viewing of wounded civilians or soldiers or the handling of dead bodies, and *post-combat experience* as a situation or event that poses no immediate threat to life or safety. Renshaw (2010) further explored these effects in a study with 207 members of the Utah Army National Guard and Air Force National Guard to determine perceived threat of combat and post-combat experiences on symptoms of PTSD. The study participants were provided with the deployment risk and resilience inventory and

the PTSD checklist, military version. Both surveys use a 5-point Likert scale. The higher the scores, the higher the probability for developing symptoms of PTSD. The findings supported that combat, post-battle experience, and perceived threat are strongly correlated with PTSD symptoms (Renshaw, 2010). When a veteran has experienced both direct and indirect exposures, there is an increased risk in the severity of PTSD symptoms (Fragedakis & Toriello, 2014; Huang & Kashubeck-West, 2015; Interian et al., 2014; Sadeh et al., 2017).

Smith and True (2014) conducted a qualitative study with 26 OIF/OEF combat military personnel and found veterans were experiencing PTSD at a rate of 13% to 20% higher than any other previous war. The study was completed through one-on-one interviews using open-ended questions and lasting up to 4 hours. These findings were reflective of all types of military personnel and branches of service. Fragedakis and Toriello (2014) found that between 12% and 30% of the military personnel who served in combat zones during OIF/OEF/OND experience combat-related PTSD. The variance in the reports of PTSD may be representative of service members who were in combat compared to those who served in support positions on base.

Research shows that PTSD is linked to combat experiences as well as other potential mental health diagnosis. Sharpless and Barber (2011) reported of those diagnosed with PTSD, 83% have multiple diagnoses which include risk factors such as additional mental illness, drug and alcohol issues, relationship issues, and health problems. Roy et al. (2015) noted these health problems include “arthritis, liver disease, digestive disease, cancer, circulatory diseases, musculoskeletal, cardiovascular disease,

and respiratory systems" (p. 757). Screenings for PTSD and addiction would add additional supporting components to all medical treatment provided to military personnel who identify with these diagnoses. By adding these screenings, veterans may get the additional help needed through supports and treatment. In addition to PTSD, veterans are experiencing an increase in maladaptive issues that include aggression, violence, legal difficulties, substance abuse, interpersonal conflicts, marital issues, and family discord (La Brash, Vogt, King, & King, 2009; McDevitt-Murphy et al., 2012; Negrussa & Negrussa, 2014; Owens et al., 2014; Scioli et al., 2009; Smith & Gala, 2014).

Drug and Alcohol Use

A significant number of veterans who have been exposed to combat reported the use of alcohol or drugs to self-medicate (Cigrang et al., 2014; McDevitt-Murphy et al., 2015; Owens et al., 2014; Weiss et al., 2012). McDevitt-Murphy et al. (2015) reported veterans with PTSD report the prevalence of the comorbidity of PTSD and substance abuse in the OIF/OEF veterans ranged from 36 – 50%. These finding were supported in a quantitative study completed with 69 OEF/OIF veterans to determine if the diagnosis of PTSD would indicate increased alcohol use. The veterans were given Clinician Administer PTSD Scale, the Timeline Follow Back, the Drinker Inventory of Consequences, and the Modified Drinking Motives Questionnaire. The mean age for the veterans in the study was 32.2 years old. The study found 91% of the veterans reported consuming more alcohol than nonveterans in their age category. The veterans in the study scored higher for heavy drinking episodes, as defined by five or more drinks in one episode, then veterans without PTSD. Those veterans in the PTSD groups scored higher

for severity of alcohol use, alcohol use for coping-depression, and coping-anxiety (McDevitt-Murphy et al., 2015). The literature review shows a correlation between PTSD and substance abuse.

Weiss et al. (2012) reported 40% of the OEF/OIF/OND combat veterans engage in heavy drinking or binge drinking while few seek treatment. Owens et al. (2014) conducted a study of 133 veterans who self-reported PTSD and hazardous substance abuse. The veterans completed the PTSD Checklist-Military Version, Experiences in Close Relationships Scale-Short Form, Depression Scale, Alcohol Use Disorder and Drug Use Disorder Test, and the Conflict Tactics Scale. The study noted that veterans exposed to combat have a higher rate of developing PTSD, depression, and substance abuse. The results of the study also found that veterans with PTSD and substance abuse had an increased risk of aggression. Possemato et al. (2017) conducted a quantitative study with 112 OIF/OEF combat veterans with PTSD and substance abuse. The veterans were given the Clinician Administered PTSD Scale and the Structured Clinical Interview for DSM-IV, the Longitudinal Interview Follow-up Evaluation, and the Coping Response Inventory. The results of the study concluded veterans with substance abuse who do not seek treatment have increased chronic and severe PTSD symptoms. These findings are supported by Owens et al. (2014) who noted that between 2001 and 2009, 10% of the veterans who served during OIF/OEF and received care at the VA received a diagnosis of Alcohol Use Disorder. Another 5% have received a diagnosis of Drug Use Disorder. Scioli et al. (2009) reported approximately 30 - 50% of men and 25 – 30% of women with PTSD also have a substance abuse disorder. These rates are highest for veterans who

served multiple deployments in combat zones. Veterans reported drinking to reinforce or enhance positive emotions, improve social interactions, and to cope with negative emotions related to anxiety or depression (Scioli et al., 2009; Weiss et al., 2012). Those with higher levels of substance abuse experienced significantly higher levels of depression and anxiety (Owens et al., 2014; Weiss et al., 2012). These studies only report finding from the OIF/OEF wars. They do not include data from OND. As more research is completed, to include these service members, it can be assumed the previous findings will remain the same or higher for the use of alcohol and drugs.

Traumatic Brain Injury

The OIF/OEF/OND conflicts have seen an increase in service members with TBIs. TBI is described as the signature injury of the OIF/OEF conflicts (Manners et al., 2016; Scioli et al., 2009; Walter, Jak, & Twambly, 2015; Wisco et al., 2014). In a study conducted with 276 service members through a quantitative retrospective review of medical records using pre- and post-injury data. The Glasgow Coma Scale was used to determine TBI. Veterans with scores between 13-15 within 3 months of injury were included in the study. The research showed those who experienced a TBI had 40% a higher incidence of PTSD (Manners et al., 2016). These finding were supported by Williams, McDevitt-Murphy, Murphy, and Crouse (2017) who reported of the OEF/OIF veterans receiving care at the VA up to 44% had a positive screening for PTSD. Scioli et al. (2009) reference a study of 340 OEF/OIF veterans were 42.1% met the criteria for a diagnosis of TBI, PTSD, and chronic pain. These studies demonstrate the need for an increased understanding and treatment modality for veterans who experience TBI.

It is estimated up to 30% of all injuries reported are traumatic TBIs. Dismuke et al. (2015) reported there were 313,816 diagnosed accounts of TBI through February 2015. Traumatic brain injuries receive a rating of mild, moderate or severe (Wallace, 2009). Most of the TBIs experienced by service members are rated as mild (Manners et al., 2016). The symptoms range from short-term to long-term and vary in severity (Dismuke et al., 2015). Those who suffer from obtaining multiple mild TBIs in a short period can experience catastrophic or fatal consequences (Dismuke et al., 2015). Wisco et al. (2014) found veterans who experienced multiple TBIs or a single significant TBI including a loss of consciousness have a higher prevalence of suicidal ideation than veterans who had only one TBI.

Suicide

Military personnel have experienced repeated extended deployments. Zinzow, Britt, McFadden, Burnette, and Gillispie (2012) report 2 million troops have been deployed during OEF/OIF/OND of these 800,000 have experienced multiple deployments. The increased number of deployments increases the likelihood of military personnel being exposed to life-threatening situations further exasperating the chance of a later diagnosis of PTSD. Wisco et al. (2014) assert suicide among OIF/OEF/OND veterans is occurring at alarming rates with up to 6,500 veterans a year completing suicide (Ganzini et al., 2013). Veterans' suicide rate is twice that of the civilian population (Kopacz, Currier, Drescher, & Pigeon, 2016; Scioli et al., 2009). Veterans with PTSD have an increase probability of suicide due to depression, substance abuse, lack of support, anxiety, financial problems, and loss of family (Scioli et al., 2009).

Ganzini et al. (2013) conducted a qualitative study with 34 OEF/OIF veterans, from three different VA sites, using semi-structured interviews. The purpose of the study was to understand veteran's perspectives on suicide screenings and assessments during routine appointments at the VA. The interviews were recorded, transcribed and coded for meaning. In a companion study, they found that up to 59% of the veterans returning from OIF/OEF had been screened for depression. Of those 81% screened positive for suicidal ideation. The study found that suicide risk screenings have limitations based on veteran's concerns related to endorsing suicidal ideation and therefore may not be an accurate measure to assess suicidality (Ganzini et al., 2013).

