

US Military Veterans' Difficult Transitions Back to Civilian Life and the VA's Response

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Introduction

During the United States' post-9/11 wars, the American public has been presented with many overly simplistic stories of how the wars affect US service members. Media accounts of troops who survive combat often highlight the devastating effects of physical and psychological trauma, and instances when the government has failed to provide adequate care for injured veterans. One prominent example was an investigation in 2007 which exposed the dilapidated living conditions of severely injured soldiers who were rehabilitating at the Army's Walter Reed hospital in Washington, DC.² More recent reporting in 2015 highlighted a disproportionately high number of suicides within a single Marine battalion.³ These dramatic portrayals of the physical and mental health consequences of war for American troops are an important part of a larger picture, but focusing primarily on the physical and emotional traumas of war survivors overshadows some of the other significant consequences of participating in – and then exiting – the military during these war years.

Young veterans regularly observe that the military does an extremely effective job of training them to operate within the military, and an extremely poor job of reversing that training or preparing them before sending them back into civilian life. The basic idea that veterans must embark on a “transition” as they move from military to civilian life has been central for researchers, doctors, policy-makers, and activists thinking about the physical, emotional, and social experiences of post-9/11 veterans. There are advantages and disadvantages to describing these consequences as a “transition.” “Transition” provides an

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² Priest, D., & Hull, A. (2007, February 18-20, March 5). The Other Walter Reed. *The Washington Post*. Retrieved from <http://www.pulitzer.org/winners/staff-65>

³ Philipps, D. (2015, September 19). In Unit Stalked by Suicide, Veterans Try to Save One Another. *The New York Times*. Retrieved from <http://www.nytimes.com/>

alternative to “trauma,” promotes a comprehensive view of veterans’ post-military difficulties, and it has been used to encourage veterans to seek help in spite of recalcitrant stigmas surrounding mental health concerns such as post-traumatic stress disorder (PTSD).⁴ At the same time, a focus on individual veterans’ personal processes of change or growth risks obscuring the fact that veterans’ post-military lives are connected to larger political, organizational, and economic contexts.

This report describes the intersecting social and medical problems indexed by the idea of “transition” for the purpose of highlighting the many ways that post-military life can be disorienting and difficult. In recent years, the US Department of Veterans Affairs (VA) has recognized this and begun increasingly to support veterans’ transitions back to civilian life. The non-medical dimensions of veterans’ “transitions” are necessary context for understanding the complexity of the VA’s institutional task, and its unique potential to provide a sense of stability for veterans, beyond caring for them in the strictly medical sense.

A new generation of veterans

People who have been members of the US military since October 2001 constitute a new generation of veterans. They are now, or will become, veterans of the United States’ post-9/11 armed conflicts—military operations which have an increasingly complex set of official titles: in Afghanistan, Operation Enduring Freedom (OEF) and Operation Freedom’s Sentinel (OFS); in Iraq, Operation Iraqi Freedom (OIF), Operation New Dawn (OND), and beginning in August 2014, Operation Inherent Resolve (OIR).⁵ Between 2002 and 2015, 1.9 million veterans who served in these wars became eligible for VA services (by virtue of having been discharged from the military in good standing).⁶

All branches of the military are staffed mostly by junior enlisted service members and noncommissioned officers. Since 2003, enlisted service members have been leaving the military at a rate of roughly 250,000 each year, and the Defense Department estimates the

⁴ Anthropologist Erin Finley’s book *Fields of Combat: Understanding PTSD among Veterans of Iraq and Afghanistan* contains a comprehensive discussion of stigma as it shapes service members’ experience of PTSD and mental health care. Finley, E. P. (2011). *Fields of Combat: Understanding PTSD among Veterans of Iraq and Afghanistan* (chapters 6 and 7). Ithaca: Cornell University Press.

⁵ Thus far, this generation of veterans has been categorized in most VA data as “OEF/OIF/OND veterans.”

⁶ VA estimates this number at 1.9 million. Epidemiology Program, Post-Deployment Health Group, Office of Patient Care Services, Veterans Health Administration, Department of Veterans Affairs. (2017, January). *Analysis of VA Health Care Utilization among Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) Veterans: Cumulative from 1st Qtr FY 2002 through 3rd Qtr FY 2015 (October 1, 2001 – June 30, 2015)*. Washington, DC: Author. Retrieved from <http://www.publichealth.va.gov/docs/epidemiology/healthcare-utilization-report-fy2015-qtr3.pdf>.

