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Psycho-Social Variables regarding Military Reintegration

by

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MSW Clinical Research Paper

Presented to the Faculty of the
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in Partial fulfillment of the Requirements for the Degree of
Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract: This project was a systematic review of the research studies that have focused on the barriers of reintegration by military service members to civilian life. This paper examined what psycho-social variables these research articles have found that have had the greatest impact on those reintegrating into civilian life. Because reintegration is a process that affects the service member, his or her spouse, and potentially children, it is an important area to research. This paper is a systematic review of the research already published regarding barriers to military reintegration for OEF and OIF veterans. Mental health was the most dominant theme as a barrier to reintegration followed by anger and aggression. It is hoped that analyzing the available data on this topic can better assist clinicians in their efforts to provide effective treatments and programs for returning service members; however, more research can always be done and the clinician should stay up-to-date with the most current findings on this topic.

Introduction

There are many challenges that families of military personnel face during the deployment cycle. These concerns vary from financial strains to changes in family roles, to feelings of loneliness and isolation (Allen, 2011). As spouses separate during the deployment stage the remaining spouse often takes on more household and parenting roles including raising and disciplining children (Allen, 2011).

Research on military deployment and reintegration stressors are important as these stressors can have long-lasting effects on all members of the family and affect many different domains of life—personal, emotional, spiritual, mental, physical, etc. Recently, research studies are beginning to find that “military deployment[s] are associated with increased rates of domestic violence and child maltreatment both during deployment and upon return of the service member compared to the predeployment period” (Lincoln, Swift, & Shorteno-Fraser, 2008, p. 988). While this is a negative outcome, it demonstrates how others in a household can be affected by a veteran’s reintegration process. However, it is also important to note that though this has increased, it is not true for every family (Lincoln et al., 2008). It is important to understand how reintegration affects the service member and his or her family so that clinicians can develop programs that assist service members in a successful transition into civilian life.

Todd Yosick, who is the Deputy Director of the Resilience & Prevention Directorate through the Defense Centers of Excellence found that veterans with PTSD from the Vietnam Conflict era self-reported “significant disruptions in the engagement component of psychological fitness. These veterans reported a higher prevalence of marital problems, family violence, and

partner distress—all situations that can inhibit reintegration” (Yosick, Bates, Moore, Crowe, Philips, & Davison, 2012, p. 14). Therefore, these researchers concluded that “greater PTSD symptomatology was associated with greater familial dysfunction in this population” (Yosick et al., 2012, p. 14).

Research regarding deployment and reintegration is important to gain an understanding of what programs are available and helpful for veterans, but also to raise awareness of what more can be done to assist the veteran in returning to home life. Yosick et al. (2012) found “Nearly all of those questioned (96 percent) in the 2010 VA survey expressed an interest in services to help service members readjust to the civilian lifestyle upon their return from deployment” (p. 6). This literature review will cover the affects of military deployment and reintegration on the veteran, his or her spouse, and their children. This study will examine the available research from studies that focus on obstacles to reintegration of military personnel to civilian life. This review of the research will determine what psycho-social variables seem to present the greatest barriers to reintegration.

Literature Review

Yosick et al. (2012) describes reintegration “as the process of transitioning back into personal and organizational roles after deployment” (p. 6). In an online article put out by the National Council on Family Relations, Marek (2014) refers to reintegration as “the stage of the deployment cycle . . . characterized by the service member’s reentry into his or her daily life as experienced prior to deployment, or into new civilian life, including the domains of work, family and personal experiences (p. 1). For the purposes of this literature review, reintegration will refer to the process of transitioning back to one’s way of life prior to deployment.

One cannot understand the affects reintegration has on a family without first acknowledging the stressors of the deployment and understanding the deployment cycle. Therefore, this paper will explore some of the stressors that arise during deployment as these can have lasting affects on an individual and family.

There are generally three distinct stages of the deployment cycle (Lincoln et al., 2008). These include “predeployment (from notification to departure), deployment (from departure to return) . . . and postdeployment” (Lincoln et al., 2008). All of these stages present its own unique challenges to the family unit that include “the need for emotional detachment, changes in family roles and routines, emotional destabilization, and reintegration of returning parent” (Lincoln et al., 2008, p. 985).

The conflicts in Iraq and Afghanistan have resulted in increased “acceleration in typical deployment rotations” which in turn has created confusion and uncertainty as extensions become more commonplace and there continues to be more deployments within a short timeframe (Lin-

coln et al., 2008, p. 985). In addition, the National Military Family Association (2005) reports that the deployment cycle represents more of a 'spiral' rather than a cycle. This association reports: "Families never come back to the same place they started. When entering a second or third deployment, they carry the unresolved anxieties and expectations from the last deployment(s) with them along with the skills they gained" (National Military Family Association, 2005, p. 14). Therefore, looking at and understanding the impact of these stages on the veteran and his or her family unit is essential for implementing programs that can help veterans reintegrate successfully back into their home lives.

The National Military Family Association (2005) conducted the *Cycles of Deployment Survey* which asks the question: "What do you feel is needed for military families in order for them to continue to be successful before, during, and after the deployment cycles?" About three-quarters of the 1,592 respondents answered that question and the National Military Family Association (2005) found that "for families, communication during deployment is directly linked to the reunion process, the reintegration of the family, and the mental health needs of all concerned" (p. 7). However, this same source found that "seventeen percent of the survey respondents reported that communication with the service member was the top challenge during the deployment" (National Military Family Association, 2005, p. 6).

"The importance of successful reintegration has consistently been recognized as vital to individual and unit success in the deployment cycle" (Yosick et al., 2012, p. 6). Yosick et al. (2012) has found studies from Mulligan et al., 2010 and Iversen et al., 2008 that have shown "a relationship between low unit cohesion and an increased rate of mental or psychological health issues, including PTSD, in individuals during deployment" (p. 24). Also, Allen (2011) found a

study from Britt, Dickinson, Moore, Castro, and Adler (2007) who found that “a sense of pride in their military job related to lower depression and PTSD for soldiers deployed on a peacekeeping mission” (p. 237). An earlier study by Milgram and Bar (1993) “found that spouses who disagreed with the military mission their partners were engaged in felt more fearful about their husbands’ safety” (Allen, 2011).

Stress on Veterans

Veterans endure a high level of stress with the intensity of their work. Therefore, the thought of returning home, while usually a happy occasion, also brings with it its own unique challenges. Marek (2014) reports that veterans may feel as if “they no longer fit into their families due to the family changes that occurred in their absence, including the normative development and maturation of children and the increased competence of the spouse” (p. 2). Wegner (2011) reports that it is common for both husbands and wives to feel as if they are strangers to each other upon return from deployment.

Marek (2012) also reports that veterans may feel disconnected upon returning home due to the cultural and environmental differences: “Several reasons were cited such as lack of respect from civilians (including a loss of status and self-esteem), the belief that they hold themselves to a higher standard than civilians, and the complexity of ‘normal’ life” (p. 2).

In addition to these stressors, veterans may also experience difficulty in their interpersonal relationships (Marek, 2012). Yosick et al. (2012) reports: “Nearly one-half of all service members surveyed following a deployment to Iraq reported experiencing difficulty with activities following their return home, including dealing with strangers and making new friends,” and a quarter of those surveyed self-reported “difficulty in maintaining their military friendships

post-deployment” (Yosick et al., 2012, p. 23-24). This may be the result of post-traumatic stress in the veteran’s experience and could include anything from poor emotion regulation to hyper vigilance to a lowered ability to adjust and cope with life’s stressors (Marek, 2012). A veteran’s mental health may also be compromised as he or she may exhibit more anxiety and/or depressive symptoms (Marek, 2012).

Within the first four months of arriving home from deployment, 12 percent of OIF (Operation Iraqi Freedom) and 19 percent of OEF (Operation Enduring Freedom) service members reported psychological problems, but only 23 to 40 percent of these service members sought treatment (Yosick et al., 2012). Yosick et al. (2012) also found that OIF and OEF service members who met criteria for PTSD were more likely than those who did not meet PTSD criteria to have more issues relating to reintegration. Such of these identified issues include anything from finding and maintaining a job to using or abusing alcohol or drugs to controlling anger and getting along with others (Yosick et al., 2012).

Stress on Spouses

Allen (2011) reports, “One of the most important aspects of stress for the non deployed spouse appears to be the level of worry about issues commonly related to deployment during wartime such as the soldier’s safety, emotional adjustment, and opportunities for communication” (p. 236). Furthermore, such stress often becomes a “potent predictor of psychological and health-related symptoms in both cross sectional and longitudinal work” (Allen, 2011, p. 236).

One study found “that wives scored significantly higher than their husbands on stress regarding combat, reintegration, loneliness, staying in touch, fear of death, physical injury, or psychological problems, and effects on the children” (Allen, 2011, p. 239). Likewise, both husbands

and wives reported, “the highest stress regarding issues related to combat, death, physical or psychological injury, loneliness, and effects on the children” (Allen, 2011, p. 242).

Allen (2011) surveyed 300 married couples with an active duty Army husband and found that “feeling that the Army is concerned about Army families was significantly related to lower stress for wives, but not husbands” (Allen, 2011, p. 241). Furthermore, families who lived ‘on-base’ identified less challenges than those who did not live ‘on-base’ (Chandra, Lara-Cinisomo, Jaycox, Tanielian, Burns, Ruder & Han, 2014). This study selected 4,674 eligible families from the National Military Family Association Operation Purple applicant pool from 2008 and conducted phone interviews with those families willing to participate (Chandra et al., 2014).

“Nearly half (42 percent) of the service members surveyed following a deployment reported difficulties getting along with a partner or spouse during their first 30 days back home while 35 percent reported a separation or divorce in the same time period” (Yosick et al., 2012, p. 24). Wegner (2011) has reported that spouses may feel like strangers to one another and cautions that it may take time to get to know each other again.