A mixed-methods study was conducted by Wisco et al. (2014) with 1649 veterans through online or mailed questionnaires and telephone interviews to determine PTSD, TBI, and increased risk for suicidal ideation. The Deployment Risk and Resiliency Inventory was used to collect combat data, and structured interviews were used to collect information on TBI. The study found that those with a diagnosis of PTSD, alcohol use, and TBI have an increased risk for suicidal ideation among male veterans but not female veterans. The finding suggests those who have experienced multiple TBIs during combat missions have a higher correlation to suicidal ideation (Wisco et al., 2014).

Finley et al. (2015) and Seppala et al. (2014) reported veterans of OIF/OEF who experience PTSD symptoms have a higher prevalence rate for suicide. Finley et al. (2015) conducted a retrospective study of VA records of 211 652 OIF/OEF veterans over a 3-year period. Of these 205 899 were screened out due to no reports of suicidal thoughts or attempts. The findings suggest that veterans with co-occurring disorders have

an elevated risk for suicidal behaviors. This was further demonstrated in veterans who served during OIF/OEF/OND, 42% have been diagnosis with PTSD, TBI, and chronic pain: all of which individually have been shown to have a higher prevalence for increased suicide risk (Finley et al., 2015; Scioli et al., 2009).

The stigma around mental illness may add to the increase in suicide among veterans. Ganzini et al. (2013) reported that in response to the number of service members returning with symptoms of PTSD, TBI, and chronic pain, the Veterans Administration has established a suicide risk screening tool. When a veteran has a positive score, based on answers in the screening for depression or PTSD screening, the suicide risk screening tool is completed (Department of Veterans Affairs & Department of Defense, 2013). The VA requires all staff to go through suicide prevention training to identify, recognize, and provide intervention for veterans experiencing suicidal ideation (Ganzini et al., 2013). Recognition and intervention are key to reducing suicide in the veteran population.

Relationships

Deployments cause stress for the military member and their families. Repeated deployments increase this stress through the addition of instability in marital relationships and parental roles (Love et al., 2014; Scioli et al., 2009). Between 2001 and 2004 reports of domestic violence increased substantially and divorce rates tripled (Bowling & Sherman, 2008). Sherman et al. (2015) found 63% of the veterans with PTSD were also parents with a child living in the home. Veterans who are returning from combat deployments who have families may have added stressors which impact their PTSD.

Sherman et al. (2015) conducted a mixed methods study with 19 veterans at multiple VA sites. The inclusion criteria included a diagnosis of PTSD, having at least one child and living in the same home as the child. The quantitative data was gathered form the PTSD Checklist, Alcohol Use Disorder Identification Test, Patient Health Questionnaire, and the Dimensions of Anger Scale. The qualitative data was gathered through semi structured interviews lasting up to 2 hours. Data was analyzed using content analysis and then coded for emergent themes around PTSD, family, and communication. The study found 95% of the veterans screened positive for PTSD, 84% were positive for depression, 42% were positive for alcohol abuse, and 95% reported difficulties with anger (Sherman et al., 2015). Asbury and Martin (2012), report 70% of the 2 million service members deployed during OEF/OIF/OND are married.

Everson, Herzog, Figley, and Whitworth (2014) asserted that deployments lasting greater than 6 months, as well as multiple deployments, have shown an increase in anxiety and depression in both the service member and their family members who are left at home. These factors can be problematic when the service member returns home from deployment and transitions to civilian life. Mustillo et al. (2014) noted veterans with PTSD have trouble reintegrating into their roles within the family and receive less satisfaction parenting while simultaneously experiencing it as more problematic

Mustillo et al. (2014) conducted a quantitative web-based study with 206 National Guard members in 2008. Of the 206 participants, 87% were married and all were fathers with a child under the age of 18 living in the home. Study participants could complete three online surveys every 4 months for 1 year post-deployment. The study participants

were given the Naval Center for Combat and Operation Stress Control, the Primary Care PTSD Screen, and the Patient Health Questionnaire to asses for combat exposure, PTSD and depression. In addition, they were provided with questions to determine parenting difficulties, marital relationship, unit support, social support, and employment status these were measured on a Likert Scale. The study found that traumatic combat exposure was related to depression and PTSD. The study further found that increased depression correlated with parenting difficulties.

Scioli et al. (2009) reported that 81% of the veterans deployed to combat zones and diagnosed with PTSD or depression committed a least one act of interpersonal violence against their partner (Owens et al., 2014). Fisher et al. (2015) conducted a qualitative study with 81 veterans and 65 family members who use services at the VA. Participants were divided between facilitated focus groups and qualitative interviews. Focus groups were divided into male veterans, female veterans, and family members. The emerging themes from the focus groups and interviews were relationship problems, problems with trust, problems with anger management, substance abuse, and physical health. Veterans expressed a desire to have family participate in reintegration post-deployment while transitioning to civilian life. These findings are supported by Negrussa and Negrussa (2014) who noted these relationships maintain stressors, anxiety, and reinforce maladaptive coping mechanisms such as drinking, domestic violence, and aggressive behaviors. Families need support during periods of reintegration to minimize the negative effects of deployment. Without additional family supports the family is at an increased risk of dysfunction.

Military personnel with untreated PTSD have an increased risk of divorce due to drinking and aggressive behaviors within the family dynamic. Research completed by Negrussa and Negrussa (2014) reported a higher frequency of divorce among OIF/OEF/OND service members with PTSD by 20% and other diagnosis by up to 75%. Longitudinal studies have correlated longer deployment times with increased probability of divorce (Cigrang et al., 2014; Negrussa & Negrussa, 2014; Sherman et al., 2015). When combined with multiple deployments and symptoms of PTSD, there is a 20% higher chance of divorce (Negrussa & Negrussa, 2014). The literature supports the experiences of OIF/OEF/OND veterans having a significant increase in PTSD, mental illness, addictions, interpersonal, and legal issues (Fischer et al., 2015; LaMotte et al., 2015; Meis et al., 2017; Negrussa & Negrussa, 2014; Owens et al., 2014; Seppala et al., 2014; Strong et al., 2014). The purpose of the study was to bridge the gaps in social workers knowledge on military experiences, potential for multiple diagnoses, and knowledge of personal experiences of veterans who served multiple deployments.

Summary

The United States has been involved in wars and military action throughout history. The OEF/OIF/OND war has been fought by an all voluntary military force with service members being deployed to combat zones multiple times (Interian et al., 2014; Parenti, 2006). The purpose of the study was to understand social workers' perceptions of the psychosocial needs of veterans who have served multiple deployments in combat zones. In addition, social workers were asked to share their experiences in addressing the

psychosocial treatment needs of veterans who served multiple deployments in combat zones.

An action research methodology was used to collect qualitative data from a purposive sample of social workers who provided services to veterans who have served multiple deployments in combat zones. The study was conducted using narrative theory as a framework allowing for the understanding of the social workers' experiences, interpretation, and perceptions of veteran's needs (Buettgen et al., 2012; Cihodariu, 2012; Haydon et al., 2017). Social workers were asked to take part in a focus group to answer questions related to their experiences when working with veterans. The study provides an increased understanding of how social workers assist veterans, who have served multiple deployments in combat zones, to enhance their mental health and social functioning. The NASW Code of Ethics (2017) provides the values, principles, and standards by which social workers conduct themselves and provided the framework for the ethical standards used in the research process.

The literature review addressed the issues veterans who have served multiple deployments experience. It has been proposed that combat veterans suffer from complex PTSD related to serving in combat zones (Renshaw, 2010). Today's combat soldiers are trained for experiences related to deployment; however, they are ill-prepared to return to civilian life thus compounding the effects of combat exposure (Negrussa & Negrussa, 2014).

The stigma associated with seeking mental illness or addictions treatment has prevented soldiers and veterans from asking for help, which leads to high rates of

substance abuse, interpersonal issues within the family, and the potential for increased risk of suicide. The Veterans Health Administration has taken an active role in the research and treatment of both active duty and veterans in the treatment of PTSD and suicide prevention services.

Veterans who have served in combat zones have an increased incidence of comorbid diagnoses (Fragedakis & Toriello, 2014; Walter et al., 2015). These diagnoses include mental illness, substance abuse, TBI, and interpersonal relationship issues, such as divorce, loss of employment, or incarceration (Fischer et al., 2015; LaMotte et al., 2015; Meis et al., 2017; Negrussa & Negrussa, 2014; Owens et al., 2014; Seppala et al., 2014; Strong et al., 2014). Without treatment, veterans who experience comorbidities may seek suicide as a means of escaping from these symptoms that they cannot manage on their own.

Section 2: Research Design and Data Collection

OIF/OEF/OND have had profound impacts on the volunteer military force that has been used to fight these wars. Interian et al. (2014) indicated that military members serving in OIF and OEF are experiencing multiple deployments in combat zones, which can have severe impacts on their psychological and physical well-being. Owens et al. (2014) and Smith and True (2014) reported that some of the consequences of multiple deployments could be increased incidence of PTSD, depression, addiction, TBI, and increased divorce rates can be the consequence of multiple deployments. Military personnel have experienced repeated deployments prior to receiving treatment for PTSD, mental health symptoms, or drug and alcohol dependence.