Defense Department annual reports suggest that the number of service member discharged from the military during this same period is closer to 3.3 million. Explaining the difference between these figures is outside of the scope of this report, but one reason for the discrepancy is the character of service members’ discharge, which effects their VA eligibility.

rate will remain high through 2019, with an estimated 230,000-245,000 enlisted service members and officers separating from the military each year.⁷

Veterans Leaving the Military (2003 - 2019)

Active Duty Separations and Reserve Losses	
2003	275,000
2004	298,000
2005	274,000
2006	262,000
2007	269,000
2008	251,000
2009	248,000
2010	240,000
2011	244,000
2012	267,000
2013	271,000
2014	245,000
2015 - 2019 (per year, enlisted and officer, est.)	230,000 - 245,000
Estimated 2003 - 2019	4.3 million⁸

As a population, enlisted service members are younger than officers. Many enlisted service members do not have college degrees when they join the military. For example, in 2008, the year in which the highest concentration of US troops deployed overseas, 52 percent of enlisted service members were 25 years old or younger, and only 4.5 percent had a bachelor’s degree.⁹ Furthermore, when service members exit the military, they need new

⁷ The numbers from 2003 - 2014 represent *enlisted* service members only, and are calculated from the Defense Department’s annual Demographics Reports. US Department of Defense. (2003-2014). *Demographics Reports*. Retrieved from http://www.militaryonesource.mil/footer?content_id=279104. I have included Active Duty Enlisted Members separations and retirements, and Enlisted Members Losses from Army National Guard and Reserve, Navy Reserve, Marine Corps Reserve, Air Force National Guard and Reserve who transferred to civilian life or to the Individual Ready Reserves or Standby Reserves. The projected numbers through 2019 represent *do not differentiate between* enlisted service members and officers. US Government Accountability Office. (2014). *Transitioning Veterans: Improved Oversight Needed to Enhance Implementation of Transition Assistance Program [GAO-14-144]*. Retrieved from <http://www.gao.gov/assets/670/661361.pdf>

⁸ This estimate is higher than the VA’s estimated 1.9 million OEF/OIF/OND veterans because the military’s separations and losses data do not distinguish between service members based on their period of service or the character of their discharge.

⁹ US Department of Defense. (2008). *2008 Demographics Report*. Retrieved from <http://download.militaryonesource.mil/12038/MOS/Reports/2008%20Demographics.pdf>

jobs.¹⁰ Between 2014 and 2016, from 65 percent to 80 percent of veterans surveyed left the military without a job, expecting to find meaningful employment quickly.¹¹

In broad strokes, this is a population of young veterans who are simultaneously finding new jobs, establishing new daily routines, and taking on new challenges like earning college degrees. Exiting the military can also mean relocating, living independently for the first time, reuniting with a partner and children after long periods overseas, or becoming a parent. These major life changes are challenging for military veterans, just as they are challenging for anyone. The challenges associated with these changes are not easily studied or represented, in part because they are not captured by medical diagnoses, and in part because it is difficult to draw meaningful lines between physiological, psychological, and social problems. Moreover, this stuff of everyday life tends to be overshadowed by veterans' other, more extreme, experiences in combat. However, recent research – in particular, survey research from the University of Southern California¹² – and the VA's increased spending on employment and education, together provide a more holistic view of veterans' post-military struggles, clarifying both the scope of veterans' needs and the scope of the VA's institutional responsibilities.

“Transitioning” out of the military

When service members become veterans, they exit an institution which trained them in very specific skills, behaviors, and values: they have learned the technical skills necessary to operate weapons, technology, and machinery; they have learned to act in extremely high-stakes situations; they have learned how to operate within an institutional hierarchy. Importantly, service members have learned all of these skills using an institutional language that is so specialized that it sometimes fails to translate even *between* different branches of the military. These gaps between military and civilian work are the subject of a brief formal training program service members complete before they leave the military and resume life

¹⁰ Reservists who were activated may return to find their jobs still available. However, 61 percent of the people who became veterans through the end of February 2015 were Former Active Duty and therefore, would be switching jobs. Epidemiology Program, Post-Deployment Health Group, Office of Patient Care Services, Veterans Health Administration, Department of Veterans Affairs. (2017, January). *Analysis of VA Health Care Utilization among Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) Veterans: Cumulative from 1st Qtr FY 2002 through 2nd Qtr FY 2015*. Washington, DC: Author. Retrieved from <http://www.publichealth.va.gov/docs/epidemiology/healthcare-utilization-report-fy2015-qr1.pdf>

¹¹ Castro, C. A., Kintzle, S., & Hassan, A. (2014). *The State of the American Veteran: The Los Angeles County Veterans Study*. Los Angeles: USC Center for Innovation and Research on Veterans & Military Families. Retrieved from http://cir.usc.edu/wp-content/uploads/2013/10/USC010_CIRLAVetReport_FPpgs.pdf; Kintzle, S., Rasheed, J. M., & Castro, C. A. (2016). *The State of the American Veteran: The Chicagoland Veterans Study*. Retrieved from <http://cir.usc.edu/research/research-projects/chicagoland-veterans-study>

¹² Between 2014 and 2016, the University of Southern California School of Social Work Center for Innovation and Research on Veterans & Military Families released reports of original survey data collected in Los Angeles (2014), Orange County (2015), and Chicagoland (2016, with Loyola University Chicago). The reports are titled “The State of the American Veteran” and they are available (open access) at USC Center for Innovation and Research on Veterans & Military Families. (2014-2016). *The State of the American Veteran*. Retrieved from <http://cir.usc.edu/publications/other-reports>.

in the civilian society from which they have been relatively isolated.¹³ Department of Defense and VA employees counsel veterans about their benefits, including employment and relocation assistance, educational opportunities, health and life insurance, and educate them about financial planning, resume writing, and job search skills. In spite of documented improvements to the military's transition program in recent years, the program's effectiveness is limited by its brevity, and by the fact that veterans complete the training in the weeks before they are released from their military contracts: they are excited, distracted, and generally unconcerned with finding work immediately.