Furthermore, Yosick et al. (2012) found that marital satisfaction rates are lowered for several months after the veteran has returned home from a deployment. Also, a study from Schumm, Bell, and Gade (2000) reported “a slight drop in marital satisfaction from redeployment to middeployment, followed by an increase from middeployment to postdeployment” (Allen, 2011, p. 245). Likewise, the National Military Family Association (2005) found that “it is at the mid-point of the deployment cycle that more than a quarter of the families reported feeling the greatest stress” (National Military Family Association, 2005, p. 6). The second highest percentage of survey participants, 25%, reported that the beginning of the

deployment was the most stressful (National Military Family Association, 2005). Marek (2014) reports “that relation stress and negative family function may reach a peak between 4 to 9 months after the service member’s return” (p. 1).

Allen (2011) found “the stronger the relationship and marital communication, the lower the stress for military couples” (p. 244). Allen (2011) reports that openly working on issues in which one or both partners can exercise control can help “improve coping and resiliency regarding military demands and reduce pile-up of stressors and additional challenges, and in turn reduce the stress related to military life and deployment” (p. 246).

Stress on Children

Not only do spouses have a difficult time in adjusting to the cycles of deployment, but so do the children of parents serving within the military. Chandra et al., (2014) found that 1.89 million children living in the U.S. had a parent serving in the military in 2006. Lincoln et al. (2008) reported that there are about 1.2 million children living in military families. Furthermore, “as of June 30, 2011, 203,400 military personnel, including reserve and National Guard members, were currently on deployment in Iraq or Afghanistan” (Marek, 2014, p. 1).

There are more and more studies as reported by Chandra et al. (2014), (i.e. Barnes, Davis, & Treiber, 2007; Flake, Davis, & Johnson, 2009, & Huebner & Mancini, 2005) that have been focusing their attention on the well-being and mental health of children who have parents who are or have been deployed. Chandra et al. (2014) found that “caregivers and children from military families reported child emotional difficulties at higher levels than have been observed in the general US population” (p. 21). Children of deployed parents exhibit a wide range of difficulties which can include sleeping disturbances, anxiety and depressive symptoms, problems with peers

and academic performance, and increases in maltreatment and neglect (Chandra et al., 2014; Lincoln et al., 2008).

A child's social supports may also be compromised when one's parent is involved in the military. Lincoln et al. (2008) reports that military families move every two to three years while most civilian children will only experience one relocation during their childhood years. Not surprisingly, children who move frequently report "more difficulty with forging new friendships, achieving academic success, and emotional/behavioral adjustment" (Lincoln et al., 2008, p. 986).

Military children can also feel isolated in their experience. Yosick et al. (2012) found that "Children of reserve service members reported experiencing a lack of understanding and support from both their peers and their teachers more often than children from active duty families during and after a parent's deployment" (p. 24). The same study found that children of reserve families reported more difficulties readjusting to the parent who has returned from a deployment. This could be because "Army National Guard and Reserve families reported the greatest stress concerning deployment length. Their service members typically experience family separations of close to eighteen months" (National Military Family Association, 2005, p. 7).

Naturally, children will exhibit different behaviors and emotions while dealing with a deployed or soon-to-return parent depending on their age and sex. Lincoln et al., (2008) has found that "young children may become more aggressive and demanding, cry for attention, and demonstrate an increase in bed-wetting" (Lincoln et al., 2008, p. 987), while school-aged children may have issues with "emotional dysregulation, worry, and sleep difficulties," which in turn affects their abilities to perform well in school (Lincoln et al., 2008, p. 987).

Chandra et al., (2014) found that “older children, and in particular those in middle or late adolescence, were experiencing more problems with parental deployment and parental reintegration than their younger counterparts” (p. 23). This may be because “older children tend to assume more responsibilities in the household during a caregiver absence” as a result of the ever-changing roles and needs of the family during the parent’s deployment (Chandra et al., 2014, p. 23). Lincoln et al. (2008) reports that older children may act out by becoming angry or aloof and/or they may also lose the interest they previously held for favored activities.

Chandra et al., (2014) found that girls had a more difficult time in readjusting to the reintegration cycle. However, Lincoln et al., (2008) found that “boys appear to suffer more effects of family disruption than girls” (p. 987). Whether it can be hard to distinguish which gender faces the most stress and challenges regarding a deployed parent, deployment and reintegration has profound affects on children.

Conceptual Framework

A veteran is placed in many various settings and seems to somehow be expected to easily adapt to these surroundings. These settings can include the home environment he or she grew up in prior to enlisting, basic training camp, deployment to an area that may include combat in a foreign land, and a return home to family life. Dr. Zapf (2010) reports that “In Western society, we tend to view the physical environment as separate from ourselves, as an objective thing, as a commodity to be developed or traded or wasted or exploited . . .” (p. 4).

While the idea of person-in-environment has been around for decades, it has only more recently been given more consideration within social work. Person-in-environment suggests that an individual is not ‘separate’ from his or her environment and that the environment plays a significant social role in developing and influencing individuals (Zapf, 2010). Weiss-Gal (2008) suggests “the individual and his or her multiple environments as a dynamic, interactive system, in which each component simultaneously affects and is affected by the other” (p. 1).

Acknowledging the exchange between the individual and the environment can help others understand the impact the environment has on human behavior (Cornell, 2006). This is especially true for veterans as they are continuously shaped by the various environments they encounter. Seeing how the individual lives within the environment shows how both are interdependent upon the other (Cornell, 2006). For these reasons, this paper is based on the conceptual framework of person-in-environment.

Methods

Methods

Military reintegration is a relevant topic as service members now are on a continuous deployment/postdeployment cycle and because trauma and PTSD has become more recognized among mental health professionals. Because of this, there has been much research done on the effects that deployment and postdeployment has had on military personnel and their families. While many articles were found regarding this there were fewer systemic reviews regarding reintegration. Therefore this study is a systemic review of the literature.

Crowther, Lim, and Crowther (2010) report that a systemic review uses strict methods “to perform a comprehensive literature search and critical appraisal of the individual studies” (p. 3140). In this case that means exploring the psychosocial factors of military reintegration among OEF and OIF veterans. This systemic review has summarized already available data regarding this topic in an objective and unbiased manner (Crowther et al., 2010).

Selection Criteria

The objective of this systemic review is to review 1) all English written journal articles that are 2) empirically based, and studies that involve 3) OEF and OIF veterans 4) and psychological and/or social barriers to reintegration.

This study examined all research articles that concern OEF and OIF veterans as journals tend to be peer-reviewed. This study excluded dissertations and book articles as a way to narrow the search. Since the conflicts in Iraq and Afghanistan concern the United States military, this

review has gathered research written in English and that which concerns these conflicts from the political involvement of the United States military. This review included articles that were empirically based. Empirically based studies help to gather data that can be measured and discussed in terms of validity and limitations.

This systemic review covered information from research and was centered on the ‘American’ serving veteran, meaning American military personnel regardless of their racial and/or ethnic background. Military reintegration is an important topic for our time especially as many veterans rotate in and out of deployment cycles. Since every war is unique in that it happens within its own context, geographical area with different governing leaders, and within a particular culture of the times, this review is focused on reintegration as it affects OEF and OIF veterans. All branches of military personnel were included in this study in an attempt to gain a broader picture of military reintegration barriers.

Search Strategy

Research articles were gathered from the following online databases: PubMed, SocINDEX, and APA PsycNET. Search terms included: *OEF/OIF veterans, military reintegration barriers, current day veterans issues, psycho-social issues, U.S. reintegration, and OEF/OIF deployment*. These articles were reviewed by this author and the findings presented in this study.

Data Abstraction and Analysis

Data for this study was reviewed by sample size, military branch if specified, tools used to gather data such as universal surveys and questionnaires, and time period (cross-sectional versus longitudinal) of the study if listed. All studies reviewed involved the reintegration process of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) military personnel.

This has been done to assist the reader in understanding how the environment, culture and political season has affected the veterans involved. It is the intention of this review that by focusing on the involvement of OEF/OIF veterans trained clinicians will have a greater knowledge base of how to assist veterans returning home from deployment. This study then can provide a helpful tool in assessing and understanding the barriers that military personnel face upon arrival home.

Data was extracted by this author according to the following categories: sample size, military branch if specified, tools used to measure and gain data, and study results. The information above was analyzed, prepared and presented in this study. All research studies were analyzed with the findings presented below.