I used a qualitative research design for this study and purposive sampling to identify social workers who provide services to veterans with multiple deployments. Through a focus group, the participants discussed their perceptions and experiences related to helping these veterans. The focus group was recorded using audio recording devices on two audio recording devices for data-collection purposes. The recordings were transcribed verbatim for analysis using a transcription software system called Dragon Naturally Speaking. I analyzed data through both deductive and inductive techniques. I used reflexivity and other tools for trustworthiness to help ensure ethical standards.

Section 2 includes specific descriptions of the design, a review of the research methodology used, the data collection method, and the plans for data analysis. To conclude the section, I present plans for how ethical research practices can be implemented.

Research Design

The purpose of this action research study was to understand the perceptions and experiences of social workers in western Washington regarding the psychosocial treatment needs of veterans experiencing multiple deployments, operationalized as three or more in a combat zone, during OIF/OEF/OND. Another goal was to understand, from the social workers' perspective, whether the services provided enhance veterans' mental and social well-being.

Action research provides a researcher with new insights, ways for potential improvements that add value and benefit for both what is currently known and the development of future practice (Fenge, 2010). Social workers who provide direct services to military personnel and veterans are a valuable resource because they have direct knowledge of the needs of the veterans served. A sample of these social workers will help understand treatment for veterans with multiple deployments for this study.

I used a qualitative research design for this action research study. Dilshad and Latif (2013) claimed that qualitative research designs gain the perspectives of the interviewees and understand the quality of their experiences about specific situations. According to Thiollent (2011), qualitative research is frequently conducted using narrative methodologies. I conducted a focus group using a narrative framework. Narrative interviews are a source for obtaining information based on experiences, insider experiences, and privileged insight.

Social workers who provide services to veterans volunteered to participate in narrative interviews through a focus group. The social workers selected to participate in

the study had an intimate knowledge of the needs of the veterans served by a VA location in Washington. Brown (2015) supported that focus groups are a means to obtain a substantial amount of qualitative data in a social context. Hickson (2016) reported that the narrative methodology provides a framework for qualitative research allowing for an increased understanding of social phenomena. I provided a setting that allowed the focus group participants to engage with each other by discussing their individual experiences in a safe and confidential environment. Dilshad and Latif (2013) defined a focus group as a group type setting for communication for a specific purpose about a specific subject. The interactions of the focus group produced data based on the perceptions, impressions, and experiences of the research topic, including the social workers' insights into potential issues and solutions. According to Thomas (2012), the basis of narrative cognition is human actions, which are determined by differences and diversity. Narrative is an approach sensitive to the human experience and helps to seek enhanced meaning and to reduce uncertainty.

Methodology

Social workers employed in western Washington explored the perceptions and experience related to the treatment for veterans of multiple deployments. These social workers provide services to veterans of OIF/OEF/OND who present with symptoms of PTSD. The focus group was a natural environment for social workers to share their experiences. Focus groups have three defining characteristics that were beneficial to this study: (a) the group facilitator used prompts to focus the discussion, (b) the group facilitator was an active participant in the process, and (c) participant interactions were

assigned value (Dilshad & Latif, 2013). Social workers who participated in the focus group provided firsthand knowledge and insights into the complex needs of veterans, enhancing the current knowledge about the treatment needs for veterans of multiple deployments.

These characteristics were of value as the focus group was assembled to gain clarity on the treatment needs of veterans. Kaner (2014) suggested that due to the fluidity of a focus group and the professional experiences social workers bring to the forum, a proposed research problem may be adjusted based on suggestions from the social workers. The focus group participants provided information to help make changes by sharing their insights and potential for changes in the way social workers use treatment approaches for veterans of multiple deployments. Social workers shared insights into the issues related to treatment approaches during the focus group.

Data Collection

The researcher used a nonprobability sample for the focus group. The nonprobability sample was used to identify social workers with experience working with veterans who have served multiple deployments. Groves et al. (2009) noted that researchers using nonprobability sampling may experience sampling bias. Sampling bias might be introduced as not all interested social workers will have an equal chance of being selected to participate in the research study. The focus group was comprised of social workers who provide services to veterans, which was appropriate for this study. The focus group was a homogenous purposive sample, a type of nonprobability sample selected based on the shared characteristics of the set (About Education, 2016; Wretman,

n.d.). I was mindful of bias resulting from the participation of social workers who were employed by the VA and participating in the research study. To maintain credibility, validity, and reliability, I used a reflexive journal to be mindful of potential biases and internal and external threats, thereby increasing the trustworthiness of the findings (Buckner, 2005). I used a reflexive journal prior to the focus group, during the focus group, and throughout writing the research findings. The journal provided a venue for me to maintain objectivity in the focus group and in the research process (St. Louis & Barton, 2002).

The focus group was the only source of data collection. According to Thomas (2012), because social workers already understand the needs of veterans, the focus group allowed for a more natural flow during the discussion and provided complex social data (Dilshad & Latif, 2013). Groves et al. (2009) stated that focus groups can identify words and terminology that may be unclear or ambiguous. According to Kaner (2014), a researcher, or interviewer, can provide clarification and help motivate the participants to provide complete responses to the interview questions being asked for the study using open-ended questions in a safe, respectful, and confidential environment. To generate discussion, the focus group should have between eight and 10 members (Vogt, King, & King, 2004). Data were collected from eight master's-degree-level social workers in Washington, who currently provide services to veterans who served multiple combat tours during OIF/OEF/OND and who work in primary care, outpatient mental health, inpatient mental health, or the warrior transition unit in western Washington. The focus group met for one session lasting 2 hours and included a rest break for the participants.

Data from the focus group were collected on three audio recorders and transcribed using Dragon Naturally Speaking dictation software.

Participants

Recruitment of social workers was done through announcements on Facebook and Linked In. These announcements included a summary about the study and how to contact the researcher if interested in participation. According to Kaner (2014), due to the fluidity of the focus group and the professional experiences the social workers bring to the forum, the proposed research problem may be adjusted based on these insights. Bradburn et al. (2004) noted the focus group might develop additional variables which would need to be included, operationalized and synthesized in the action research study. The social workers brought increased insights, knowledge, and expanded on earlier ideas.

Participants were social workers who provide services to veterans who served in multiple deployments. These social workers were voluntary participants in the focus group. The focus group was the only source of data collection for this study. The reason for this purposive sample was that social workers have experience working with veterans who have served multiple deployments and therefore understand the veteran's psychosocial treatment needs (Dilshad & Latif, 2013; Thomas, 2012). Based on my knowledge of the population and the purpose of the study, a purposive sample was selected. I was able to provide clarification as necessary and provided prompts to motivate the participants to provide complete responses to the questions.

The focus group consisted of a session lasting 2-hours. A break was provided at the 1-hour mark. This break allowed the participants to regroup and refocus for the

second half of the focus group. According to Stringer (2007) the initial meeting will consist of an explanation of the purpose of the focus group, answering any questions about participation in the focus group, and obtaining signed informed consent forms from the social workers (Stringer, 2007). Once informed consent was received, I outlined the rules of conduct, allowing all members of the focus group to be comfortable in expressing opinions and ideas, and maintain confidentiality of what was shared in the group as well as information about the study (Dilshad & Latif, 2013).

Instrument

The instrument was a self-designed interview protocol, based on material from the literature review, the theoretical lens, and my understanding of the topic. Prior to the start of the focus group, protocols were put in place to ensure that the participants felt safe and respected. These rules allowed for open and candid answers to questions related to the research topic. Questions were related to social workers experiences when providing services to veterans who have served multiple deployments. The interactions of the social workers in the focus group produced a set of data based on their perceptions, impressions, and experiences when working with veterans who served during OIF/OEF/OND. The answers to these questions provided for the outcomes analyzed for this study.

Data Analysis

A qualitative focus group was used for data collection. The focus group consisted of eight master's-degree-level social workers who have experience working with veterans. The social workers were provided with a number unique to each of them to ensure confidentiality. The focus group was audio-recorded using three devices. Dragon

Naturally Speaking dictation software was used to aid in the transcription of the recordings. The use of an audio recording device ensured the proper identification of group participants and the accuracy of the data collected.

I manually transcribed the audio recordings verbatim into written text. The transcription for the two recording devices was compared for accuracy. Once this process was completed a comparison of the manually completed transcription and the Dragon Naturally Speaking dictation software transcription was completed assessing for accuracy. Focus group participants were asked for clarification when necessary to ensure accuracy and to decrease threats to validity (see Norton et al., 2011). Once accuracy was verified by the focus group, transcripts were read for content analysis. The data were organized using Excel documents and Word software. The content analysis involved both deductive and inductive techniques. Per Baffour and Chonody (2009), an inductive approach was used to define emerging codes in the data set. This was done using descriptive and NVivo coding. Once coded, the data were categorized and further refined by themes that address the research questions. Once the emerging themes from the focus groups were identified, the frequencies and percentages for these themes was computed.