Eventually, when veterans are ready to look for new work, they may be unprepared for a variety of reasons. Military work happens in a disciplined, rigid, high-stakes environment with a relatively transparent salary structure and authority hierarchy. Being accustomed to a military work environment diminishes veterans' job preparedness in unexpected ways. For example, interviews with case managers showed that veterans have unrealistic expectations of how their skills will transfer to the civilian job market. Although they are highly motivated to work hard and move up corporate hierarchies, veterans were frustrated by having to start in low-paying entry-level positions, and felt as if they were starting over completely.¹⁴

The "soft skills" ¹⁵ that veterans bring with them from their military experience, such as persistence, reliability, conscientiousness and attention to detail, can also be barriers to successful civilian employment. When surveyed, veterans themselves noted that their military identity (characterized by the imperative to be punctual, professional, and respectful to people in authority) makes it difficult to adapt to civilian workplaces, where they perceive these behaviors to be undervalued. At the same time as veterans rejected civilians' lateness and lack of deference to authority, they reported feeling rejected by civilian employers, whom they perceive as dismissive of military skills and experience, or unaware of and insensitive to the needs of veterans. More extreme still, when surveyed, over a third of post-9/11 veterans said they thought prospective employers believe that veterans are dangerous or "broken."¹⁶

¹³ Versions of this program have been in place in 1991. It is currently known as the Transition Assistance Program.

¹⁴ Kintzle, S., Keeling, M., Xintarianos, E., Taylor-Diggs, K., Munch, C., Hassan, A. M., & Castro, C. A. (2015). *Exploring the Economic and Employment Challenges Facing US Veterans: A Qualitative Study of Volunteers of America Service Providers & Veteran Clients*. Los Angeles: USC Center for Innovation and Research on Veterans & Military Families. Retrieved from <http://cir.usc.edu/wp-content/uploads/2015/05/CIR-VOA-Report-FF.pdf>

¹⁵ There are many efforts to make veterans' skills more legible to corporate employers. See, for example, this 2016 "toolkit" compiled by the RAND Corporation: Hardison, C., & Shanley, M. G. (2016). *Essential Skills Veterans Gain During Professional Military Training: A Resource for Leaders and Hiring Managers*. Retrieved from <http://www.rand.org/pubs/tools/TL160z2-2.html>

¹⁶ Kintzle, S., Keeling, M., Xintarianos, E., Taylor-Diggs, K., Munch, C., Hassan, A. M., & Castro, C. A. (2015). *Exploring the Economic and Employment Challenges Facing US Veterans: A Qualitative Study of Volunteers of America Service Providers & Veteran Clients*. Los Angeles: USC Center for Innovation and Research on Veterans & Military Families. Retrieved from <http://cir.usc.edu/wp-content/uploads/2015/05/CIR-VOA-Report-FF.pdf>

Veterans who are looking for work also report being continuously referred to online hiring initiatives that ultimately “did not lead to substantial job prospects.”¹⁷ These dead-ends and frustrations lead veterans to name lack of employment as one of their greatest post-military concerns. Of post-9/11 veterans surveyed in Los Angeles, for example, 65 percent said that they needed meaningful help finding a job. This is a higher number than those surveyed who reported needing physical healthcare (56 percent) or mental healthcare (47 percent).¹⁸

Likewise, veterans need access to education. Of veterans surveyed in Los Angeles, 61 percent reported a need for educational assistance, which mirrors their reported need for employment assistance (65 percent).¹⁹ Although higher education is a logical path to post-military employment, it can also be the source of unexpected frustrations. Veterans’ physical and mental health concerns can impede their success in school – particularly when these problems compound challenges familiar to all students (time management and financial stress, for example). VA reports consistently demonstrate that post-9/11 veterans’ most frequent medical diagnoses are musculoskeletal ailments (principally joint and back disorders), mental disorders, and general symptoms (e.g. fatigue, sleep disturbance, headache, diarrhea).²⁰ Veterans’ own descriptions of their somatic symptoms echo the VA’s list, and post-9/11 veterans surveyed between 2014 and 2016 reported being “bothered a lot” by joint pain, trouble sleeping, back pain, and headaches. Post-9/11 veterans reported higher rates of all of these somatic symptoms than veterans from the pre-9/11 wars²¹ and it stands to reason that these problems present barriers to excelling in college.