Table 1

Author	Reintegration Barrier Identified	Sample Size	Time Period of Study	Measurement Tools
Sayer et al. 2011	mental health	745 OEF/OIF veterans who received VA healthcare	cross-sectional	Military to Civilian Questionnaire M2C-Q
Eisen et al. 2012	mental health and substance misuse	596 OEF/OIF veterans	cross-sectional	Veterans Rand12 (VR-12) Behavior and Symptom Identification Score BASIS-24 PTSD Checklist Military Version (PCL-M), Alcohol Use Disorders Identification Test (AUDIT-C), & Drug Abuse screening Test, DAST

Author	Reintegration Barrier Identified	Sample Size	Time Period of Study	Measurement Tools
Tsai et al. 2012	mental health and social functioning	164 OEF/OIF veterans	cross-sectional	PTSD Checklist-Military version, PCL-M; Quality of Marriage Index; Family Adaptation and Cohesion Scales, FACES III; Social Functioning Questionnaire, SFQ; Satisfaction with Life Scale, SWLS; Postdeployment Social Support Scale, PSSS; Thought Control Questionnaire, TCQ; Cognitive-Behavioral Avoidance Scale, CBAS; & Fear of Loss of Vigilance Questionnaire, FLOVQ
Street, Vogt & Dutra 2009	mental health	no sample size; review	NA	NA
Lapierre, Schwelger & LaBauve 2007	mental health	2,275 OIF Army veterans and 1,814 OEF Army veterans	cross-sectional	Screen for Posttraumatic Stress Symptoms, SPTSS; Center for Epidemiological Studies Depression Scale, CES-D

Author	Reintegration Barrier Identified	Sample Size	Time Period of Study	Measurement Tools
James et al. 2013	mental health and substance misuse	271 OEF/OIF veterans who registered for VA health care	longitudinal study	Big Five Inventory, BFI; Deployment Risk & Resilience Inventory, DRRI; PTSD Checklist-Civilian Version, PCL-C; Beck Depression Inventory-Short Form, BDI-SF; Alcohol Use Disorders Identification Test, AUDIT
Pietrzak et al. 2010	mental health	272 OEF/OIF veterans in Connecticut	cross-sectional	Combat Experiences Scale, CES; Posttraumatic Stress Disorder Checklist-Military Version, PCL-M; Patient Health Questionnaire-9, PHQ-9; CAGE Questionnaire; Psychosocial Difficulties Scale, PDS; Connor-Davidson Resilience Scale, CD-RISC; Unit Support Scale, USS; Postdeployment Social Support Scale, PSSS; Perceived Stigma and Barriers to Care for Psychological Problems; Mental Healthcare utilization

Author	Reintegration Barrier Identified	Sample Size	Time Period of Study	Measurement Tools
Knobloch et al. 2013	mental health and suicide	236 OEF/OIF veterans	longitudinal study	Mental Health Inventory, MHI-d; Knobloch and Solomon's 1999 scales; Knobloch and Solomon's 2004 measure; Chandra et al. 2011 difficulty w/ reintegration scale
Bowling and Sherman 2008	mental health, substance misuse, divorce and suicide	none; review	NA	NA
Erbes et al. 2011	mental health	313 married or partnered National Guard soldiers returning from OIF deployment	longitudinal study	Abbreviated Dyadic Adjustment Scale, ADAS; Navy Quality of Life Survey, NQOLS; PTSD Checklist-Military Version, PCL
Sayers et al. 2009	mental health and violence	199 OEF/OIF veterans serving after 2001 and referred for behavioral health evaluations	cross-sectional	Mini-International Neuropsychiatric Interview, MINI; Patient Health Questionnaire, PHQ-9
Meis et al. 2010	mental health	223 MN National Guard soldiers deployed for OIF	longitudinal study	Abbreviated Dyadic Adjustment Scale, ADAS; Navy Quality of Life Survey, NQOLS; NQOLS-Marriage/Intimate Relationship Satisfaction scale; PTSD Checklist, PCL

Author	Reintegration Barrier Identified	Sample Size	Time Period of Study	Measurement Tools
Lewis, Lamson & Leseuer 2012	mental health, substance misuse, and suicide	none; review	NA	NA
Mallen et al. 2014	mental health, TBI and aggression	149 OEF/OIF veterans reviewed for the Seamless Transition Committee	cross-sectional	qualitative data from records
Blevins, Roca & Spencer 2011	mental health	144 OEF/OIF veterans w/ at least 1 deployment	longitudinal study	Post-Deployment Health Re-Assessment, PDHRA; Trauma History Screen, Global Functioning or SF-12; Depression sub scale of the Patient Health Questionnaire, PHQ-9; Generalized Anxiety Disorder Scale, GAD-7; Panic Screen from Brief Patient Health Questionnaire, PD, PTSD Checklist-Civilian version, PCL-C; Anger Subscale of Buss-Perry Aggression measure; Dyadic adjustment Scale, DAS; Conflict Tactics Scale, CTS; Alcohol Use Disorders Identification Test, AUDIT

Author	Reintegration Barrier Identified	Sample Size	Time Period of Study	Measurement Tools
Beder, Coe & Sommer, 2015	mental health	871 OEF/OIF veterans	cross-sectional	Post-Deployment Health Re-Assessment, PDHRA
Demers 2011	mental health	45 OEF/OIF veterans	cross-sectional	semi-structured interview
Nazarian, Kimerling & Frayne 2012	mental health	73,720 OEF/OIF veterans	cross-sectional	International Classification of Diseases, Ninth Revision Clinical Modification, ICD-9-CM; and Agency for Healthcare Research and Quality's (AHRQ) clinical classifications software
Ross & DeVoe 2014	mental health, suicide, substance misuse & TBI	none; review	NA	NA
Renshaw & Kiddie 2012	anger/aggression & mental health	143 OEF/OIF National Guard/ Reserve veterans	cross-sectional	PTSD Checklist-Military Version, PCL; Ways of Coping Questionnaire-Revised, WCQ; Aggression Questionnaire, AQ
Sreenivasan et al. 2013	anger/aggression	none; review	NA	NA

Author	Reintegration Barrier Identified	Sample Size	Time Period of Study	Measurement Tools
Schamling, Blume & Russell 2011	anger/aggression	546 married or cohabiting couples mostly linked with Reserve Component Army Soldiers	longitudinal study	Dyadic Adjustment Scale; CAGE Questionnaire; TRICARE Health Enrollment Assessment Review, HEAR; Conflict Tactics Scale, CTS
Elbogen et al. 2014	anger/aggression	1,090 OEF/OIF veterans	longitudinal study	Quality of Life Interview; DRRI; AUDIT; Davidson Trauma Scale
Bryan, McNaughton-Cassill & Osman 2013	suicide	273 active duty Air Force Security service members	cross-sectional	Beck Scale for Suicidal Ideation, BSSI; General Distress subscale of the ADDI-27; the Combat Experiences Scale, CES and Aftermath of Battle Scale, ABS; and Interpersonal Needs Questionnaire, INQ
Griffith 2012	suicide	4,567 OEF/OIF veterans	cross-sectional	Army Reintegration Unit Risk Inventory
Resnik and Allen 2007	work/employment	14 injured OEF/OIF veterans	cross-sectional	qualitative study; semi-structured interviews

Author	Reintegration Barrier Identified	Sample Size	Time Period of Study	Measurement Tools
Blow et al. 2013	drinking and mental health	1,143 National Guard service members and 674 spouses	cross-sectional	AUDIT; Revised Dyadic Adjustment Scale, RDAS; Parental Stress Scale; Confusion, Hubbub, and Order Scale, CHAOS; Beck Depression Inventory, 2nd edition; PHQ-9; PTSD Checklist-Military Version, PCL-M
Kleykamp 2013	work/employment	none; review studying Surveys from the Current Population Survey CPS	NA	Current Population Survey
Adler et al. 2011	work/employment	797 OEF/OIF veterans; 473 veterans employed at time of study	cross-sectional	structured interviews & Work Limitations Questionnaire, WLQ
Wright et al. 2014	functional impairment	Time 1 = 2,297 OEF/OIF veterans Time 2 = 1,955 OEF/OIF veterans Time 3 = 2,076 OEF/OIF veterans	longitudinal study	PTSD Checklist-Specific Version; PHQ-Depression; Hoge et al. 2004 combat exposure model
Negrusa & Negrusa 2014	divorce and mental health	none; review	NA	NA
Hazle, Wilcox & Hassan 2012	divorce and work/employment	none; review	NA	NA

Author	Reintegration Barrier Identified	Sample Size	Time Period of Study	Measurement Tools
Plumb, Peachey & Zelman 2013	sleep	348 OEF/OIF veterans	cross-sectional	Pittsburgh Sleep Quality Index, PSQI; PHQ-9; CES; PTSD Checklist-Military, PCL-M; Pittsburgh Sleep Quality Index Addendum for PTSD, PSQI-A; Generalized Anxiety Disorder-7, GAD-7
Sozda et al. 2014	TBI	103 OEF/OIF veterans with a mild brain injury	cross-sectional	reviewed neuropsychological test data
Hwang et al. 2014	driving	103 OEF/OIF veterans returning from deployment	cross-sectional	Driver's Stress Profile, DSP; Driving and Occupational Limitations, DOL
Smith, Benight & Cieslak 2013	social support	89 OEF/OIF veterans	cross-sectional	PTSD Checklist, PCL; Centre for Epidemiological Studies Depression Scale, CES-D; Post-Deployment Coping Self-Efficacy, PDCSE; Provisions of Social Relations scale; Inventory of Post-diaster Social Support Scale

Findings

Forty-four articles were analyzed to gain an understanding of the most common barriers to military reintegration. However, 8 articles were not effective in assessing barriers to reintegration and although they were reviewed, they provided no useful information to the findings of this systematic review. Table 1 presented above provides a closer look at the remaining 36 articles that were reviewed and presented within this research. Of these 36 articles, 26 articles were quantitative in design, 4 were qualitative, and 6 were reviews of the literature. Most studies included a sample size between 100 and 300 participants. Fifteen studies had a sample size of 299 participants or less and 13 had a sample size of 300 participants or more. Furthermore, 20 studies were cross-sectional in nature and 8 were longitudinal studies.

Seven studies utilized the PTSD Checklist, Military Version, and two studies used the PTSD Checklist, Civilian Version. Three studies also reported using a PTSD Checklist but did not specify which version. Five studies used the Patient Health Questionnaire to gather data and four studies used the Alcohol Use Disorders Identification Test or AUDIT. Three studies assessed combat experiences with the Combat Experiences Scale (CES). All other surveys and scales were used two times or less.

The 36 articles which were reviewed were then categorized into major and minor themes. Every article had only one major theme, but each article could include anywhere from 0 to 3 minor themes.

The themes were assessed by the quantity of the articles. Two major themes emerged from this research, mental health and aggression/violence. There were 23 articles that addressed

mental health concerns and 6 articles that reviewed aggression/violence. Three themes—employment/work problems, suicide, and substance misuse all had four articles a piece on the subject. Four minor themes—divorce, traumatic brain injury, sleeping difficulties and driving issues—were identified by only one or two articles.

