Societal Culture and the New Veteran

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ABSTRACT

Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Veterans are Veterans of the Armed forces that served in combat or in support of combat operations in Iraq and Afghanistan after September 11, 2001. This returning Veteran population is in need of unique, culturally appropriate interventions to improve motivation to access health care. This article explores the United States current societal culture and the influence of this culture on our newest Veterans. The returning Veteran population is described as a cohort of the current youth culture of fast "fooders, thinkers, and do'ers". A demographic and cultural "snapshot" of the newest Veteran population is provided for consideration in promoting proactive health care utilization. Non-traditional communication modes, off site services, family support and peer liaisons will be essential in providing successful health care to meet the cultural and health care needs for this population.

Societal Culture and the New Veteran: Considerations and Implications for the Psychosocial Treatment of Returning Veterans

Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Veterans are Veterans of the Armed forces that served in combat or in support of combat operations in Iraq and Afghanistan after September 11, 2001 (US Department of Veterans Affairs, The Office of Care Coordination, 2008). This cohort of our newest Veterans of war presents during a time of technological advances that heavily influence popular culture in all aspects: information accessibility, communication and behavior outcomes. Before these young American men and women went off to war in support of OEF/OIF, the American societal culture of "urgency" had already begun to shape who they are: a population of fast "fooders', thinkers' and do'ers". Societal culture, youth and the experience of War are interconnected for the OEF/OIF Veteran, and each concept must be harnessed for its strength to promote and improve accessibility to health care for this population. The Veterans Administration (VA), public and private health care organizations are

challenged to consider the unique needs of this Veteran population, and the health care implications for this cohort of young Veterans who are encouraged to access preventive and intervention health care at early stages in their lives.

Purpose of the Article

The purpose of this article is to explore the influence of societal culture on returning Iraq and Afghanistan war Veterans and highlight culturally considerate health care interventions for this population. A demographic and cultural "snapshot" of the newest Veteran population is provided for consideration in promoting proactive health care utilization.

Who Are The Newest Veterans?

OEF/OIF Veterans experienced combat in urbanized, high civilian utilized area settings. War in Iraq and Afghanistan (at times) often exemplify "combat" in the city. Combat zones in Iraq were informal: one could experience enemy fire or improvised explosive devices (IED's) in the market place, driving under a bridge or securing an occupied building (Tanielian & Jaycox, 2008). As a result of this urbanized combat setting, returning OEF/OIF Veterans may encounter difficulty transitioning and discerning differences between the urbanized Iraqi combat zones, American civilian life and an overall cultural sense of safety (Jacupak, Luterek, Hunt, Conbeare, & McFall, 2008). Not only does the type of combat experienced by this population make the transition to civilian life challenging, but so does the age of returning OEF/OIF Veterans. The largest population of OEF/OIF Veterans is under the age of twenty-nine, followed by age group thirty to thirty-four years of age (Department of Veterans Affairs National Center for Veterans Analysis and Statistics, 2008). This is a sharp contrast in age differences and life stages when compared to the average age of Vietnam Veterans who are initiating VA health care at age sixty. A significant portion of OEF/OIF Veterans are in life stages that involve securing self identity/careers, establishing and maintaining romantic relationships (Tanielian & Jaycox, 2008; Chartrand, Frank, White, & Shope, 2008). In comparison, the Vietnam era Veteran may be nearing retirement, enjoying children and dealing with the realities of declining health due to aging (Tanielian & Jaycox, 2008). Families, full time employment, college and/or training often leave limited time and resource to access traditional health care services. Clearly, OEF/OIF Veterans are different in terms of life stages, psychosocial, and re-integration needs.

Veterans of OEF/OIF are also unique in terms of the number and roles of women in the military. In 1971, women constituted less that 1% of the United States military. This is a sharp contrast to the OEF/OIF Veteran population: eleven percent of the current OEF/OIF American forces are women (US Department of Veterans Affairs, The Office of Care Coordination, 2008). Due to the aforementioned combat setting, women Veterans of OEF/OIF have also had increased exposure to combat and combat type environments (Tanielian, et al., 2008; Rank, 2008). Further, the number of women in the

Unites States military is expected to grow to approximately 600,000 by the year 2013 making it vital for VA and other health care providers to incorporate gender specific re-integration, treatment and recovery in rehabilitative care efforts.

Of the returning Iraq and Afghanistan Veterans who have been evaluated by the VA, approximately 41% have been diagnosed with a mental illness – most commonly Post Traumatic Stress Disorder (PTSD) and substance abuse (Alvarez, 2008). The only diagnoses seen more often than mental health were diseases of the musculoskeletal system/connective system, which include Traumatic Brain Injuries – thought to impact approximately 30% of returning OEF/OIF Veterans (Tanielian et al., 2008). Thus, returning OEF/OIF Veterans are dealing with what are often called the visible and invisible injuries of war. The complexity of said injuries can often impact Veterans and their families' perceptions and expectations regarding recovery.