In education, as well as in employment, veterans’ life experiences can cause friction. In a college or university, the concerns of traditionally-aged students can seem trivial to people with combat experience, making it difficult for veterans to relate to their peers. Less than 0.5 percent of the country’s population is serving in the military at any time, and post-9/11 veterans are a minority among their peers and families.

Some veterans’ education is also impeded by trouble concentrating and remembering. During wartime, it is common for the media – and also researchers – to focus on health conditions which seem particularly symbolic of the wars, or which present a pressing need for action. In the post-9/11 era, traumatic brain injury (TBI) has been one such health problem. Traumatic brain injuries – even mild ones – can affect mood, cognition, and

¹⁷ Castro, C. A., Kintzle, S., & Hassan, A. (2014). *The State of the American Veteran: The Los Angeles County Veterans Study*, p. 23. Los Angeles: USC Center for Innovation and Research on Veterans & Military Families. Retrieved from http://cir.usc.edu/wp-content/uploads/2013/10/USC010_CIRLAVetReport_FPpgs.pdf

¹⁸ Castro, C. A., Kintzle, S., & Hassan, A. (2014). *The State of the American Veteran: The Los Angeles County Veterans Study*. Los Angeles: USC Center for Innovation and Research on Veterans & Military Families. Retrieved from http://cir.usc.edu/wp-content/uploads/2013/10/USC010_CIRLAVetReport_FPpgs.pdf

¹⁹ Castro, C. A., Kintzle, S., & Hassan, A. (2014). *The State of the American Veteran: The Los Angeles County Veterans Study*, p. 23. Los Angeles: USC Center for Innovation and Research on Veterans & Military Families. Retrieved from http://cir.usc.edu/wp-content/uploads/2013/10/USC010_CIRLAVetReport_FPpgs.pdf

²⁰ These general symptoms appear in VA data as “Symptoms, Signs, and Ill-Defined Conditions,” which is a catch-all ICD-9-CM code, not a single unknown or unusual illness.

²¹ USC Center for Innovation and Research on Veterans & Military Families. (2014-2016). *The State of the American Veteran*. Retrieved from <http://cir.usc.edu/publications/other-reports>

emotions. Because the rate of TBI in post-9/11 combat veterans has been estimated to be up to 10 percent^{22,23} it can be tempting to either explicitly or implicitly attribute veterans' memory problems and trouble concentrating to head injuries they sustained in combat. However, veterans' cognitive problems are caused and perpetuated by a number of intersecting factors including sleep problems, persistent pain, alcohol use, drug use,²⁴ PTSD and depression.^{25,26} Further, the stress of underemployment, unemployment, and strained social relations could plausibly negatively affect veterans' cognitive capacities.

Even among those veterans with confirmed personal histories of TBI, factors other than head injuries affect cognition. For instance, service members' problems with attention, concentration, memory, and ability to organize information are not necessarily confirmed by specialized (neurocognitive) testing, which has caused some researchers to conclude that psychological distress, including anxiety and depression, is the primary cause of these cognitive problems.²⁷ Between 2007 and 2010, nearly three-quarters of a group of 55,070 OEF/OIF veterans evaluated for TBI reported forgetfulness, poor concentration, anxiety, poor frustration tolerance, headache, sleep disturbance, and feelings of being easily overwhelmed,²⁸ but these are symptoms which are also present in people with psychiatric disorders, pain disorders, and people without medical diagnoses.²⁹ Veterans' trouble remembering college-level course material is one example of how physical and mental health concerns can affect their ability to work and go to school, but associating these problems with a single cause – like traumatic brain injuries – obscures how the stress of balancing education and underemployment affects a new generation of American veterans.

Although combat violence and its immediate effects draws our attention, not all of veterans' post-military experiences are caused by combat-related trauma or health

²² Taylor B. C., Hagel E. M., Carlson K. F., Cifu D. X., Cutting A., Bidelspach D. E., & Sayer N. A. (2012). Prevalence and costs of co-occurring traumatic brain injury with and without psychiatric disturbance and pain among Afghanistan and Iraq War Veteran V.A. users. *Medical Care, 50*(4), 342-6. doi: 10.1097/MLR.0b013e318245a558

²³ Cifu D. X., Taylor B. C., Carne W. F., Bidelspach D., Sayer N. A., Scholten J., & Campbell E. H. (2013). Traumatic brain injury, posttraumatic stress disorder, and pain diagnoses in OIF/OEF/OND Veterans. *Journal of Rehabilitation Research and Development, 50*(9), 1169-76. <http://dx.doi.org/10.1682/JRRD.2013.01.0006>

²⁴ Hoge, C. W., & Castro, C. A. (2014). Treatment of Generalized War-Related Health Concerns: Placing TBI and PTSD in Context. *JAMA, 312*(16), 1685-1686. doi:10.1001/jama.2014.6670

²⁵ Hoge, C. W., McGurk, D., Thomas, J. L., Cox, A. L., Engel, C. C., & Castro, C. A. (2009). Mild Traumatic Brain Injury in US Soldiers Returning from Iraq. *The New England Journal of Medicine, 358*(5), 453-63. Retrieved from <http://www.nejm.org/doi/pdf/10.1056/NEJMoa072972>

²⁶ Verfaellie, Mieke, Lafleche, G., Spiro, A. 3rd, Tun, C., & Bousquet, K. (2012). Chronic Postconcussion Symptoms and Functional Outcomes in OEF/OIF Veterans with Self-Report of Blast Exposure. *Journal of the International Neuropsychological Society, 19*, 1-10. doi:10.1017/S1355617712000902.