For purposes of this review, two topics were grouped within larger categories. The first was aggression/violence which included anger outbursts, physical aggression, violence, and violence that led to incarceration. The second topic is employment/work problems which could range from difficulties at work to not finding employment.

Mental Health

PTSD

In analyzing the available data on psycho-social barriers to military reintegration, mental health was the most reoccurring theme across articles. Twenty-three articles discussed mental health as a leading barrier to reintegration. Mental health disorders may come as no surprise as there are many possible traumatic situations a veteran may experience overseas. A study by Bowling and Sherman (2008) found that out of 894 Army service members deployed to Iraq, “95% observed dead bodies or human remains, 93% were shot at or received small-arms fire, 89% were attacked or ambushed, 65% observed injured or dead Americans, and 48% were responsible for the death of an enemy combatant” (p. 451; further documented by Hoge et al., 2004).

However, a study by James, Van Kampen, Miller and Engdahl (2013) which included 271 OEF/OIF participants found that perceived threat during deployment was the most predictive measure of PTSD symptoms following combat experiences. The two most common diagnoses

given to OEF/OIF veterans were Posttraumatic Stress Disorder (PTSD) and Depression. While some articles discussed either PTSD or Depression, many articles included both making it difficult to determine which diagnosis was most challenging during reintegration to civilian life.

A study by James et al. (2013) reported that about one in five OEF/OIF veterans report having mental health symptoms once they return from deployment (further documented by Hoge, Auchterlonie, & Milliken, 2006). Ross and DeVoe (2014) found that 19.8% of veterans met criteria for PTSD, depression or anxiety upon their return home from deployment (Adler, Possemato, Mavandadi, Lerner, Chang, Klaus, Tew, Barrett, Ingram & Oslin, 2014).

Reporting from earlier research done by Tanielian and Jaycox in 2008, Pietrzak, Goldstein, Mallery, Rivers, and Southwick (2010) found that about 14% of nearly 2,000 OEF/OIF veterans screened positive for PTSD. While PTSD is usually varied among military departments, Lewis, Lamson, and Leseuer (2012), report that 20% of Marines have met criteria for PTSD and 18% of Army personnel also have PTSD. This is further supported by Eisen, Schultz, Vogt, Glickman, Elwy, Drainoni, Princess, Osei-Bonsu and Martin (2012) who found that Army and Marine service members report more mental health symptoms, more alcohol and drug use and more conflict in relationships than Air Force service members report. Breaking this down further, the same study found that 15% of Army personnel and 25% of Marines had probable PTSD as compared with 9.5% of Air Force personnel and nearly 6% of Navy service members (Eisen et al., 2012). Although first reported by Kang in 2006, Bowling and Sherman (2008) found a report from Veterans Affairs which recorded that over 35,000 U.S. veterans fighting in the Global War on Terrorism had visited VA clinics for possible PTSD as of June, 2006.

Eisen et al. (2012) reported that there are significantly more mental health symptoms with OIF veterans than there were with OEF veterans. A study from Hoge, Castro, Messer, McGurk, Cotting and Koffman in 2004 reported that 11% of OEF veterans returning from duty in Afghanistan had PTSD as compared with 15-17% of OIF veterans who returned from deployment in Iraq (Lapierre, Schwegler, & LaBauve, 2007; Sayers, Victoria, Farrow, Ross, & Oslin, 2009). Lapierre et al. (2007) also found higher rates of post traumatic stress symptoms in OIF veterans as compared to OEF veterans and also noted that OIF veterans were more likely to seek counseling services.

James et al. (2013) also reported that mental health symptoms continue to increase for veterans in the months following postdeployment (Wright, Cabrera, Adler, & Bliese, 2014; further documented by Milliken, Auchterlonie, & Hoge, 2007; and Seal, Bertenthal, Miner, & Marmar, 2007). Within four months of return from deployment 12.2 to 12.9% of active duty combat veterans screen positive for PTSD (Plumb, Peachey, & Zelman, 2014; also reported by Grieger et al., 2006; and Hoge et al., 2004). Furthermore, Griffith (2012) found that compared to currently deployed active duty personnel, reservists who have returned from deployment endorse more symptoms related to PTSD. Likewise, Adler, Possemato, Mavandadi, Lerner, Chang, Klaus, Tew, Barrett, Ingram, and Oslin, (2011) found that in the three to six months following the return of deployment to Iraq, 25% of reservists and 17% of active duty service members screened positive for PTSD (Adler et al., 2011).

Nearly one-third of OEF/OIF veterans who engage in care at Veterans Affairs clinics are diagnosed with PTSD (21.8%) and depression (17.4%) (Plumb, Peachey, & Zelman, 2014). Meis, Barry, Kehle, Erbes, and Polusny (2010) found that anywhere from 12 to 20% of OEF/OIF

veterans have screened positive for PTSD. In contrast another study found that as many as 31% of service members have PTSD (Demers, 2010; also reported by Tanielian & Jaycox, 2008).

Veterans with PTSD are also commonly diagnosed with other disorders as well (Mallen, Schumacher, Leskela, Thuras & Frenzel, 2014; also researched by Kehle et al., 2011). One study found that over 85% of OIF service members “diagnosed with PTSD had at least one other mental health diagnosis, with depressive disorders being the most common” (Mallen et al., 2014; also documented by Kehle et al., 2011). A study by Pietrzak and Southwick (2011) found that service members with high intensity combat trauma and PTSD severity also had higher levels of depression and alcohol misuse and lower levels of general social support. Mallen et al. (2014) report that service members diagnosed with PTSD also report a history of a concussion or mild traumatic brain injury.

Comparing past research Eisen et al. (2012) found that women are at higher risk of mental health diagnosis after a traumatic event whereas men are at a higher risk for substance use disorders. However, in their study of 596 veteran participants Eisen et al. (2012) did not find a statistically significant difference on mental health and gender differences, but did find evidence that more military men misuse alcohol than military women.

A study conducted by Knobloch, Ebata, McGlaughlin and Ogolsky (2013) report that “Both returning service members and their romantic partners are susceptible to depression, anxiety, posttraumatic stress, and relationship problems during the 6 months following homecoming” (p. 755; Blow, Gorman, Ganoczy, Kees, Kashy, Valenstein, Marcus, Fitzgerald, 2013; further documented in McNulty, 2005; Nelson Goff, Crow, Reisbig, & Hamilton, 2007; Renshaw, Rodrigues & Jones, 2008). Blow, Gorman, Ganoczy, Kees, Kashy, Valenstein, Marcus, and

Fitzgerald (2013) reports that “34% of spouses of recently deployed NG [National Guard] service members met the screening criteria for one or more mental health problems” (p. 305; also backed by Gorman, Blow, Ames & Reed, 2011). A study by Knobloch et al. (2013) which included 236 service members and utilized paired sample t tests found that at-home partners reported more depressive symptoms and more reintegration difficulty than the returning service member. Negrusa and Negrusa (2014) further support this by reporting that wives of deployed servicemen have poorer overall mental health than the wives of servicemen who have not deployed. Knobloch et al. (2013) found that “women’s depressive symptoms were positively associated with men’s reintegration difficulty” (p. 760). It is also important to note that research by Knobloch et al. (2013) refers to depressive symptoms and not clinical diagnosis of depression. Wright, Cabrera, Adler and Bliese (2014) reports that “not only is PTSD a risk to marital satisfaction, but PTSD is also more strongly related to relational problems for military couples than in civilian marriages” (p. 266).

A study by Lapierre, Schwegler, and LaBauve (2007) that screened 4,089 active duty Army service members that had recently returned from deployment in Iraq or Afghanistan in 2005 found two predictive variables that lowered an OEF service member’s scores of post traumatic stress. These variables for OEF veterans included being a noncommissioned officer, company grade officer or field grade officer as compared to being junior enlisted and secondly, being single rather than married (Lapierre, Schwegler, & LaBauve, 2007). They further found that among OEF veterans those who were separated or who had sought out counseling services since redeployment were linked with higher post traumatic stress symptoms (Lapierre, Schwegler, & LaBauve, 2007).

This same study found that among OIF veterans, “reporting a Pacific Islander ethnic background (vs. White) and being a senior NCO [noncommissioned officer], company-grade officer, or field-grade officer (vs. junior enlisted)” were correlated with less posttraumatic stress symptoms (Lapierre, Schwegler, & LaBauve, 2007, p. 937). Variables among OIF veterans that correlated positively to higher levels of posttraumatic stress symptoms included having sought out counseling services since redeployment and being separated or divorced rather than married (Lapierre, Schwegler, & LaBauve, 2007).

Veterans who suffer from PTSD also struggle in other interpersonal ways as well. Veterans who had screened positive for PTSD self-reported having fewer social supports, increased difficulties in relationships with loved ones, less family cohesion, lower marital satisfaction, less positive bonding, commitment, communication and more disorganization in thought control processes than other veterans seeking treatment (Tsai, Harpaz-Rotem, Pietrzak & Southwick, 2012; Lewis, Lamson & Leseuer, 2012; Sayers, Farrow, Ross & Oslin, 2009, Erbes, Meis, Polusny, & Compton, 2011; Meis et al., 2010). Beder, Coe, and Sommer (2015) found that those who had PTSD had negative reintegration experiences with family and work. Service members with PTSD report having poorer relationship adjustment than service members who do not have PTSD (Erbes, Meis, Polusny, & Compton, 2011).