This qualitative research study followed the standards outlined by Kaner (2014) for conducting a focus group. The focus group was conducted using open-ended questions. The use of open-ended questions is designed to allow participants to engage in conversational dialogue. This dialogue provides a rich source of information regarding the social workers' experiences serving veterans of multiple deployments. Both audio recordings and transcripts will be kept in a secured, locked cabinet providing further

evidence the study was completed and providing another layer of validity. Following this framework ensures that rigor has been met. According to Stringer (2007) rigor in action research is outcome-based and supports trustworthiness. To establish the trustworthiness, the research study followed the ethical procedures as directed by the NASW Code of Ethics (NASW, 2017). Following the ethical guidelines for research protects the data collected and prevents research participants from harm. Hughes, Pennington, and Makris (2012) further report the collection of data through interviews and recordings ensures for research validity. A reflexive journal was kept monitoring for bias and thereby increasing the validity and trustworthiness of the research (Barusch, Gringeri, & George, 2011; Malacrida, 2007).

Ethical Considerations

The established guidelines of Walden University and the Internal Review Board (IRB) guided all research. The IRB reviews research proposals for ethical standards and compliance with federal regulations. IRB approval (03-07-19-0600084) was required prior to the beginning of the data collection phase of the research project. Confidentiality was maintained in the interview setting and storage of research materials. Informed consent was discussed prior to the focus group, and signatures were obtained before research questions were asked. Group participants were given the option of declining further participation as well as information on excusing themselves from any future groups related to this study.

The social workers were asked if they would be willing and able to participate in future groups if necessary, to complete the study. Social workers were asked to provide

their availability for future groups related to this study. As the social workers committed to a 2-hour group; refreshments were provided at the break and at the completion of the group. The focus group was conducted in the conference room at a library in Pierce County to ensure a safe, comfortable environment with no interruptions allowing the social workers to openly share their experiences working with veterans who have served multiple deployments.

Each social worker was assigned a number for use during the focus group. This assigned number was recorded on their informed consent form. The study participants were asked to identify themselves by this number prior to responding to the research questions ensuring participant confidentiality. The group participants were given direction to state their number before beginning their response to questions as well as direction for only one speaker at a time, maintaining a respectful environment allowing for the sharing of experiences.

The focus group was conducted in person using three recording devices to capture all data. The recorded data was analyzed through comparisons of the social workers' experiences working with veterans of multiple deployments. One audio recording device includes Dragon Naturally Speaking dictation software that transcribe the information provided. The data on the other audio recording device was transcribed verbatim by the author. All research materials, audio tapes, and transcribed data is being maintained in a locked filing cabinet, within an office with restricted access, to ensure security. This data will be kept for a period of 5 years. After 5 years the data will be shredded and disposed of through a confidential document collection company. In the event, I leave my current

position; the data will be transferred to my home where it will be stored in a double-locked cabinet. There will be no identifiable client information on any reports disseminated to the public.

Summary

A homogenous purposive sample, a type of nonprobability sample, of social workers was selected based on the shared characteristics of the social workers who work with veterans who with multiple deployments. The social workers participated in an audio recorded, focus group to understand their perceptions and experiences working with veterans who have served multiple deployments. These recordings were transcribed verbatim. The participants were given the opportunity to review the transcriptions for accuracy. The content analysis involved both deductive and inductive techniques. Content themes were determined, and keywords reviewed for coding. After all the material was coded, themes were identified to answer the research questions. The information gathered from the focus group may increase the understanding of the social worker's experiences of providing services to veterans who have served in multiple deployments. The research data will be shared with social workers' who provide valuable service to OEF/OIF/OND veterans. In the following section, I will describe the sample characteristics and the findings of the study.

Section 3: Presentation of the Findings

The purpose of this qualitative research study was to understand the perceptions and experiences regarding multiple deployments, operationalized as three or more tours in a combat zone, during OIF/OEF/OND which have had cumulative effects on the mental health and social functioning of veterans who receive care through veteran services in western Washington. Through this action research study, I developed an understanding from the social workers' evaluations of the cumulative mental health and social effects of multiple deployments on their veteran clients. Two primary research questions and one subquestion guided this study. The questions were specific to social workers who provide services to veterans who have served multiple deployments.

RQ1: What are the perceptions of social workers in western Washington regarding the psychosocial treatment needs of veterans who experienced three or more tours in a combat zone during Operation Iraqi Freedom/Operation Enduring Freedom/Operation New Dawn?

RQ2: What are the experiences of social workers in western Washington providing services to address the psychosocial treatment needs of veterans who experienced three or more tours in a combat zone during Operation Iraqi Freedom/Operation Enduring Freedom/Operation New Dawn?

SQ1: From the social workers' perspective, are the services provided enhancing the mental and social well-being of veterans?

I analyzed the data collected from the focus group using descriptive and NVivo coding. The results were filtered down to determine the categories and themes relevant to

answering the research questions. In the following sections, I provide a summary of the processes used to analyze the data and present the findings to answer the research questions.

Data Analysis Techniques

After receiving IRB approval number 03-07-19-0600084, I started the data collection process with a 3-week period of recruitment for social workers interested in participating in this research study. The focus group consisted of eight social workers, one of whom had to leave at the 30-minute break. All the social workers held a master's degree in social work and had a minimum of 2 years of experience working with veterans who have served multiple deployments. One focus group was used to gather the necessary data for the research study. The focus group was held at the local branch of the public library and lasted 2-hours with a 30-minute break after the first hour.

Once the focus group was completed, I transcribed the data. Transcription was completed in 1 week. Three audio recording devices were used in case error or malfunction occurred. Only two of the three audio recording devices were used for transcription because one malfunctioned and did not record. One of the recording devices was transcribed through Dragon Naturally Speaking dictation software. I manually transcribed the data on the second recording device. The data from the two devices were compared for accuracy. Upon completion of the transcription process, I began the coding process using Microsoft Excel to organize the data with descriptive and NVivo coding, which produced the categories and identified themes. I started the data analysis of the focus group with 507 NVivo and 457 descriptive codes, which I analyzed and

synthesized down to 10 categories. The overall process of coding took 1 week. To better understand the research questions, I developed five themes from the stated categories. I used NVivo coding to identify keywords and terms used by the participants of the focus group. Descriptive coding was used to categorize the keywords and terms. I identified themes following the coding process through synthesis of the information. I discuss the themes further in the findings section.

Using a reflexive journal helped me to be aware of any personal biases and be mindful of how these biases could affect research outcomes. I used a peer debrief process to help eliminate any biases. This peer was not employed at the VA and was not a part of the research study, which helped to provide me with unbiased feedback. I communicated with my peer support every few days to discuss the coding process and synthesizing of data to include the categories and themes identified. The peer debriefing process provided the opportunity to process my thoughts and feelings related to the research process and analysis to ensure the accuracy of the information gathered from the focus group to conclude the findings. I maintained the reflexive journal prior to the focus group, during transcription, coding, member checking, and data analysis.

Limitations

A limitation of this study was that all participants were employees of the VA, although they represented different treatment specialty sections. Having representation from only the VA and not external organizations may have limited the information regarding social workers' experiences when working with veterans who have served multiple deployments. Another limitation of the study was that all participants were

Caucasian; therefore, there was no ethnic diversity among the study participants. In addition, only one of the participants was male, thereby limiting the male perspective on the research study. An identified potential conflict was that some of the social workers who participated in the study and provide services to veterans are veterans themselves. This opens the possibility of potential biases, even though none of these social workers had experienced multiple deployments to combat zones themselves.

Findings

The purpose of the study was to understand social workers' experiences working with veterans of multiple deployments and how multiple deployments impact the veterans they provide services to. I wanted to understand the barriers and limitations of social workers who provide services to veterans with multiple psychosocial needs. The social workers who participated in the study provided increased insight into the care needs of these veterans and the barriers they encounter in their work with veterans. The findings from the focus group supported the literature review that veterans who served multiple deployments have increased psychosocial needs. This section will include the demographics of the focus group participants, specifics about coding, and research findings.

Sample Characteristics

The focus group was comprised of seven female social workers and one male social worker. Each held a master of social work degree. The participants were all Caucasian. The areas in which the participants worked included transition service from active duty to civilian, mental health, substance abuse, residential care, homeless

services, and case management services for both inpatient and outpatient care. Participant responses were quoted verbatim. To maintain confidentiality, these participants were given the following pseudonyms: Bella, Henry, Jade, Lola, Natalie, Patti, Ryanne, and Victoria. Social workers who work with veterans who have served multiple deployments reported experiences centered around five themes.