²⁷ French, L. M., Lange, R. T., & Brickell, T. A. (2014). Subjective cognitive complaints and neuropsychological test performance following military-related traumatic brain injury. *Journal of Rehabilitation Research and Development, 51*(6), 933-950. <http://dx.doi.org/10.1682/JRRD.2013.10.0226>.

²⁸ Scholten, J. D., Sayer, N. A., Vanderploeg, R. D., Bidelspach, D. E., & Cifu, D. X. (2012). Analysis of US Veterans Health Administration comprehensive evaluations for traumatic brain injury in Operation Enduring Freedom and Operation Iraqi Freedom Veterans. *Brain Injury, 26*(10), 1177-84. doi:10.3109/02699052.2012.661914.

²⁹ Sayer, N. A. (2012). Traumatic Brain Injury and Its Neuropsychiatric Sequelae in War Veterans. *Annual Review of Medicine, 63*, 405-419. doi:10.1146/annurev-med-061610-154046.

problems. Veterans surveyed in 2008, for instance, reported strained social relations, such as difficulty confiding in others and getting along with their spouses, children, and friends, and productivity problems, such as difficulty keeping a job and completing tasks at home, work, or school. Veterans also reported feeling as if they were starting over with their career and social relationships, and feeling disconnected from the world around them, or as if they do not belong.³⁰ Certainly, it is possible to attribute strained relationships to unaddressed mental health concerns or drug and alcohol use, but to assume a causal connection between combat experiences and post-military stressors without *also* considering the experience of undergoing a disorienting shift in social identity is too narrow a view.

Young veterans report social difficulties with greater frequency than the rate at which they are diagnosed with specific mental health concerns.³¹ In 2008, nearly all (96 percent) of a group of post-9/11 combat veterans surveyed reported that they were interested in receiving services to ease “community reintegration problems,” even though they were already using VA primary care or mental health services.³² More recently, in studies published between 2014 and 2016, veterans of the post-9/11 wars reported adjustment difficulties at rates between 61 percent and 68 percent. All of these numbers are much higher than the number of OEF/OIF/OND veterans who are diagnosed with PTSD, which has been estimated to affect about 30 percent of post-9/11 veterans.^{33,34}

It is practically impossible to draw meaningful boundaries between mental health concerns, physical health concerns, and social concerns as they manifest in veterans’ lives. Consider, for instance, a veteran who is having trouble finding work and enrolls in school. Perhaps back pain makes it difficult to sit for hours in a college classroom, in the company of classmates who are a decade younger, and perhaps exhaustion from insomnia makes it difficult to study effectively. Are these medical problems? Are they combat-related problems? The more holistic idea of “transition” is useful for thinking about veterans with problems like this.

³⁰ Sayer, N. A., Noorbaloochi, S., Frazier, P., Carlson, K., Gravely, A., & Murdoch, M. (2010). Reintegration Problems and Treatment Interests Among Iraq and Afghanistan Combat Veterans Receiving VA Medical Care. *Psychiatric Services, 61*, 589–597. doi: 10.1176/appi.ps.61.6.589.

³¹ The military, the VA, and veterans’ advocates have publicized “transition” (or “readjustment”) as a language for talking about post-combat social difficulties. Again, for a discussion of stigma, PTSD and VA mental health care, see Finley, E. P. (2011). *Fields of Combat: Understanding PTSD among Veterans of Iraq and Afghanistan* (chapters 6 and 7). Ithaca: Cornell University Press.

³² Sayer, N. A., Noorbaloochi, S., Frazier, P., Carlson, K., Gravely, A., & Murdoch, M. (2010). Reintegration Problems and Treatment Interests Among Iraq and Afghanistan Combat Veterans Receiving VA Medical Care. *Psychiatric Services, 61*, 589–597. doi: 10.1176/appi.ps.61.6.589.