This same study also found that veterans who had screened positive for PTSD had an increased fear in losing vigilance in their environment, more avoidant strategies, poorer functioning in social situations and lower life satisfaction than other veterans who sought treatment and did not screen positive for PTSD (Tsai et al., 2012). A study by Renshaw and Kiddie (2012) also

reported “maladaptive coping is also highly correlated with PTSD symptom severity” (p. 223; also documented by Sharkansky et al., 2000; Tiet et al., 2006; Rodrigues & Renshaw, 2010).

Street, Vogt and Dutra (2012) report that military women face unique challenges surrounding both deployment and reintegration that greatly affect their mental health. Women now make up a higher proportion of military forces than ever before with about 14% of military personnel being female; this further breaks down to more than 180,000 women who have been deployed (Street et al., 2012). Not only do women make up a higher percentage of the military now than in the past, but their roles are also changing meaning that women are now allowed to do more than in any other previous conflict (Street et al., 2012).

Some findings indicate that military women are about twice as likely to be diagnosed with PTSD than their male counterparts (Street, Vogt & Dutra, 2009; also reported by Tonlin and Foa, 2006). A study by Tanielian and Jaycox (2008) found that upon returning home from deployment in Afghanistan or Iraq, women were more likely than their male counterparts to screen positive for PTSD symptoms (Street et al., 2009). However, this study did not address whether or not the relationship between PTSD and gender varies with various levels of combat exposure (Street et al., 2009).

However, Street et al. (2012) also found that among Veterans Affairs users there is only a slight difference between men and women who meet criteria for PTSD; 13% for men and 11% for women. In contrast, a study by Lapierre, Schwegler, & LaBauve (2007) found that female OIF veterans were more likely to report depression symptoms than their male counterparts. In comparing PTSD avoidance symptoms among female and male service members, females seemed to have a greater difficulty adjusting to their relationships than men (Erbes et al., 2011).

While 44% of military men and 38% of military women have children, military mothers are “three times more likely to be single parents and five times more likely to be married to a military spouse” who may also be deployed (Street et al., 2012, p. 691). Furthermore, women who have served in the military are “two to four times more likely than their civilian counterparts to be homeless” (Street et al., 2012, p. 691).

Pietrzak, Goldstein, Malley, Rivers and Southwick (2010) report that confirmatory factor analysis propose that PTSD symptoms are best represented by either a dysphoria or emotional numbing model. Pietrzak et al. (2010) further stated that among various trauma exposed populations, the numbing/dysphoria symptoms associated more strongly with measures for anger, anxiety and depression (further documented by Palmieri et al., 2007; Milanak & Berenbaum, 2009; Asmundson et al., 2002). In addition to these findings, Pietrzak et al. (2010) also found that “dysphoria symptoms were associated with increased perceptions of stigma and barriers to care, decreased perceptions of unit and post deployment social support, and increased likelihood of suicidal ideation and mental health treatment” (p. 327).

“PTSD was associated with poorer functioning and that numbing/avoidance symptoms were the strongest predictors of social functioning” (Sayers et al., 2009, p. 661; also documented by Shea et al., 2010). A study by Nazarian, Kimerling, and Frayne (2012) found that a diagnosis of PTSD among service members had a positive relationship with poorer physical health, even more so than having a substance misuse disorder (also documented by Hoge et al., 2007; Anderson et al., 2010). Furthermore, this same study found that female service members with a diagnosis of PTSD had significantly increased chances of receiving a medical diagnosis in every category except for skin and infectious diseases (Nazarian et al., 2012). Likewise male service

members diagnosed with PTSD had an increased risk of other medical diagnoses except for genitourinary and infectious diseases (Nazarian et al., 2012).

Although there was a small effect size for both, Pietrzak et al. (2010) found that scores on the avoidance factor had a positive relationship with psychosocial difficulties and scores on the re-experiencing factor had a positive relationship with alcohol misuse.

In an original study by Charuvastra and Cloitre in 2008 and reported by Tsai et al. (2012) found that external resources such as a strong social supportive system have been correlated with less symptoms of PTSD.

Depression

Some studies have found that PTSD diagnoses among OEF/OIF veterans are usually comorbid with other mental health disorders (James et al., 2013; Lapierre, Schwegler, & LaBauve, 2007; Mallen et al., 2014). Likewise a study by Lapierre, Schwegler, & LaBauve (2007) found that veterans who self-reported more depressive symptoms also had more posttraumatic stress symptoms indicating a positive relationship between the two. This study further discovered that 24% of OEF and 24% of OIF veterans demonstrated “clinically significant levels of both post-traumatic stress and depressive symptoms” (Lapierre, Schwegler, & LaBauve, 2007, p. 940). Alder et al. (2014) noted that 13% of reservists and 10% of active duty service members screened positive for depression.

A study by Lewis, Lamson, and Leseuer (2012) found that the depression rate for female military service members is 22% and 15% for male service members. Compare this to the civilian rate of depression where 20-25% of civilian women have depression and 7-12% of civilian men have depression (Lewis, Lamson, & Leseuer, 2012). Rates of depression varied only slight-

ly for service members before and after deployment (Lewis, Lamson, & Leseuer, 2012). Lewis, Lamson, and Leseuer (2012) found that less than 12% of service members screened positive for depression prior to a deployment whereas the rate for depression increased to 15% following a deployment (further documented by Hoge et al., 2008). This is similar to Blevins, Roca and Spencer's (2011) finding that 15-20% of combat troops have depressive or anxiety symptoms (also supported by Milliken et al., 2007; Tanielian & Jaycox, 2008). However, a study by Beder, Coe, and Sommer (2015) reported a link between depression and combat exposure (Demers, 2010; also reported by Wells, LeardMann, & Fortuna, 2010).

Lapierre, Schwegler and LaBauve, (2007) found the following among OEF veterans: being divorced or separated rather than married, being female and having sought out counseling services since redeployment were associated with higher depression scores. However, being a noncommissioned officer, a field grade officer or company grade officer rather than junior enlisted were associated with lower depression scores (Lapierre, Schwegler, & LaBauve, 2007).

Results for OIF veterans were slightly different for depression scores. OIF veterans who scored lower depression scores identified as being Black or Pacific Islander as compared to being Caucasian and being a noncommissioned officer, senior noncommissioned officer, field or company grade officer as compared to being junior enlisted (Lapierre, Schwegler & LaBauve, 2007). Furthermore, OIF veterans who were white as compared with a black ethnic background reported more depression symptoms (Lapierre, Schwegler & LaBauve, 2007). OIF veterans who reported higher depression scores reported being divorced or separated rather than married (Lapierre, Schwegler, & LaBauve, 2007). They also tended to be more likely to seek out counseling services since redeployment (Lapierre, Schwegler & LaBauve, 2007).

In conclusion this study by Lapierre, Schwegler, and LaBauve,(2007) found three variables that were likely to be reliable predictors of increased depression and posttraumatic stress symptoms: having sought out counseling services since redeployment, being junior enlisted veterans, and being divorced or separated. One plausible reason for the last variable may be that social support through close relationships may mitigate symptoms of mental health; however, being single rather than married was also correlated with less posttraumatic stress scores among OEF veterans (Lapierre, Schwegler & LaBauve,, 2007).

Depression affects many domains of an individual's life. Some researchers have found that regardless of having a trauma history, depression in OEF/OIF veterans have increased insomnia (Plumb, Peachey & Zelman, 2014). Also, Sozda, Muir, Springer, Partovi, and Cole (2014) report that both memory and learning difficulties are most commonly found in those service members who have depression (further documented by Austin, Mitchell & Goodwill, 2001). Furthermore, higher levels of depressive symptoms were likely to be a significant predictor of a "reduced verbal learning performance" (Sozda et al., 2014).

Depression also affects a person's interpersonal relationships as well. It may not be surprising then to find that veterans and spouses/significant others who were depressed reported greater parenting distress, greater family chaos, and little relationship satisfaction (Blow et al., 2013). This same study found that a diagnosis of depression is a larger barrier to reintegration in terms of parenting, dyadic distress, and family chaos than alcohol misuse (Blow et al., 2013). In addition to impairing family and personal relationships, depression can also impair career advancement and lead to financial strain (Hazle, Wilcox & Hassen, 2012).

Mental Health Recovery

Smith, Benight and Cieslak (2013) report that impaired social relationships have negatively impacted trauma recovery (originally reported in a study by Ozer, Best, Lipsey, & Weiss, 2003). The reverse is also true. A study by Street, Vogt and Dutra (2009) reported that “socially supportive relationships among military personnel have been identified as a major resilience factor for military-related stressors, including those associated with combat exposure” (p. 690; James et al., 2013; Pietrzak & Southwick, 2011; also documented by Bliese, 2006; and Griffith & Vatikus, 1999). A study by Pietrzak and Southwick (2011) that involved 272 OEF/OIF service members found that those categorized as resilient, meaning high combat exposure but few combat-related PTSD symptoms, reported greater social support, self-perception of control and purpose, greater understanding from friends and family and increased relational support.

Levels of high social support have been shown to have a negative association with PTSD and depression for both a year and two years past deployment (Demers, 2010; James et al., 2013). Also, Smith, Benight and Cieslak (2013) report that a pivotal predictor of mental health disorders among combat veterans is a lack of perceived social support.

Smith, Benight and Cieslak (2013) further found that “enhanced social support promotes self-efficacy perceptions resulting in reduced distress severity levels” (p. 458; also reported by Schwarzer & Knoll, 2007). Similarly, both tangible support and the perception of available support seem to promote a healthier reintegration adaptation (Smith, Benight & Cieslak 2013).

In addition to these findings, cohesive relationships with unit service members has also been shown to mitigate the link between military stressors and PTSD (Street, Vogt & Dutra 2009; also documented by Brailey, Vasterling, Proctor, Constans, & Friedman, 2007). Further-

more, the perception of the unit's leadership ability and supportive service members have also been correlated with improved psychological well-being (Street, 2009; also documented by Griffith, 2002).