The mentally and/or physically injured OEF/OIF veteran has a difficult time acknowledging and grieving a loss related to trauma and combat. In general, American society projects youth to be a time free of illnesses, impairment and disabilities. For the OEF/OIF Veteran, this way of thinking is coupled with military training and a military culture that prepares the OEF/OIF service member to think, live and breathe invincibility in order to survive. If these Veterans are willing to acknowledge their need for care, some will decline assistance to preserve resources for other Veterans perceived to be in "worse" condition (Rank, 2008). Within these considerations, the defense mechanism of denial is natural and sometimes necessary to maintain some sense of self as the service member transitions to a survivor of trauma.

Indeed, the newest Veterans of war are by all measures of our society's Litmus Tests - survivors. Therefore, acknowledging the influence of societal culture on the returning Veteran population it is essential to meeting the population's health and psychosocial needs. Beyond statistics, societal culture – America's way of being, doing and judging, shaped these young men and women prior to the decision to fight for our country. America's way of being, doing and judging has contributed to a society, and Veteran cohort that expects prompt, speedy outcomes and gratification in every interaction and exchange. Exploring returning Iraq and Afghanistan Veterans health care needs - in the cultural context, as fast "fooders, thinkers and do'ers" allows health care providers an opportunity to redesign health care services in an innovative, culturally considerate, and accessible way.

Fast: "Fooders"

Veterans of the Iraq and Afghanistan war have aged in a time of easy, highly marketed and quick access to food. Without the rigor and structure of military life, eating, diet and exercise rituals often change sharply upon the return to civilian life. Fast and easy access to unhealthy food has contributed greatly to obesity in Americans of younger age groups, which include OEF/OIF Veterans. Obesity is linked to several other poor health factors such as diabetes, cardiovascular disease and high blood pressure (Trioano, Kuczmarski, Johnson, Flegal, & Campbell, 1995).

In fact, Veterans who experience the negative physical health outcomes of obesity tend to concurrently engage in to other health risk behaviors such as sexual risk taking, and smoking (Tanielian et al., 2008). War related medical and mental health needs are further exasperated by obesity in the OEF/OIF Population. The diagnosis of PTSD alone has been show to negatively impact the physical health functioning of OEF/OIF veterans (Jakupak et al., 2008; Heppner, Crawford, & Haji, 2008). Iraq and Afghanistan veterans are also at risk of encountering region specific rashes, infections and parasites that may contribute to gastrointestinal symptoms (Tanielian & Jaycox, 2008). The high risk for obesity culture coupled with war related illnesses makes the cause for OEF/OIF Veterans to access preventive care and treatment even more compelling.

Fast "Thinkers"

Multimedia, multi-stimulant modes of engagement and interactions have lead to a culture of young, fast thinkers. In the age of the video game, America's youth culture has been exposed to a life time of speediness related to coordination, mental processing and attention. The military has used this fast culture aspect to its advantage by incorporating video games in training and rehabilitation. With most OEF/OIF Veterans under the age of 35, there are also physiological considerations that can be coupled with the fast thinking culture. Physiologically, brain development impacts impulsivity and fast decision making. Conkle (2007) highlights that the amount of dopamine released and the number of dopamine synapses increase during adolescence. This increase in dopamine has been correlated with an increase in sensation-seeking behavior -- which in our media saturated culture often leads to impulsivity and poor decision making that can have long lasting life impacts. Some war injuries and impairments have also been shown to impact on ways of thinking and processing information. For example, Traumatic Brain Injury (TBI) impacts approximately 30% of returning OEF/OIF and has been shown to increase impulsivity, even with a decreased mental processing speed (US Department of Veterans Affairs, The Office of Care Coordination, 2008; Rank, 2008). The injuries/impairments of this war can mimic adjustment and adherence to the current culture of ongoing, rapid, mental stimulation. In fact, this mal-adjustment may go unnoticed until the Veteran exhibits behaviors such as difficulty controlling anger, aggressive driving and substance abuse (Rank, 2008).

The transition from a war environment that fuels and necessitates fast thinking into an environment that requires control and discernment for this skill is a confusing one. It is the task of health care professionals to assist in a recovery process of education, balance, support to decrease impulsivity and encourage good decision making.

Fast "Do'ers"

The cultural zeitgeist of the OEF/OIF Veteran population embraces expediency and "now-ness" in all aspects of life, including health care. Through email and texting Americans have become accustomed to fast, but disconnected communication styles. On

our jobs, we are rewarded for efficiency. Speedy recovery, service and transportation processes are of great preference. However, in the current culture, seeking instant gratification in all we do can be a detriment, particularly for the returning Iraq and Afghanistan Veteran. In terms of health care, American society trends towards reactive (instead of proactive) health interventions. As such, it may be difficult for the OEF/OIF "fast doer" Veteran to conceptualize how small, preventive and early intervention steps in health care may be helpful (Williams, 2008).