³³ There is great variation in how rates of PTSD diagnoses are calculated, but for instance, one study estimated that about 30 percent of post-9/11 veterans who used VA health care between 2009 and 2011 were diagnosed with PTSD. Cifu D. X., Taylor B. C., Carne W. F., Bidelspach D., Sayer N. A., Scholten J., & Campbell E. H. (2013). Traumatic brain injury, posttraumatic stress disorder, and pain diagnoses in OIF/OEF/OND Veterans. *Journal of Rehabilitation Research and Development, 50*(9), 1169–76. doi: 10.1682/JRRD.2013.01.0006

³⁴ Kintzle, S., Rasheed, J. M., & Castro, C. A. (2016). *The State of the American Veteran: The Chicagoland Veterans Study*. Retrieved from <http://cir.usc.edu/research/research-projects/chicagoland-veterans-study>

However, there are good reasons to be cautious about “transition” as well. The term “transition” is vague and it fails to name any specific problem. It fails to point to any people, organizations, or policies who might be held accountable for having caused any of these intersecting problems, and it risks blaming individual veterans for failing to adequately “adjust” to their post-military civilian lives. Policies and programs organized around the problems of “transition” essentially support service members as they go through an individual process of resuming civilian life, rather than altering underlying conditions that affect all service members (such as the military’s continual need for more troops to fight ongoing wars, or political and ideological motivations for legislators to explicitly or implicitly authorize war) and the country as a whole (such as funding for higher education). In these wars, for instance, service members’ personal processes of adjusting to post-war civilian life happened amidst the larger backdrop of the country’s economic recession. 2008 was the year in which the highest number of US military personnel deployed overseas at once. By the time those service members returned to the United States and left the military, the recession was in full force.

Nonetheless, “transition” has been a central concept for thinking about post-9/11 veterans’ experiences, and it has distinct advantages. First, it allows researchers to collect information about veterans’ post-combat and post-military experiences without relying solely on medical diagnoses as categories of analysis. “Transition” points to a complicated nexus of social and medical issues that veterans face, and highlights the difficulty of distinguishing between the effects of medical problems, family problems, unemployment, and the stress of adjusting to a different social environment.

At the same time, this complicated nexus of social and medical problems is a consequence of military participation, and a consequence of war. Even if “transition” sanitizes or obscures the military’s responsibility for these rather mundane challenges in civilian life, assistance with “transition” is still part of the care that the VA is tasked with providing to veterans. Thus, the second advantage of moving away from using medical diagnoses as the primary way of identifying veterans’ needs is that it can expand our view of what veterans need and require from VA services.

VA services for “transitioning” veterans

Like any hospital system, the VA provides emergency, preventative, and routine healthcare, much of it to an aged veteran population with chronic and aging-related ailments. Media reports about the VA’s performance and outcomes are often based on data that represents the organization’s entire patient population. In 2015, veterans of the post-9/11 era constituted only 27 percent of the VA’s 9.6 million users.³⁵ More than three quarters of the OEF/OIF/OND veterans who have enrolled in the VA are under the age of 36, and more

³⁵ National Center for Veterans Analysis and Statistics. (2016, December). *Unique Veteran Users Profile FY 2015*. Retrieved from <https://www.va.gov/vetdata/docs/SpecialReports/Profile of Unique Veteran Users 2015.pdf>

than half of them are under 26 years old.³⁶ Young veterans do not have the same needs as older veterans, and their use of VA benefits are not necessarily captured by data-collection practices that might be logical for a national organization that provides primarily medical care. Rather, looking at some recent policy changes along with federal spending on vocational rehabilitation provides a better sense of how the VA addresses the specific challenges of returning to everyday life in civilian worlds.

VA policy and programs have acknowledged veterans' *social* post-combat difficulties, instead of being focused solely on providing individual medical diagnosis and treatment for veterans. For instance, the VA has expanded post-9/11 veterans' access to the system. Generally, free healthcare is available for any veterans whose health problems are determined to be related to their military service, and those who are living in poverty. Other veterans pay a co-pay. Before the policy change, post-9/11 veterans would go through the standard lengthy bureaucratic and medical examination process to determine what kind of care they could receive for free (and veterans who couldn't afford to pay for healthcare would have received free care on the basis of poverty alone). In 2008, the VA streamlined this process for new veterans to enroll in the system.³⁷ For five years after they leave the military, veterans can enroll in the VA and start receiving free care immediately, without first completing the entire bureaucratic process of having combat-related disabilities officially recognized. This is not simply an across-the-board improvement in the bureaucracy; this policy change specifically made it possible for "transitioning" veterans to receive supportive services (including group and individual counseling, and educational support) without the need for these services to be straightforwardly linked to medical diagnoses. Furthermore, the VA's new policy takes steps toward accounting for the possibility that combat-related symptoms may take months to fully manifest.³⁸

At the same time, the VA's spending on programs related to employment and education has grown substantially. From the beginning of the wars through 2015, federal funds spent on employment and education programs together totaled \$92.7 billion.³⁹ Investment in education and spending on vocational rehabilitation are subsets of the VA's larger non-healthcare benefits spending, which includes service-connected disability benefits and indemnity payments to deceased veterans' surviving family members. Though