Meis, Barry, Kehle, Erbes and Polusny(2010) report that only about 23-40% of OEF/OIF veterans who screen positive for mental health disorders seek treatment. This can potentially skew the numbers listed above. Although the majority of studies use self reports to gather data it is unclear how accurate this data is and whether or not they under- or overreport their symptoms. Wright et al. (2014) reports that more mental health symptoms may occur after deployment than what can be studied as about one-fifth of service members will not accurately report their mental health symptoms when asked (also documented by Warner et al. 2011).

While social support can be a protective factor against mental health symptoms, Knobloch et al. (2013) found that for service members who did not participate in a program after deployment had more relational and reintegration difficulty and increased self doubt than those who did participate in such a program. Street, Vogt and Dutra (2009) reports that the goal of helping a service member should be to prevent "trauma exposure in the war zone, to identify significant negative mental health effects . . . as early as feasible, and to facilitate access to evidence-based treatment for these mental health conditions in an effort to reduce the burden of illness for . . . service members" (p. 694).

Aggression/Violence

Six articles reviewed anger, aggression and/or violence as a challenge to military reintegration. A 2008 survey involving more than 28,000 service members found that almost one-third of deployed Army soldiers self-reported that they had more conflict or argued more with their

partner since deployment (Schmaling, Blume, & Russell, 2011). Renshaw and Kiddie (2012) also report that avoidant coping and other maladaptive coping strategies among service members have been correlated with higher levels of anger and external aggressive behaviors (further documented by Maxwell and Sui, 2008; Taft et al., 2007).

Some research has found that younger age is associated with more aggressive behaviors, including intimate partner violence among combat veterans (Renshaw & Kiddie, 2012; Schmaling, Blume, & Russell, 2011; also documented by Taft et al., 2007; Taft, Vogt, et al., 2007; Jakupcak et al., 2007; Pietrzak et al., 2009). However, age by itself may not be the sole reason for this correlation. Research has found that younger age has also been associated with more maladaptive coping strategies (Renshaw & Kiddie, 2012).

In their study involving 143 male service members who had at least one OEF/OIF deployment, Renshaw and Kiddie (2012) found that anger was not associated with age, but with avoidant coping while both physical and verbal aggressive behaviors were associated with age and not avoidant coping strategies. However, one large limitation of this study is the homogeneity of the participants—most were White married males who were involved in the National Guard/Reserves (Renshaw & Kiddie, 2012). However, along with avoidant coping Renshaw and Kiddie (2012) reported that anger and aggression are also positively correlated with PTSD.

When examining violence an analysis done by Sreenivasan, Garrick, McGuire, Smeed, Dow and Woehl (2013) found that despite exposure to combat stressors, “an extremely small minority of combat veterans commit murders or serious violence” (p. 272). To break this down further, Sreenivasan et al. (2013) reported that while *New York Times* journalists Sontag and Alvarez

reviewed 121 cases in 2008 of Afghanistan and Iraqi veterans who were charged with homicide between 2005 and 2007, another 1.6 million veterans were serving during this same time period.

The Bureau of Justice 2004 Survey reported no relationship between combat exposure and veterans committing violent crimes (Elbogen, Cueva, Wagner, Sreenivasan, Brancu, Beckham & Male, 2014; Sreenivasan et al., 2013). Screenivasan et al. (2013) reports that veterans were incarcerated at less than half the rate of nonveterans (veterans: 630 per 100,000 and non-veterans 1,390 per 100,000). The rate of nonveteran violent offenders is nearly two times higher than veteran violent offenders (Screenivasan et al., 2013). Also, one study of 676 Iraq and Afghanistan veterans did not find a correlation between traumatic brain injuries endured during deployment and issues of anger and violence (Screenivasan et al., 2013).

A study by Elbogen et al. (2014) found two things—that veterans' self report of violent acts is related to the arrest records for violence and that PTSD is not directly linked to a higher risk of violence among veterans; therefore, other, non-PTSD risk factors should also be considered. While veterans with PTSD may have higher rates of anger and aggression as mentioned by Renshaw and Kiddie (2012) it may not lead to violence as discovered by Elbogen et al. (2014).

Schmaling, Blume and Russell (2011) report that intimate partner violence (IPV) is most severe and most common among military couples (also documented by Rentz et al., 2006). This study used a sample size of 546 mostly Reserve Component Army Soldiers who had served in Operation Iraqi Freedom and found that about one in seven or 13.5% of these soldiers had engaged in intimate partner violence within that year (Schmaling, Blume & Russell, 2011).

Those most likely to be the aggressor with intimate partner violence tended to be either moderate or heavy drinkers as compared to light drinkers or abstainers (Schmaling, Blume, &

Russell, 2011; further documented by Bell, Harford, McCarroll & Senier, 2004). Other factors from previous research that seems to increase likelihood of intimate partner violence after deployment include redeployment IPV, younger age, less relationship satisfaction, and increased stress (Schmaling, Blume & Russell, 2011; Blow et al., 2013; also documented by McCarroll et al., 2003; Newby et al., 2005; Fonseca et al., 2006; Rosen, Kaminski, Parmley, Knudson, & Fancher, 2003). Previous research studies have found mixed results with whether or not race and ethnicity play a role in intimate partner violence (Schmaling, Blume, & Russell, 2011).

Substance Use

Four articles addressed substance use as a barrier to military reintegration. Substance abuse is also a growing concern for veterans (Ross & DeVoe, 2014; Demers, 2010). Hazle, Wilcox and Hassan (2012) report that veterans who do not seek treatment for mental health symptoms are at increased risk for “self-medicating symptoms with alcohol or substances, which can further impair their reintegration and damage their personal relationships and financial security” (p. 234). Gouws (2013) reports that “many returning soldiers isolate themselves and engage in maladaptive behavior patterns to cope with the significant emotional impact of their experiences” (p. 167).

Alcohol use and abuse is most common following a service member’s return from deployment (Blow et al., 2013; Hazle, Wilcox and Hassan, 2012; also documented by Jacobson et al., 2008; Spera, Thomas, Barlas, Szoc & Cambridge, 2011; & Karney, Ramchand, Osilla, Caldarone & Burns, 2008). A study by Eisen et al. (2012) found that out of their 596 survey participants, 39% screened positive for ‘probable alcohol abuse’ and that those who most commonly abuse alcohol are military men rather than military women.

Alcohol misuse tends to be co-morbid with mental health disorders including PTSD, depression and anxiety (Blow et al., 2013; Lewis, Lamson & Leseuer, B. 2012; Nazarian, Kimerling & Frayne, 2012; also reported by Karney et al., 2008; Jacobson et al., 2008; and Boudewyns, Albrecht, Talbert & Hyer, 1991). Nazarian, Kimerling, and Frayne (2012) report that among OEF/OIF service members who have substance and/or drug use disorders, 63-76% also have a PTSD diagnosis (also reported by Seal et al., 2011). This relates strongly to a study done by Lewis, Lamson and Leseuer (2012) which found that veterans who have been diagnosed with depression or PTSD are more than two times likely to misuse alcohol as compared to veterans who are not diagnosed with these disorders.

Veterans who are at higher risk for alcohol misuse include those who are young, have been deployed more frequently and for longer durations, those who have experienced combat, and those who are involved in the National Guard or Reserves (Blow et al., 2013; also reported by Spera et al., 2011; and Jacobson et al., 2008). In contrast, a study by Eisen et al. (2012) found that while 26% of Air Force and Navy personnel screened positive for alcohol use, those who more often misuse alcohol are Marines (45%) and Army personnel (47%). Blow et al., (2013) also reports that National Guard and Reserves veterans who had recently been exposed to combat were more likely to engage in binge drinking, new-onset heavy drinking and other alcohol related problems compared to National Guard and Reserves veterans who did not deploy (further documented by Jacobson et al., 2008).

A study by Blow et al., (2013) which included 1,143 National Guard members and 674 spouses or other significant others who assessed their alcohol use by utilizing the AUDIT scale, or Alcohol Use Disorders Identification Test. This study found that 29.2% of National Guard

veterans and 10.7% of spouses/significant others reported hazardous drinking within 90 days of returning from deployment (Blow et al., 2013). Of veterans that reported hazardous drinking, 75% of participants reported drinking at least 2-3 times weekly, 27.3% reported blacking out at least once a month after drinking, 21.9% reported feeling guilty after drinking, and 11.3% reported needing a drink to get moving in the morning at least once monthly (Blow et al., 2013). There were similar results among spouses/significant others who met criteria for hazardous drinking: 62% reported drinking alcohol at least 2-3 times weekly, 21.4% reported blacking out at least once monthly after drinking, 21.4% also reported feeling guilty after drinking, and 8.6% reported needing a drink to get going in the morning (Blow et al., 2013).

This same study found that veterans who were more likely to be involved in hazardous drinking were less educated, childless, unmarried, younger (< 30 years), male, made less income (< \$30,000) and had a rank between E1 and E4 (Blow et al., 2013). Spouses or significant others who met the criteria for hazardous drinking tended to be unmarried, younger, and childless (Blow et al., 2013).

This same study found that “when service members’ spouses drank more, service members perceived more family chaos” (Blow et al., 2013, p. 308). However, Blow et al., (2013) also found that “when service members drink more, their spouses report less stress in their own parenting” (p. 308). Service members also report being less happy in their relationships when one or both parties in the relationship misuse alcohol (Blow et al., 2013). Blow et al. (2013) concludes that mental health disorders should be treated first as this may be what exacerbates alcohol misuse in veterans.