Theme 1: Increased Trauma Exposure

Veterans who served multiple deployments in combat zones have an increased risk of exposure to trauma. Veterans with multiple exposures to trauma have increased incidence of PTSD, substance abuse, mental illness, psychosocial need, and relationship issues. The participants quickly identified trauma as the common factor for many of the veterans they provide services to. Bella stated:

> We all know that the more deployments that you have, your odds go up that you are going to be affected by more and more trauma. Veterans can many times have multiple layers of trauma that they are dealing with, so a great deal of time and energy goes into developing trust and rapport.

Jade agreed and shared her experiences working with veterans with the group:

> Veterans with multiple deployments report a myriad of PTSD symptoms more often than those with just one deployment. Symptoms include high anxiety, severe depression, fearful, hyperactivity, active leg movements, poor eye contact, and many report recent, if not chronic, suicide ideations and are poor historians based on their inability to remember dates or specifics related to their trauma.

This finding was supported from the experiences of other social workers who participated in the focus group. Natalie reported that the veterans she works with present with "extreme anxiety, anger and irritability, avoidance and isolation, hypervigilance, mistrust, numbing of emotions, nightmares, substance or alcohol misuse or dependence, depressed mood, negative intrusive thoughts, suicidal/homicidal ideation, and paranoia related to their mistrust." Jade agreed with Natalie and stated, "It is clear that these veterans need a lot of support and kindness, along with validation of their symptoms, and encouragement to engage in outpatient or inpatient PTSD treatment." All the social workers' agreed that veterans who served multiple deployments need support that includes supportive therapy services.

The social workers discussed how detrimental trauma can be to the veterans and how this not only relates to PTSD but also other areas of functioning, such as addiction and psychosocial concerns. Victoria discussed this further when she stated:

> The effects of PTSD are often crippling. It often does lead some to self-medicate, which then introduces substance abuse into the equation of their challenges. They will often self-isolate and display a lot of avoidant behaviors. These behaviors have negative effects in making social connections and building meaningful relationships with others.

The compound effects of trauma can be seen in the comorbidity of mental health issues and concurrent drug or alcohol abuse. The social workers discussed how these psychosocial needs impact the veterans they see. Ryanne shared her experiences when she engages with veterans:

> Primarily a lack of trust in large systems as well as complicated multisystem needs due to comorbidity and increased psychosocial needs. I see an increase in lack of engagement coupled with increased expectations from the veterans. Serious complicated psychosocial needs include homelessness, substance abuse, and legal.

These comments led to a discussion on how veterans who experience multiple deployments and trauma have a higher incidence of substance abuse or dependence.

Substance Abuse. The use of substances was identified as a subtheme to the theme of increased trauma exposure. The social workers discussed how trauma, pain, and a culture of alcohol use all contribute to veterans experiencing issues with substance abuse. In addition, the social workers reported that with every deployment, the potential of developing addiction increases. Henry added to this further:

Environmental forces are what can bring these things to light and there is probably not a better fodder than or worse environment to get somebody triggered who might have a propensity to become addicted than combat. The more we expose them, the more the environment can trigger those situations and the more trauma they are potentially exposed to. This brings to light an opportunity for people who may not have normally had an environmental trigger to become addicted. The chances are significantly increased with every additional deployment.

The social workers agreed that there is a culture of alcohol use in the military and this culture of use leads to the abuse and dependence of substances. The acceptance and perceived expectation to consume alcohol is prevalent, as noted by Ryanne:

> Longer in service means more exposure to a culture of alcohol or substance abuse, so the longer they are in the military environment it is going to increase the rate of deployments, but I think the exposure to the cultural of substance use in the military is just inherent, and I think is a component.

Victoria agreed, reporting that "of the multiple deployed veterans I have worked with, I would say about 50% are afflicted with significant substance abuse issues." Veterans who are engaged in substance and alcohol use as a means of adaptive behaviors are also harder to engage in treatment, as noted by Henry:

> Veterans who have served multiple deployments appear to have become more firmly rooted in the culture of the theater of combat. They have often normalized maladaptive behaviors, such as substance use, and now struggle to see the benefit of letting go of these protective mechanisms. It seems to take longer to build rapport and establish therapeutic relationships with veterans who have participated in multiple deployments.

The reluctance to engage in a therapeutic relationship and therapy may impact all areas of veterans' lives. The group discussed how pain can be an entry into addiction. This was further explored by Lola whose experiences reflect how veterans report having pain:

> Most of the time back issues, knee issues, everything is painful. So over time as the deployment drags on, that ranger candy is what you are chewing on; eventually, you move on to something which will sustain you for a longer time.

> So that's when we have the opiates. In my head, opiate addictions start with an injury or physical pain.

Lola's experience was validated by Henry who added, "Absolutely, we hear report after report of people coming back from deployment on pain medication for acute pain or semichronic pain from combat." The use of pain medications for the treatment of injuries sustained during deployment may potentially lead to addiction.

The social workers identified veterans' resistance to treatment as a factor in ongoing addiction and mental health issues. They identified many issues and shared some of their insights. Jade reported that veterans may be "quite fearful about treatment and need a good deal of support and reassurance." Veterans' lack of trust and fearfulness of the system impacts their ability to engage in treatment and further impacts their psychosocial needs. The issues around trauma and trust were discussed as a reason for not making appointments or engaging in treatment. These experiences were supported by Natalie:

> I believe the psychosocial stressors which impact one's ability to fully immerse themselves into treatment is one of the biggest challenges. When veterans are faced with homelessness, legal, substance dependence, and relationship difficulties, it can feel like they are constantly in crisis mode, which makes it difficult for them to engage in addressing the underlying causes to their barriers.

The social workers agreed that when veterans have developed maladaptive behaviors, it takes longer for the social worker to engage the veteran in therapeutic

services. The social workers reported that when they are able to validate and normalize the veteran's experiences, they see increased engagement in treatment by the veterans.

Theme 2: Evidence-Based Treatment

The second theme identified by the social workers was the use of evidence-based treatment modalities to address the compound treatment needs of veterans. The social workers report employing a variety of evidence-based treatments. These treatment modalities include acceptance and commitment therapy, adaptive exposure, case management, cognitive behavioral therapy, cognitive processing therapy, distress tolerance, mindfulness, motivational enhancement therapy, motivational interviewing, prolonged exposure, and systems theory.

There are a variety of evidence-based treatments utilized in providing services to veterans. The services veterans receive should include validating while also normalizing these experiences. Evidence-based treatments have gone through numerous studies to determine the efficacy of specific approaches (Miller, Zweben, & Johnson, 2005). During the focus group the social workers discussed their thoughts on evidence-based treatments and the treatment methods they currently utilize in their work with veterans. The social workers employ several evidence-based therapeutic models in their work with veterans.

Most of the social workers work in different departments and provide a variety of services but they were all in agreement that motivational interviewing and mindfulness are two of the most frequently used treatment modalities. The social workers reported using these as complementary treatment modalities with other evidence-based therapies Natalie shared that she has "found the evidence-based treatment approaches to be the

most helpful such as prolonged exposure, cognitive processing therapy, adaptive disclosure, distress tolerance skills." Bella shared with the group that as a first step to treatment she finds that using "motivation interviewing just really assists veterans to focus in on what it is or where to begin." Ryanne agreed with Bella:

> Definitely, motivational interviewing because they really struggle with that internal motivation and often times when they see me, they in a residential environment it is an external reason that they are there. I also take a systems approach with them so they can understand the correlations between what is happening outside of them as well as what is happening inside of them how they relate. Cognitive behavioral is really digging into the distorted thoughts.

Patti agreed with the others and reported "motivational interviewing then cognitive behavioral are my team's main modality." The use of motivational interviewing assists the veteran in developing understanding into their ambivalence into their treatment needs (Crowe & Parmenter, 2012). In addition to motivational interviewing Henry reported using motivational enhancement therapy:

> Mindfulness would be another modality in which we try to help veterans to find some way to get grounded and centered at least when dealing with acute stress, coming home and managing acute symptoms, and cultivating long-term peace of mind. Motivational enhancement therapy is very much the treatment of choice right now. It crosses the boundaries of co-occurring disorders it can be used for a variety of things and just trying to help get them clear headed enough to where a more focused treatment approach for their symptoms of PTSD could be effective.

The use of mindfulness was supported by many of the social workers in the group. Bella reported, “I incorporate mindfulness activities some mediation to kind of end our group.” Veterans are requesting mindfulness, as noted by Ryanne:

> We found the responses from the veterans who were younger and had more deployments than those who either didn’t deploy or just had one they requested mindfulness more, so we increased the amount of mindfulness that we use in our program.