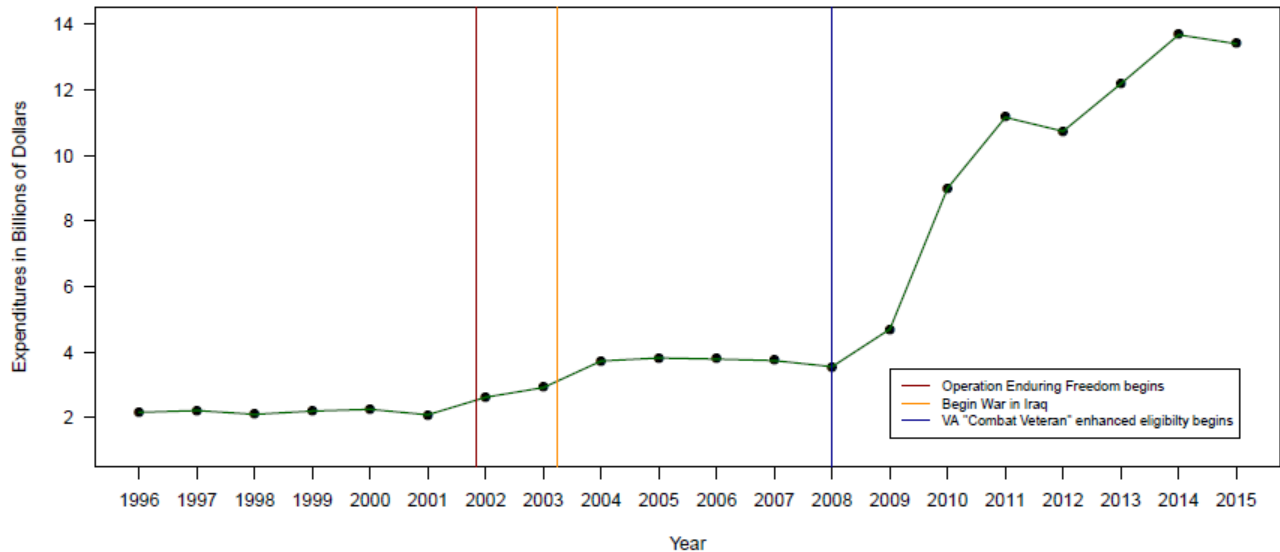
³⁶ Epidemiology Program, Post-Deployment Health Group, Office of Patient Care Services, Veterans Health Administration, Department of Veterans Affairs. (2017, January). *Analysis of VA Health Care Utilization among Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) Veterans: Cumulative from 1st Qtr FY 2002 through 3rd Qtr FY 2015 (October 1, 2001 – June 30, 2015)*. Washington, DC: Author. Retrieved from <http://www.publichealth.va.gov/docs/epidemiology/healthcare-utilization-report-fy2015-qtr3.pdf>

³⁷ This program is called "Enhanced Eligibility for Health Care Benefits" and the authorization for the VA to provide medical care to recently-separated combat veterans was included in the United States National Defense Authorization Act of 2008 (Public Law 110-181).

³⁸ Thomas, J. L., Wilk J. E., Riviere, L. A., McGurk, D., Castro, C. A., & Hoge, C. W. (2010). Prevalence of mental health problems and functional impairment among active component and National Guard soldiers 3 and 12 months following combat in Iraq. *Archives of General Psychiatry*, 67(6), 614-623. doi: 10.1001/archgenpsychiatry.2010.54

³⁹ Calculated from Department of Veterans Affairs' Office of Policy and Planning. (1996-2015). *Geographic Distribution of VA Expenditures (GDX) Reports*. Retrieved from <https://www.va.gov/vetdata/expenditures.asp>

Readjustment Benefits and Vocational Rehabilitation (in 2015 dollars)



they are reported as a single category, education and vocational rehabilitation are administered through many different programs, each with different eligibility requirements but with essentially the same purpose: to help veterans use their educational benefits and find and sustain meaningful post-military employment.⁴⁰

For example, vocational rehabilitation is available for veterans whose abilities have been altered by service-connected disabilities, and therefore need to begin new careers. This might be the case, for instance, for a veteran trained in the military as a police officer, but who can no longer work in that field. Vocational rehabilitation includes support for apprenticeships and “On-the-Job Training,” post-secondary training at a college, technical or business school, and supportive case management. By contrast, veterans do not need to claim a service-connected disability to access the set of educational benefits commonly known as the GI Bill, which provides tuition, books, and stipend payments for living expenses (on which many veterans depend during these periods of “transition”). Between 2011 and 2015, the number of veterans using post-9/11 GI Bill benefits increased from 555,329 (in 2011) to 790,507 (in 2015).⁴¹ Eighty-four percent of recipients of VA education benefits in 2015 were using the post-9/11 GI Bill. More than half of the VA education benefits paid out

⁴⁰ VA Education and Vocational Rehabilitation expenditures include: automobiles and adaptive equipment for certain disabled veterans and members of the Armed Forces; specially adapted housing for disabled veterans; dependent’s educational assistance (US Code Chapter 35); vocational rehabilitation for disabled veterans (Chapter 31); post-Vietnam era veterans’ educational assistance (Chapter 32); Montgomery GI Bill for Selected Reserves (Chapter 1606); and Montgomery GI Bill (Chapter 30) for disabled veterans (Chapter 31); post-Vietnam era veterans’ educational assistance (Chapter 32); Montgomery GI Bill for Selected Reserves (Chapter 1606); and Montgomery GI Bill (Chapter 30), and, beginning in 2008, the Post-9/11 Veterans Educational Assistance (Chapter 33).