Suicide

Two articles discussed suicide as a barrier to reintegration although it has been a re-occurring theme that has been casually discussed by other researchers (Bowling & Sherman, 2008; Griffith, 2012; Lewis, Lamson & Leseuer, 2012; Mallen et al. 2014; Ross & DeVoe, 2014). Research by Mallen et al. (2014) found that suicide is the third leading cause of death within the Army population. Griffith (2012) found that the suicide rate for veterans, particularly for Army veterans and the Marines have risen since 2004. Furthermore, the military suicide rate surpassed the rate of civilian suicides in 2008, even after adjusting for age (Griffith, 2012). This would equal 20.2 military suicides versus 19.2 civilian suicides per 100,000 (Griffith, 2012).

Bowling and Sherman (2008) discovered that the rate of completed suicides among Army personnel who had been deployed to Iraq for Operation Iraqi Freedom was greater than that compared with personnel from the Army at large. This breaks down to 19.9 OIF Army soldiers out of 100,000 compared with 13.1 general Army soldiers per 100,000 (Bowling & Sherman, 2008; also reported by the Office of the Surgeon, Multinational Force—Iraq and Office of the Surgeon General, U.S. Army Medical Command, 2006). Lewis Lamson and Leseuer (2012) reported that while about 4% of military personnel have suicidal ideation another 9% have gone on to attempt suicide. The Army National Guard is the military branch which reports the highest rates of suicide (Griffith, 2012).

A study by Bryan, Mc-Naughton-Cassill and Osman (2013) report past studies that have attempted to explore a connection between military personnel who experienced both combat and suicidal thoughts and actions have yielded only mixed results. Griffith (2012) found a review done by Martin, Chahramanlou-Holloway, Lou, and Tucciarone in 2009 which found strong evi-

dence “that severe, untreated PTSD is associated with suicidal behavior” (p. 454). In contrast, Griffith (2012) also found a meta-analysis by Krysinska and Lester in 2010 which found that while PTSD was linked to previous suicide attempts and current suicidal ideation, there was no “increased risk of completed suicide among those individuals with PTSD” (p. 454). In his own study, Griffith (2012) found that out of 4,567 survey respondents, only 4% of veterans who had directly witnessed a traumatic event had endorsed any suicidal symptoms both during and after deployment.

However, PTSD is commonly co-morbid with depression and major depressive disorders and are the “most prevalent co-occurring mental health condition for completed suicides” (Griffith, 2012; also supported by Arsenault-Lapierre, Kim & Turecki, 2004; Rihmer, 2007; Isometsa, 2001). Mallen et al. (2014) discovered that a diagnosed mental health disorder has been correlated with a greater risk of suicide among OEF/OIF service members as compared with non-OEF/OIF service members (also researched by Ilgen et al., 2012). A study originally conducted by Guerra and Calhoun in 2011 found that among OEF and OIF veterans those who were diagnosed with PTSD and co-occurring alcohol abuse and depression were equally at risk for suicidal ideations as those who were diagnosed with only PTSD; however, both PTSD and depression diagnoses among veterans were linked with a history of suicide attempts (Griffith, 2012). Griffith (2012) concluded in his study that it appeared in a greater or lesser extent that “the effects of war specifically related to post deployment PTSD symptoms and suicidality lie . . . in negative mood” (p. 464). He also found that veterans who had previous deployments were positively correlated with both suicidality and symptoms of PTSD both during and after deployment (Griffith, 2012).

Combat and mental health symptoms may not be the only reasons why the suicide rate for military personnel has increased. Knobloch et al. (2013) reported that in 2010, 30% of completed suicides among military personnel had experienced the dissolution of a romantic relationship in the preceding month whereas 50% of completed military personnel suicides followed a failed romantic relationship. Blow et al. (2013) reinforces this by stating that distressed marriages and divorce can also lead to suicide. Another factor that seems to increase suicidal behavior is lacking the financial resources to meet basic needs (Mallen et al., 2014).

Some studies that reported samples with the mean age above 30 years have found significant suicide risk effects while studies who report the mean age to be below 30 years did not find significant suicide risk effects (Bryan, Ray-Sannerud, Morrow & Etienne, 2013b; also documented by Maguen et al., 2012, Thoresen & Mehlum, 2008; Bryan et al., 2013a, Griffith, 2012; Sareen et al., 2007). However, Bryan et al. (2013b) reports that no current study has sought to use age as a moderating factor between suicidal ideation and exposure to combat.

Bryan et al. (2013b) conducted a study with 273 active duty U.S. Air Force Security Forces personnel who varied in age from 19 to 50 years old with the average age being 25.9 years old. Of these participants Bryan et al. (2013b) found that 2.2%, or 6 Air Force personnel attempted suicide at least once while 14.3% or 39 Air Force personnel endorsed recent suicidal ideation. This same study found that even after controlling for suicide risk factors including past suicide attempts, emotional distress, gender, and perceived burdensomeness, there is a strong correlation between the intensity of the combat exposure and the severity of suicidal ideation among Airman personnel (Bryan et al., 2013a). He also found that as age increased so did the

severity of suicidal ideation, particularly more so in Airman personnel above the age of 34 (Bryan et al., 2013a).

Regardless of mental health, Lewis, Lamson and Leseuer (2012) reports that service members returning from OEF/OIF deployments were more likely to self-report suicidal ideations if they also had endured pain as the result of an injury (further documented by Pietrzak et al., 2011). Suicidal ideation may also relate to survivor guilt, re-adjustment to civilian life and inner turmoil (Bowling & Sherman, 2008; also reported by Hoge et al., 2006).

Divorce

More than one half of service members are married; therefore, the gradual increase in divorce rates among service members since 2001 is an important component to examine (Negrusa & Negrusa, 2014; Lewis, Lamson & Leseuer, 2012; Hazle, Wilcox & Hassan, 2012). Some research has found that service members tend to marry earlier and divorce earlier than their civilian counterparts (Hazle, Wilcox and Hassen, 2012; also reported by Hogan & Seifert, 2010; Karney & Crown, 2007). Hazle, Wilcox and Hassen (2012) report that female service members are 2-3 times more likely to be divorced than their male counterparts (also documented by Karney & Crown, 2007).

Negrusa and Negrusa (2014) found that PTSD symptoms among Army enlisted personnel increased the likelihood of divorce by 10 to 20%. This same study found that for officers the chances of divorce were even higher, 50 to 75% comparatively (Negrusa & Negrusa). Even in the civilian population, mental health disorders are “negatively correlated with marital satisfaction and stability” (Negrusa & Negrusa, 2014, p. 898; also researched by Davila et al., 2003;

Kessler et al., 1998; Whisman, 2001). Furthermore, when these changes in mental health are unexpected, they also increase the risk of divorce (Negrusa & Negrusa, 2014).

However, PTSD and other mental health disorders are not the sole reasons for divorce among military personnel either (Negrusa & Negrusa, 2014). Service members who deploy versus those who do not are more likely to get divorced even without having any mental health disorders or symptoms (Negrusa & Negrusa, 2014). Negrusa and Negrusa, (2014) also found that the longer the duration of deployment, the more likely they would become divorced or separated (Schmaling, Blume & Russell, 2011). Negrusa and Negrusa (2014) report that with multiple deployments, the damage is already done after the first deployment. This seems to support earlier research done by Karney and Crown in 2007 that found that the number of deployments does not increase the risk of divorce (Negrusa & Negrusa, 2014).

Also, Schmaling, Blume and Russell (2011) found that more junior enlisted soldiers rather than noncommissioned officers reported anticipating a divorce or separation upon return from deployment. However, this same study did not examine possible factors leading to divorce outside of deployment (Schmaling, Blume, & Russell, 2011).

Sleep

Sleep disturbance emerged as a minor theme of military reintegration. Sleep disturbances are often linked to mental health disorders such as PTSD, depression, anxiety and substance abuse (Plumb, Peachey & Zelman, 2014). Sleep disturbances are the most endorsed symptoms of PTSD and affect about 90.5% of service members who have this diagnosis (Plumb, Peachey & Zelman, 2014). Plumb, Peachey and Zelman (2014) reports that every cluster of PTSD (re-experiencing, hyperarousal, and avoidance per DSM IV) is affected by sleeping difficulties:

“nightmares are a form of reexperiencing, individuals may purposefully delay sleep onset in order to avoid distressing dream content, and chronic hyperarousal may produce insomnia” (p. 209).

A study by Plumb, Peachey and Zelman (2014) found that those participants who reported having symptoms of depression, anxiety or PTSD were more likely to have decreased total sleep time, poor overall sleep, increased sleep latency (time it took to fall asleep), and other specific sleep complaints. Plumb, Peachey and Zelman (2014) also reports that those who experience sleep disturbance shortly after a traumatic event are more likely to be diagnosed with PTSD than those who do not report sleep disturbances after a traumatic event (also documented by Harvey & Bryant, 1998). This study also found that potential warning signs of sleep apnea such as snoring and problems with breathing while asleep were significantly correlated with levels of anxiety, depression and PTSD (Plumb, Peachey & Zelman, 2014).

In addition to mental health disorders, a study originally done by Wallace et al. (2011) reported that of 30 OEF/OIF veterans, participants who had insomnia also had higher levels of pain and fatigue (Plumb, Peachey & Zelman, 2014).

Some sleep patterns were found regarding sleep latency or the time it took for one to fall asleep per self-reports. These patterns include: shorter sleep latency for veterans who reported light combat exposure (30.76 minutes on average) to greater sleep latency for veterans who reported heavy combat exposure (73.57 minutes on average); and as one's rank increased his or hers sleep latency decreased (Plumb, Peachey & Zelman, 2014). Plumb, Peachey and Zelman (2014) also found that those with a rank of E1 to E3 reported the greatest sleep latency out of all ranks and that those who were divorced or widowed reported less total sleep time as compared to

married or single participants. Women and those with less education also reported more difficulties relating to sleep (Plumb, Peachey & Zelman, 2014). It is also important to note, however, that no sleep difficulties were found based on military branch or ethnicity (Plumb, Peachey & Zelman, 2014).