According to Lola “general case management helps to just try and nail down what are the treatment goals and where do we need to head with this” in regard to the veteran’s treatment needs.” Ryanne shared her thoughts on case management:

> Case management services kind of really digging into the psychosocial concerns that are happening. Their immediate needs, because often times there is some substance abuse going on or homelessness going on, just really trying to find the nuts and bolts of what do they need right now. To help them focus on their immediate needs and why they are seeing me. When they present with substance use, we also use acceptance commitment therapy (that is ACT) a lot. To help them come to terms with this idea of just generalized acceptance.

The social workers agreed there are many evidence-based treatments used which support veterans and the approach chosen is based on the individual needs of the veteran. In addition to evidence-based treatment the group participants discussed the need to normalize the veteran’s experiences through listening, educating, and validation. Patti discussed how she “provides them with the education piece of what is going on in their

brain. Why do they respond this way now to stress? It helps them feel like it is normal." Ryanne shared how when working with veterans "who struggle with suicide ideation and when you normalize suicide ideation as a natural symptom of depression how much relief that take for them in that moment. Being able to normalize these things is really good for them." The concept of normalizing was shared by Henry when he talked about group work:

> I think what I have witnessed is group therapy in general is just amazing at letting them normalize with each other and realizing I am not alone in this process. Allowing them to realize I am not alone is just instantly obvious when you see and watch that process.

Natalie added that "through normalizing their symptoms, encouraging the recovery-oriented model approach to treatment, we provide healthy copings skills." The use of these models as well as utilizing a client-centered approach allows the social workers to normalize and validate the veteran's experiences. Members of the group reported once the veteran felt validated it was easier to build rapport and engage in meaningful treatment.

Theme 3: Reintegration

The third identified theme expressed by the group participants is related to the difficulty's veterans have when reintegrating into civilian life. Issues related to reintegration include their inability to connect with family and friends due to emotional numbing and isolative behaviors. Veterans have difficulty reintegrating into their families and communities due to their combat experiences which result in emotional numbing,

avoidance, and isolation. Social workers have found that veterans who connect culturally are able to build trust and relationships aiding in their reintegration.

During the focus group the social workers discussed how veterans struggle to reintegrate into, post deployment, civilian life. The social workers reported many of the veterans they work with report being numb after deployment. There was agreement among the social workers that the numbing of emotions makes it difficult for the veterans to reintegrate with family, friends, and community leading to isolative behaviors. When providing services to these veterans the social workers reported using evidence-based client-centered recovery models. Patti reported when working with veterans who served multiple deployments:

> So, what we see is an extreme numbing of any sort of symptom, so they are dead. They are emotionally dead. The product of that is very poor relationship skills with their marriages and their children, because they can't connect and their spouses are unhappy when they come home, which is leading to the only emotion that they do show is anger and when they show that it leads to divorces or problems at home.

Many of veterans do not reintegrate into their families due to combat experiences which have resulted in emotional numbing, avoidance, and isolation. These families were left to carry on as normal a life as possible while the deployed member was absent from the family. Upon returning to their families these veterans experience difficulties reintegrating into their families. Henry shared that:

> Veterans with multiple deployments seem to struggle with reintegration into the family system. Family systems learn to operate without them and become more independent with each deployment. Veterans often struggle returning to previous responsibilities within the family system and/or coming to terms with new responsibilities. Relationships with partner and children tend to suffer when the veteran presents with hypervigilance, problematic substance use, or a general feeling that 'the world is unsafe.' Anecdotally, it would appear that these problems increase in relation to the number of deployments the veteran experiences.

Failure to reconnect may result in increased incidents of domestic violence, divorce, and ineffective parenting. Jade noted how the veteran's mental health impacts on the marital relationship and children:

> After multiple deployment veterans often return to a fractured home environment. Relationships have often been tested and stretched to their limit and there appears to be more a tendency to end a relationship rather than engage in couples' therapy. Those with children often struggle with child rearing as their anger, fear, depression, and anxiety may temper their parenting skills. Veterans also struggle with friendships as their friends who didn't serve may no longer seem relevant to a veteran with significant trauma related to their military experience. These veterans often end up with symptoms of avoidance and isolation as they feel no one understands how they are feeling.

Bella found veterans have “difficulty stepping in to take on the role of parent and head of household. Increased anxiety, hypervigilance, anger, and numbing of feelings.”

Ryanne agreed with Bella and said she finds “they struggle with increased hypervigilance that heightens the state of hypervigilance on the whole family. Like perimeter checks, checking locks. Their lack of presence for multiple periods creates adjustment conflicts with spouses and children.” In providing services for the treatment of veterans with multiple deployments the social workers all agree treatment needs to include assisting them in normalizing their experiencing which will aid in their reintegration to post-deployment life. Victoria reports similar experiences when working with veterans:

> They have difficulty integrating back into the family dynamic and the workforce. For the ones that end up on my caseload, their PTSD and other mental health effects from trauma and deployment experiences render them unable to even tackle basic life tasks such as securing permanent housing or obtaining income.

In her work with veterans Natalie has found “they are often guarded and have learned coping skills to assist them with their avoidant patterns of shutting down or quickly altering the conversation. Many are reluctant to share their trauma.” This tendency to isolate impacts their mental health and psychosocial circumstance. Bella shared in her experience working with veterans she has seen “more complicated mental health issues, more hypervigilance, more anxiety, more chemical dependency, less ability to make decisions for themselves. I definitely see them wanting to isolate.” When

engaging in isolative behaviors veterans have significantly more issues in all areas of their lives.

Natalie shared her experiences with veterans who report “difficulties finding meaningful, stable, employment. They have difficulties with interpersonal relationships, and often isolate to avoid other people who they perceive have different values and beliefs.” It is difficult to engage these veterans in treatment when they do not believe others share their values or are judging them based on these values. Ryanne has found that veterans “desire to actually be by themselves and not be around others because of their perception they can’t fit in or others don’t understand. Isolation increases all those other psychosocial factors.” Social workers spend a considerable amount of time developing trust and rapport before they can engage in meaningful conversation to determine the veteran’s individual treatment needs.

The social workers agreed that veterans who connect culturally, find a new purpose, or new meaning experience a smoother transition from military to civilian life. The social workers shared that in their experiences they have found that veterans who connect culturally are able to build trust and relationships aiding in their reintegration. Bella noted:

> When I have seen people be successful, and it hasn’t been a huge number of veterans, it is usually because they have been able to connect culturally. Their culture of origin, whatever that is, whether that is their Native American community where they can derive some strength and a feeling of belonging. Substituting or finding a way of recapturing that brotherhood, kinship and making

> that a part of their life, I think this is what I have seen that has been really successful. It is hard to link someone with this.

This need for culture and purpose was supported by Patti:

> Like motorcycle club or other organizations, a military club or outside the military. Needing to find a new meaning, a larger purpose. Identity change says that you need to connect with meaning again. You need to find meaning a larger purpose again if you got this crisis moment, you have to find that new purpose again. I will talk to them about being in the military and having a mission and now needing to find a new mission.

The social workers agreed that to aid veterans in their reintegration into civilian life all of their psychosocial needs will have to be validated, normalized, and treatment provided if the veteran is to reintegrate into family, community, and employment.

Theme 4: Clinical Challenges

The fourth theme the social workers identified are the clinical challenges they experience from the organization in providing services to veterans who have served multiple deployments. Social workers who provide services to veterans who have served multiple deployments report a lack of support from the administration. The social workers endorsed feeling supported by their direct supervisors and peers.

The majority of the social workers in the focus group reported a lack of support from the administration. All the social workers endorsed feeling supported by their supervisors and peers. Patti stated, “I don’t feel very well supported by my organization. I feel more support from my peers working together to ensure needs and resources are

pooled together, but I don't feel very supported from my organization." Bella agreed saying:

> I don't feel that the organization supports social workers much. I have had to grow as a professional and develop my critical thinking and creativity to meet Veteran care needs. I personally get a tremendous amount of support from my co-workers and a good deal of support from my supervisor. The best support comes from watching these veterans actively engage in treatment and seeing their symptoms reduce and, at times, extinguish, so they can go on with their lives in a positive way.

A general agreement about the lack of organizational support was also reported by Ryanne:

> I do not feel the organization does a sufficient job supporting us. I believe the organization struggles in utilizing the skill sets of social workers and essentially treats them as lower paid psychologists with additional duties that psychologists often fail to do. There is little to no mentorship programs for social work, no formalized and supported training program for CEUs or advanced training. Veterans with complex care needs require professionals skilled in advance techniques as well as the availability to be present for their needs. The organization does not support this as it currently is a culture of do more with less.

Henry was the only social worker who reported feeling fully supported:

> I am encouraged by my supervisor and team members to initiate adequate self-care. We have weekly team meetings where we are encouraged to express

> concerns and requests help. My supervisor has an open-door policy which I am able to access easily. I am able to request the time off that I need. All of these things allow me to provide better care for the veterans I work with.