An important component of transitioning from military to civilian life involves slowing down to debrief, process, and reconnect with others (Rank, 2008; Chartrand et al., 2008). The expectation that the recovery process should be a quick and easy process can lead to frustration when the nightmares, anxiety and hyper vigilance symptoms do not go away quickly (Alvarez, 2008; "National Guard Virtual Armory: Battlemind Training", 2009). Taking time to heal can seem counter intuitive in the fast doing culture of today. At times, OEF/OIF Veterans may engage in quick fix, high risk behaviors, as a way to cope, which further reinforce the societal expectations of being able to have it all right now (Rank, 2008).

Interventions for Fast Fooders, Thinkers, and Do'ers

As highlighted, the OEF/OIF Veteran is caught in a tug of war with youthfulness on one end and health care intervention urgency on the other. The returning Veteran is in a life stage of defining and integrating life goals in the mist attempting to deal with combat experiences and trauma. To formulate and execute effective health care interventions, the cultural, military and demographic snapshot must be viewed as an integrated impact on the recovery experience of the Veteran. The following recommendations attempt to facilitate the implementation culturally considerate interventions meant to engage OEF/OIF Veterans in health care.

Home Visits

With the aforesaid considerations in mind, health care providers must truly "meet the Veterans where they are". And where the veteran is right now is a place that requires expeditiousness in communication, interventions and outcomes. Unwin and Jerant (1999) found that home visits can lead to improved medical care through the discovery of unmet health care needs and information obtained in this setting can be more significant than outpatient clinic encounters. McFall, Malte, Fontana, and Rosenheck, (2000) further stated that veterans who received outreach interventions were significantly more likely than those who did not to schedule an intake appointment (27%) and attend the intake.

Further, it seems that the younger, OEF/OIF Vet population is tending to shy away from the group experience in preference for more one to one interventions by health care providers and clinicians (Rank, 2008; Alvarez, 2008). Upon proper assessment, clinical judgment and safety considerations, home outreach services could assist clinicians and providers with establishing rapport, identifying and reducing barriers to

keeping appointments and provide an opportunity for brief assessment and crisis intervention (National Association of Social Workers-Massachusetts, 2006). Peer support representatives who also conduct home visits can utilize this intervention to provide advocacy and establish a non-clinical rapport with a health care representative. If OEF/OIF veterans cannot meet us in our offices, exam rooms and clinic settings, we must meet them at their need –sometimes this will mean knocking at their doors - before they will step inside ours.

Non-Traditional Modes of Communication

The newest modes of communication should be used to improve health care partnerships among providers and our newest Veterans whenever possible (Rank, 2008). Emails and text messages can be used to communicate appointment reminders and upcoming events. Websites that allow ordering or refilling prescriptions online can also be quick and convenient. Social networking sites monitored and created by the health care facilities could be used when sharing important health information such as how to access Post Traumatic Stress Disorder education and suicide prevention assistance (Mondello, 2008).

Family/Support Systems Involvement in Health care

Fast Thinkers require a high effort of family involvement and engagement with their health care treatment (Rank, 2008; Chartrand, et al., 2008; Tanielian, et al., 2008). Often times, Veterans may minimize or deny key symptoms important in establishing appropriate health diagnoses (McFall et al., 2000). Family members on the other hand, will often openly communicate about changes or symptoms that have been observed in the Veteran. Once educated about health symptoms and recovery needs, family members are often capable of offering empathy and support to veterans in recovery.

Peer Support

As with many other groups of people seeking recovery from a significant life experience, peer support allows for the Veteran to gain a sense of commonality among comrades. Interacting with a peer can provide hope to the Veteran who felt at one point that things would never get better (Tanielian & Jaycox, 2008; Williams, 2007). Sometimes they are willing to hear from a peer corrective feedback that they would resist from a health care provider. Healthy peer support with appropriate boundaries can be helpful for veterans recovering from grief, amputation and PTSD (Williams, 2007; US Department of Veterans Affairs, The Office of Care Coordination, 2008).

All Inclusive Care

Fast fooders, thinkers and do'ers are naturally attracted to opportunities where they can get many things done in one place and at one time. Think "Health Care Mega Mart", with all 40 lanes open 24 hours a day. Returning Veterans want health care services to be holistic, convenient and efficient (US House of Representatives Committee on Veterans Affairs, 2007; Rank, 2008). OEF/OIF veterans want to be treated in more integrated, less stigmatized methods to combat the negative, societal, and military culture perceptions about mental illness (Mitchell & Selmes, 2007; Tanielian et al., 2008). New Veterans want care all in the same day, with the least amount of office visits as possible. Health care providers should also integrate and collaborate with community organizations when possible to provide access to resources such as employment, financial and educational information.

Concluding Remarks

Health care providers must strategically plan, shift paradigms and redesign health systems for returning OEF/OIF Veterans. Social attitudes which encourage supporting the "warrior" despite views of the war, and a focus on early detection, recovery and rehabilitation are smart steps in the direction of positively transitioning our newest heroes into civilian life. Utilizing non-traditional communication modes, off site services, family and peer liaisons will be essential in providing successful health care to meet the cultural and health care needs for this population. To close gaps, health care providers will also need to ensure comprehensive recovery plans are in place that include non-traditional mental health services, employment/education assistance, case management, and community support systems.

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