Plumb et al. (2014) found three common themes as related to sleep difficulties from the 348 participants who participated in the study: nightmares, hyperalert symptoms and ruminative worry. Bowling and Sherman (2008) found that some military personnel can only sleep if surrounded by sound such as having a television playing or a fan running. Participants from the Plumb et al. (2014) study also reported initial and middle insomnia, excessive movements during sleep, pain, awakening frequently, and avoiding sleep (Plumb, Peachey & Zelman, 2014).

Driving

Along with sleep disturbances, driving was another very minor theme for reintegrating back to U.S. culture and norms following a deployment. Hwang, Peyton, Kim, Nakama-Sato and Noble (2014) report that motor vehicle crashes (MVCs) are the leading cause of death for veterans in the first few years of returning from deployment and that OEF/OIF veterans have a greater chance of dying from an MVC than the general population. While it is unknown why exactly this is some possible explanations could be that veterans may practice more unsafe and more risky driving behaviors or that MVCs are the result of mental health symptoms, a traumatic brain injury, driving stress, or substance abuse issues (Hwang et al., 2014; also reported by Lew, Amick, Kraft, Stein, & Cifu, 2010; Sayer et al., 2010; Prudencio & Sadler, 2011; Burke, Olney, & Degeneffe, 2009). However, in a 2011 study by these same researchers—Kim, Nakama, Noble and Peyton found that veteran participants reported that the stress and anxiety they felt while

driving was related to combat driving restrictions which would include things such as convey rules and the constant threat of roadside violence (Hwang et al., 2014).

In their study involving the Driver's Stress Profile (DSP) Hwang et al. (2014) found that veterans who drove more frequently while deployed had a higher score on their DSP than those veterans who drove less frequently. This study further found that nearly 55% of their 103 participants were able to return to normal driving within 6 months of returning from deployment (Hwang et al., 2014). It also found that almost 17% of veterans needed six months or longer to return to normal driving, but nearly 29% still reported being unable to resume normal driving (Hwang et al., 2014). While this study helps to give some statistics to the concern of safe driving for veterans, it is also a study that used convenient and snowball sampling and therefore may not be generalizable to the broader population.

Traumatic Brain Injury

Rates of traumatic brain injuries (TBI) have risen considerably within the veteran population (Ross & DeVoe, 2014). Sozda, Muir, Springer, Partovi and Cole (2014) found that an estimated 10-22% of OEF/OIF veterans have endured a TBI as a result of combat (further documented by Edler, Mitsis, Ahlers, & Cristian, 2010; Hoge et al., 2008; Terrio et al., 2009). This study further reports that since 2000, there have been nearly 260,000 incidences of TBI within the military (Sozda et al., 2014; further documented by Defence and Veterans Brain Injury Center, 2013). Bowling and Sherman (2012) report that nearly 22% of the wounded military personnel have experienced a TBI (also reported by Okie, 2005). TBIs are usually associated with "changes in mood and behavior, including depression, anxiety, impulsiveness, and difficulty with concentration and memory" (Bowling & Sherman, 2012, p. 451).

TBIs were rarely addressed directly in the research; instead, the byproduct of a TBI was reported more frequently. For example, Lewis, Lamson and Leseuer (2012) reported that when service members returned home from deployment with physical injuries, huge negative changes also occurred within their marriages (also documented by Collins and Kennedy, 2008). Also, a study by Sozda et al. (2014) found that somewhere between 22-31% of service members who had endured a mild TBI also reported more depression symptoms (further documented by Hoge et al., 200; Vasterline et al., 2012). Furthermore, Lewis, Lamson and Leseuer (2012) found that service members who had a TBI and a diagnosis of PTSD also had an increased likelihood of alcohol misuse than those who had a TBI but no diagnosis of PTSD.

One reason that mild TBIs are not recorded or researched may be that soldiers with these conditions rarely seek medical attention and therefore, many medical records do not exist for the vast majority of mTBIs that do occur (Sozda et al., 2014).

Unemployment

Alder et al. (2011) reports that 18% of OEF/OIF veterans have difficulty in holding a job (Resnik & Allen, 2007). Research from the Bureau of Labor Statistics has found that veterans involved in the most recent conflicts in Afghanistan and Iraq and those veterans who are young experience higher rates of unemployment than their civilian counterparts (Kleykamp, 2013). In contrast, Beder, Coe and Sommer (2015) found a correlation between veterans who were between the ages of 40 and 50 years of age and negative work experiences. However, employment is one of the biggest challenges among veterans who have physical injuries (Resnik & Allen, 2007).

Female service members experience greater unemployment rates than male service members, and are also nearly twice as likely to face unemployment (13.7 compared to 7.3) as civilian women are (Kleykamp, 2013). When studying unemployment by race, Kleykamp (2013) found that black service members are less likely than all other racial groups to encounter unemployment. However, veterans who have a college degree do not face statistically significant unemployment rates compared with their civilian counterparts (Kleykamp, 2013).

Research from Adler et al. (2011) found that veterans who were unemployed were more likely to have problems with physical and mental functioning as well as be diagnosed with depression. Nazarian, Kimerling and Frayne (2012) found that PTSD is associated with more missed days at work (also reported by Hoge, Terhakopian, Castro, Messer, & Engel, 2007). In comparing civilians with PTSD and veterans with PTSD in relation to impaired work functioning which included multiple days of missed work and difficulty with coworkers, Alder et al. (2011) found similar levels of impairment among both civilians and veterans. Therefore, combat and deployment itself may not be the cause of work impairment.

The Work Limitations Questionnaire (WLQ) was utilized to find various work impairments among veterans of OEF/OIF (Alder et al., 2011). This study found significant impairment in the mental-interpersonal aspects of work performance among those veterans who had a diagnosis of PTSD, major depression, panic disorder or generalized anxiety disorder (Alder et al., 2011). Impairment with time management was also strongly related with these same mental health disorders as well as enduring a significant head injury (Alder et al., 2011). Impairment regarding work output was correlated with having met the criteria for PTSD, major depression, panic disorder, generalized anxiety disorder, alcohol dependence or illicit drug use and being

male (Alder et al., 2011). Impairment with meeting the physical demands of work was correlated with having a partner or being married, having endured a significant head injury and having alcohol dependence or illicit drug use (Alder et al., 2011).

Furthermore, productivity loss was mostly correlated with mental health disorders such as PTSD, major depression, panic disorder, generalized anxiety disorder and alcohol dependence or illicit drug use (Alder et al., 2011). In considering median salaries the average costs in lost productivity includes: \$929 for major depression; \$904 for panic disorder or generalized anxiety disorder; \$651 for PTSD; and \$561 for alcohol dependence or illicit drug use (Alder et al., 2011).

The average national unemployment rate in 2011 was 8.95% as compared to an unemployment rate of 12.1% for active duty service members (Hazle, Wilcox & Hassan, 2012). Possible reasons for a greater unemployment rate among veterans may be that their mental health symptoms can greatly impair their work ability or that they have struggled with translating their military work experience into positive work skills.

Discussion

This systematic review found a total of 44 articles regarding psycho-social barriers to military reintegration. Eight articles were reviewed but discarded for this review. Of the 36 remaining articles that were reviewed, analyzed and incorporated within this research, 23 articles focused on mental health barriers and was thus identified as the biggest barrier to reintegration in this research.

This review found that anywhere from 15 to 25% of military personnel develop PTSD (Adler et al., 2014; Eisen et al., 2012; Lewis, Lamson, & Leseuer, 2012; Pietrzak et al., 2010; & Ross & DeVoe, 2014). Furthermore, far more mental health symptoms were found among OIF veterans rather than OEF veterans and OIF veterans were more likely to seek treatment (Eisen et al., 2012; Hoge et al., 2004; & Lapierre, Schwegler & LaBauve, 2007). However, research has found that positive social supports help to mitigate mental health symptoms (Demers, 2010; James et al., 2013; Pietrzak et al., 2010; Smith, Benight, & Cieslak, 2013; Street, Vogt, & Dutra, 2009).

Aggression and violence was another major theme throughout the articles. Six articles dealt with this issue. Some research has found a correlation between younger age and aggressive behaviors (Renshaw & Kiddie, 2012; Schmaling, Blume & Russell, 2011). However, younger age is also associated with more maladaptive coping skills (Renshaw & Kiddie, 2012). While anger and aggression may be a byproduct of PTSD or other mental health symptoms, very few veterans go on to commit serious or violent acts to others (Sreenivasan et al., 2013).

Other areas that were reviewed include work difficulties and unemployment, suicide, divorce, substance misuse, traumatic brain injury, sleep disturbances and driving difficulties.

Strengths and Limitations

Research such as this is important as it can help clinicians gain a deeper understanding of the issues that returning service members face when reintegrating back into civilian life. This information can help clinicians develop and create programs that will be better able to address some of these presenting issues.

Another strength of this review is that it combines research from multiple domains of reintegration. Whereas other research tends to focus on one or two aspects of a service member's return from deployment this research broadens that scope to be more inclusive of the issues that face military personnel.

This systematic review found many articles that identified mental health as the biggest challenge to reintegration. Future research should address stigma and barriers related to accessing mental health care. Also, future research could focus on other barriers related to reintegration such as family life, relational conflict, and social functioning.

Contributions to Clinical Social Work

This systematic review is relevant to social work as it provides an overview of the biggest challenges that service members face as they return from deployment and reintegrate into family and societal life. Understanding what these challenges are can help social workers to advocate for funding and programming. Furthermore, this information can help social workers organize programs that are relevant to the issues that military personnel face. Hopefully such programs will be able to help service members successfully reintegrate back into civilian life.

This information is also important so that services and programming can be expanded to reach the most veterans possible.

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