The social workers reported their belief that the VA does not understand the role of social workers or appreciate the level of therapeutic care they provide to the veterans they serve. Although they do not feel valued by the organization, they did report being supported by their supervisors and co-workers. Having supportive supervisors and co-workers mitigates the lack of support the social workers felt from the organization.

Theme 5: Services

The fifth theme identified by the social workers relates to the services provided by the VA and if these services are enhancing the veterans social and mental well-being. The social workers were in consensus that the VA has several services and recovery-based treatments designed to support veterans. The social workers were asked regarding the services provided by the VA to determine if the services provided are enhancing the mental and social well-being of the veterans. The social workers believe the VA provides comprehensive services for the veterans who receive care at the VA. Victoria noted the following:

> They receive wrap-around care, including housing support, medical care, mental healthcare, and substance abuse services. They also often need significant help with job attainment and very much benefit from employment services or assistance with how to apply for GI benefits from employment services or assistance with how to enroll in school. Once stabilized they go on to connect

with mental health, file for service connection, build their income, go back to school and so forth.

Jade added she “makes every effort to validate the veteran’s symptoms and offer reassurance that they are in an excellent PTSD inpatient treatment facility.” The social workers also noted some barriers to care exist for veterans. The social workers discussed the services the VA has to support the veterans in recovery-based treatment. In addition, the social workers noted some barriers to the veterans receiving the care they need.

Barriers. An identified sub-theme to theme 5- services was barriers to service. The social workers identified barriers the veterans experience in receiving care as wait times, limited resources in rural areas and a general attitude that veterans who seek care at the VA are “broken.” When discussing barriers to treatment Lola stated:

> We also try to remove barriers for access to care because it seems like if there is any type of roadblock or wait time, they are less likely to access services, so we try to have walk in or same day access if that is possible.

Henry added that “typically, the veterans report ‘wait times’ as the biggest barrier to receiving services. If the requested treatment is not available within a day or two, these veterans often do not return at all.” Both Patti and Bella agreed with Henry regarding wait times being a barrier to care. Victoria noted when working with veterans:

> They lack the skills to organize themselves in connecting with services. It is not that services aren’t available, it’s just that they are unable to do this independently of a social worker’s assistance. Without my assistance, they would not have been able to navigate these tasks and make the connections on their own.

The VA can be difficult to navigate without assistance and even with assistance can be frustrating and at times overwhelming. The social workers reported that veterans who live in rural areas face unique challenges in receiving care.

Veterans who live in rural areas often do not have access to VA care, which affects their treatment needs. Bella shared she has found that “due to the need to be isolative, veterans live in remote areas, and resources are very limited or nonexistent in remote or rural areas.” Additionally, Natalie noted the gaps in care as “specifically through non-VA providers, Vet Centers, and CBOCs are providers not being properly trained or equipped to do trauma focused treatment.” Bella agreed sharing:

> Timely access to care and competent care that is effective. Choice providers are not demonstrating veteran competent care. I have had veterans report that providers are afraid to touch them during a physical exam, providers seem to demonstrate a lack of knowledge of care issues that are veteran specific.

The social workers discussed how there is a general assumption that veterans are somehow broken. During the conversation the social workers discussed the stigma involved with seeking treatment as noted by Natalie “the stigma associated with receiving care is still too high for many of the veterans.” The group discussed a general assumption that veterans who seek care are sick or broken which can cause veterans to avoid seeking services. Patti shared that even professionals make assumptions regarding the needs of veterans:

> I was trying to point out is that people who present to us with multiple deployments, we are quick to make them sick, it is important for us to also be

> using the strengths perspective. They are not always quote unquote sick. Not everyone has high level symptomology just because they have deployed. So, we have services we provide that aren't just targeted to people with active symptomology.

Lola agreed adding "not everybody comes back from deployment broken and not everybody who experiences the exact same trauma has the exact same reaction to that trauma." Patti expanded on this further when she stated "our media can stop portraying them all as crazy veterans with PTSD. We need to normalize that multiple deployments changes them—it doesn't break them."

The socials workers agreed that outside providers and the media appear to have a perception of veterans being 'crazy' and 'dangerous.' They discussed the need for increased education on veteran needs so as to eliminate these beliefs.

Unexpected Findings

From the data gathered, an unexpected finding was the social workers' report of not being supported by the organization. The social workers also reported a perception that others do not understand the services social workers provide. As previously reported, the VA is the largest employer of social workers in the county, so it is surprising that there is a general misconception regarding the services social workers provide. Another unexpected finding was that veterans who seek care at the VA are viewed as broken. Care at the VA should not be viewed any differently than any other health maintenance organization.

Summary

The findings support the social workers' experiences working with veterans who have served multiple deployments in combat zones and how these deployments have a negative effect on the veterans they serve. Social workers shared their experiences with veterans who present for care in the various clinics in which they work. They all reported that of the veterans with whom they have worked, those who had served multiple deployments presented with more symptoms of PTSD, mental health, substance abuse, and psychosocial problems, as well as an increased intensity of symptoms, as opposed to veterans who have no deployments or only one deployment.

Veterans who are deployed may be exposed to trauma and with subsequent deployments the risk of exposure to trauma increases. The severity of symptoms ranged from moderate to severe. PTSD was only one of the issues the social workers discussed in their work with veterans. The veterans present with multi-system needs due to increased psychosocial needs. Social workers reported the veterans they treat present with issues of divorce, domestic violence, employment, family problems, income, legal, mental health, reintegration, and relationships. These issues are compounded by the veteran's issues around avoidance, emotional numbing, and isolation. Another problem veterans encounter is ongoing stigma related to seeking treatment. An additional component of the stigma they encounter is that some mental health professionals assume veterans who seek care are sick, broken, or damaged. Despite the social workers reported experiences with some mental health professional they reported that overall the VA offers many services for the veterans they provide care to.

In Section 4, I discuss how the findings of this study can be applied to the professional practice of social workers and the services they provide. I will also present implications for social change.

Section 4: Application to Professional Practice and Implications for Social Change

The purpose of the study was to understand social workers' experiences working with veterans of multiple deployments and how multiple deployments are affecting the veterans they provide services to. For this study, I used a qualitative research design with a purposive sample of social workers employed in western Washington and working with veterans who have served multiple deployments in combat zones. I gathered data through a focus group. The use of this forum provided flexibility in collecting data through a discussion forum (Kaner, 2014) regarding the social workers' perceptions and experiences working with veterans who have served multiple deployments in combat zones. By understanding these experiences, changes can be made to improve the social workers' experiences and the services they provide for veterans.

The findings included that repeated deployments in combat zones increases the risk of trauma resulting in the complex psychosocial needs of veterans. These psychosocial needs include addictions, employment, family, income, legal, mental health, PTSD, and reintegration. A review of the evidence-based treatment models the social workers use in their work with veterans to assist with normalizing, treating, and validating their experiences was included. The social workers discussed the barriers to care the veterans experience as well as their perception of the organizations not understanding the many services social workers provide. The study's findings can inform social work practice regarding the complex needs of veterans who have served multiple deployments in combat zones. An additional finding was that social workers do not feel

appreciated or validated within their organization. The social work participants advocate for the veterans they provide services to but fail to advocate for themselves.

The findings add to the existing knowledge in the field of social work by bringing an awareness about how multiple deployments increase veterans' risk of exposure to trauma and the resulting complex psychosocial needs they experience as well as the myriad of services social workers provide. These services include case management, individualized treatment, group therapy, intervention, substance abuse treatment, and suicide prevention. Social workers provide additional services as program leads, program managers, supervisors, program developers, and researchers. By increasing awareness of the complex psychosocial needs of veterans and the evidence-based treatment used, social workers may be able to provide effective trauma-informed treatment in their work with veterans.

Application to Professional Ethics in Social Work Practice

The NASW (2017) social work values that relate to the research study include the core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence. The finding regarding the experience of social workers who provide services to veterans who served multiple deployments in combat zones demonstrates that social workers embrace the values of dignity and worth of the person and the importance of human relationships. Dignity and worth of the person, as well as the importance of human relationships, correlate to the work and the services social workers provide to veterans. The social workers achieve this through client-centered care, compassion, acceptance of veterans' unique experiences, and

through normalizing and validating these experiences. Social workers recognize the importance of human relationships in their work with veterans as they seek to restore and enhance veterans' treatment experiences at the VA. Social workers provide support for veterans who experience difficulties reintegrating with their families and communities.

Social workers demonstrate integrity as evidenced by practicing within their scope of knowledge and maintain competency in professional expertise while working with veterans. In addition, the social work participants exemplified the social work value of service as demonstrated by their commitment to the veterans they serve, despite the belief the organization does not appreciate or understand the depth of the services they provide

The NASW Code of Ethics (NASW, 2017) informs clinical social workers' practice with veterans. Research is guided by the Code of Ethics, providing for the protection of focus group participants through the ethical responsibilities of social workers conducting research and evaluation, thereby ensuring the values of social workers are considered during data collection and analysis. By understanding the perceptions and experiences of social workers who work with veterans who have served multiple deployments in combat zones, social workers may be better able to provide trauma-informed, client-centered, and evidence-based care. This research upholds the social work values as outlined by the NASW Code of Ethics (2017).

Social workers who provide services to veterans encounter an array of complex psychosocial needs and treatment challenges. The goal of this research was to understand the social workers' experiences when providing services to veterans who have served

multiple deployments in combat zones. The goal was to further increase the knowledge base of the social work profession regarding the complex psychosocial treatment needs of veterans. An unintended goal of the research was to identify strategies for improving the social workers' experiences working in large organizations.

Recommendations for Social Work Practice

Based on the findings, two action steps are being recommended for clinical social workers who work in this area of focus while considering practice, research, and policy to underscore the importance of social workers' experiences in providing services to veterans who have served multiple deployments in combat zones. The first recommended action step is to provide social workers with education and training on trauma-informed care, as well as training on the complex psychosocial needs of veterans, offered at agencies where social workers work with veterans. Many of the social workers at the VA work in a specialty sections, such as addiction, housing, inpatient psychiatric care, mental health, primary care, PTSD, suicide prevention, and transition services. Cross-section training would help social workers to enhance their therapeutic skills benefitting veterans with complex psychosocial needs while understanding the treatment approaches used by other departments and further enhance the wraparound services perspective. Continuing education opportunities that focus on veterans' needs would support the education and training of social workers, and it is recommended that the agencies that employ these social workers support continuing education opportunities for the social workers' licensure requirements.

The second recommended action step is to address how organizations understand the roles and functions of social workers. Social workers provide many services to veterans who have served multiple deployments and have experienced trauma during combat, which adds to the complexity of their psychosocial needs. All the services and treatment the social workers provide are based on client-centered, evidence-based care. Social workers provide case management, counseling, crisis intervention, and therapy services for veterans who receive services in the substance use disorders clinic, mental health clinic, primary care clinics, PTSD clinic, housing, and residential care service. The organization would benefit from learning about the therapeutic role social workers perform with veterans. By increasing the organizations awareness about the value of the social workers who provide services to veterans, the organization may provide increased education, opportunities, resources, support, and value.

The findings from the study support social workers' perceptions that veterans who experience multiple deployments in combat zones have increased trauma resulting in PTSD and complex psychosocial needs. These findings impact social workers' roles as both practitioners and supervisors. Social workers would benefit from being mindful of veterans' individualized, unique experiences and needs. Providing a nonjudgmental space for the social workers to discuss their organization concerns, veteran issues, and treatment modalities without fear of blame and space to express personal issues or stresses triggered by their work with veterans can decrease the stress of the work environment. This approach to supervision is supported in the literature (Bogo, Paterson, Tufford, & King, 2011; Steiker & Malone, 2010). Open discussions regarding veterans'

experiences and needs helps to decrease stigma and prevent thinking of veterans as being broken.

As a social worker and supervisor, I find that the study has reinforced the need for continuing education opportunities for social workers in evidence-based practices. I will work with social work leadership to develop a discussion forum for social workers to discuss their experiences in providing services to veterans who have served multiple deployments. The experiences these social workers bring is key to understanding the veterans' treatment needs and implementing program changes which re-enforce self-directed individualized treatment.

Transferability

The transferability of the findings from this study may impact social workers who work in large multi-disciplinary organizations and provide a variety of services. Social workers who work in these organizations frequently report not being supported or validated (Bogo et al., 2011). The experiences shared by the participants may not be unique to the organization in which they work. Education and training, if supported by the organization may aid social workers to be more effective when providing services to veterans, increasing their sense of value to the organization resulting in a greater sense of job satisfaction. The goal is to use the findings from this study as a tool for promoting social change within organizations for the enrichment of social workers' experiences. Knowledge regarding the social workers' perceptions of the cumulative effects of multiple deployments on veterans may help social workers have increased effectiveness in providing services.

Limitations

Limitations of the findings from this study could be the specificity of the veteran population served by the social workers who participated in the focus group. Another limitation of the study is the limited number of participants in the focus group. Two of the participants identified as veterans, per their report they had not served in combat, but this may have skewed their experiences regarding veterans' needs. Another limitation of the study was that it was localized to western Washington and more specifically to the Puget Sound region. Social workers' experiences may differ regionally and thereby limit the transferability of the study. An additional limitation would be the study was rooted in veteran care and large organization; social workers will need to determine whether the findings are useful to their individual settings.

Recommendations for Further Research

One recommendation for future research related to social worker's experiences working with individuals with complex psychosocial needs is to complete a comprehensive study to include various treatment settings. These agencies should range from small agencies, community agencies, state, and federal. The inclusion of all types of agencies will support the transferability of knowledge regarding the perceptions and experiences of social workers who provide services to clients with complex psychosocial needs. This may provide important information to the agencies on how to best support social workers. Another recommendation would be to do a research study with social worker's supervisors and administrators on their perceptions of the role of social workers within their agencies. Additional research with social workers based on their perceptions

and experiences will positively promote the social work profession. Recommendations for future research may address the limitations of this study.

Dissemination

The findings from this study will be disseminated to agencies that have social workers and work with veterans to encourage the sharing of experiences and develop a sense of cohesion among the social workers through their shared perceptions and experiences of being social workers in a large organization. The findings may encourage service line managers to provide education on social workers' experiences with supervision and organizational leadership. Administrators will be apprised of social workers' perceptions of not being valued or supported in their work with veterans. This process is a first step in bridging the needs of organizations with the needs of social workers. The dissemination of the findings of social workers' perceptions and experiences working with veterans of multiple deployments in combat zones with complex psychosocial needs with organizational leaders may create the opportunity for dialogue with social workers within the agency. This dialogue could bring about positive changes for the organization, social workers, and the clients they serve. The study's findings can be further disseminated through the Veterans Service Network, and the sharing of these findings may increase the organizations' understanding of the social workers' experiences. Disseminating the information with other social work agencies can be achieved by sharing the findings with social work networks such as the NAMI, NASW, other social work organizations as well as social work groups on social media.

The sharing of these findings can increase the understanding of the roles social workers fill and enhance social worker’s experiences.

Implications for Social Change

The findings from the research study have potential implications for positive social change at the micro, mezzo and macro levels of practice, research and policy. At the micro level, social workers provide education and therapy services to veterans by providing client-centered evidence-based treatment for the veterans who receive care at the VA. The focus group participants use individualized treatment models, clinically appropriate for the veterans served. The use of an individualized approach enhances the veteran’s treatment and aids them in their reintegration into their families, employment, and communities.

Implications for change at the mezzo level include the education of organizations on the services social workers provide. Social workers can work with the organization to improve organizations policies and procedures, which directly affect the services social workers provide to veterans. The study can inform agencies outside the VA on evidence-based practice when working with veterans who experienced trauma and have complex psychosocial needs.

Social workers who have open supportive relationships with their direct supervisors have increased job satisfaction (Bogo et al., 2011). Supervisors who recognize the many roles social workers have within the agency can advocate up to leadership for the needs of social workers to include support for continuing education. Supporting social workers continuing education needs allows the agency to enhance and

expand the services offered to clients. The current research and future research involving social workers' perceptions and experiences may be used to affect positive social change within the organizations where they are employed.

Summary

Veterans who have served multiple deployments in combat zones present with complex psychosocial needs due to their exposure to trauma. Social workers are responsible for the assessment, treatment, and care of the veterans who seek care at the VA. The findings from this study may help organizations understand the complexity of the services social workers provide. State licensure bodies require clinical social workers to engage in continuing education. Due to the complexity of psychosocial needs of veterans, social workers need to be supported by their agencies in their pursuit of ongoing evidence-based care treatment modalities. Social workers report first level support and validation from supervisors, but do not feel validated, supported or understood by organizational leadership. Results of the study's finding will be presented to VA leadership to open communication regarding the role of social workers and the value they bring to the organizations and the veterans served.

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Appendix: Interview Protocol

- How do veterans with multiple deployments report experiencing PTSD symptomology? How are these symptoms presenting when the veteran meets with you?
- What treatment approaches are you using when working with veterans with multiple deployments to help them manage symptoms of PTSD?
- What services have you provided which have been the most helpful to veterans who served multiple deployments?
- What are the differences that you have seen in substance abuse in veterans who experienced multiple deployments as opposed to those who experienced single deployments?
- What type of family challenges do veterans with multiple deployments report upon their return home?
- To what extent are veterans with multiple deployments reporting successful reintegration into the community?
- How can veterans with multiple deployments be empowered to become productive well-functioning civilians?
- What are the gaps in care the veterans are reporting? What are the gaps in care you notice and are they the same as those reported by the veterans?
- As a social worker, what are the challenges you experience when working with veterans who have served multiple deployments?

- How does your organization support you when working with veterans who have complex care needs?