⁴¹ US Department of Veterans Affairs. (2016, February 3). *VA Reports: Education*. Retrieved from: <http://www.benefits.va.gov/REPORTS/abr/ABR-Education-FY15-02032016.pdf>

that year were to veterans who were earning Bachelor's degrees, and three quarters of those veterans earning Bachelor's degrees were paying for them using the post-9/11 GI Bill.⁴²

From 2002 to 2015, the percent of the agency's total investment in educating veterans and preparing them for employment more than doubled. In 2002, VA spent \$1.9 billion on education and employment, which constituted only 3.6 percent of its total expenses for the year. By 2015, that fraction had more than doubled to over 8 percent of the agency's total annual spending. The increase in the VA's non-healthcare benefits spending clearly captures, in financial terms, how a new generation of veterans is using benefits and services administered through the VA. However, as with the multiple dimension of veterans' own "transitions," the VA's efforts to help veterans "transition" are not neatly contained in a single category of institutional spending.

Medical care constitutes the bulk of VA spending, but nationwide spending figures do not reflect how VA medical staff address veterans' "transitions." VA clinical services for recent veterans include clinicians training veterans in study skills, strategies for improved sleep, financial management skills, parenting skills, and so on. In some cases, this support takes shape through formal programming, such as parenting classes run by psychologists inside VA clinics. I have observed, for instance, an eight-week course, wholly designed and taught by VA therapists in a VA clinic, in which a "class" of post-9/11 veterans sat together in a conference room for two hours a week, learning about cognition and memory in a way that mimics a college classroom. The veterans worked from a course syllabus, discussed weekly assigned readings, listened to lectures accompanied by PowerPoint slides, and completed writing assignments. In other instances, recreational therapists organize events aimed at reducing veterans' social isolation, such as hikes and outdoor activities like boating or surfing. Also, the significance of the VA's character as an integrated healthcare system is not to be underestimated: enrolled veterans have access to primary care doctors, social workers, mental health care, and substance abuse treatment, often within a single VA medical facility.

Services that address various dimensions of veterans' needs as they move between military and civilian life are peppered throughout the VA and not easily captured in one type of data or category of spending. Like "transition," rehabilitation occurs across and between combat-related physical and psychological trauma, employment, education, and veterans' social and family lives. Young veterans need reliable and timely access to healthcare, but it is a mistake to reduce their needs – or VA services – to the provision of healthcare alone. When the American public considers the unique needs of the roughly 230,000 service members who will leave the military each year for the next several years, and how to best allocate financial resources for meeting those needs, it is vital that we not overlook veterans' need for social services. Distinguishing strained social relations from specific medical problems is important because how we define problems shapes our efforts to solve them. In this case, veterans' "transitions" are not easily represented by hospital and clinic billing codes or VA performance data, nor are the efforts of VA care providers to help veterans

⁴² US Department of Veterans Affairs. (2016, February 3). *VA Reports: Education*. Retrieved from: <http://www.benefits.va.gov/REPORTS/abr/ABR-Education-FY15-02032016.pdf>

address these problems particularly visible, as they are integrated into an enormous system with multiple, complex goals.

Conclusions

Isolating how federally-funded veterans' employment and educational benefits have (or will) shape the "transition" of an entire generation of post-9/11 veterans is a difficult task. It is clear that there have been problems administering these benefits. We have seen much of this federal funding end up in for-profit universities,⁴³ and the GAO has documented a variety of bureaucratic snags that interfere with veterans' ability to consistently access their benefits and that make it challenging for researchers to adequately assess veterans' academic outcomes.^{44,45} On the positive side, however, my research shows that VA clinicians are providing services tailored to young veterans' non-medical needs, but they do so within the relative isolation of their own clinics. This means that meaningful support for veterans' "transitions" exists beyond the VA's formal vocational rehabilitation programs and the GI Bill, but it is disorganized and therefore practically impossible to see from a top-down perspective on the institution and its operations.

I have argued that the idea of "transition" indexes two important things: the complexity of veterans' post-military needs, and the complexity of the VA's task. The VA's educational and vocational rehabilitation benefits for veterans are an acknowledgement that not all post-military challenges are caused by combat-related trauma. The \$92.7 billion that the VA alone has put toward re-training veterans since 2002 is a combination of VA spending on rehabilitation and investment in veterans' education and job training. As such, this spending is not a "cost of war" in the strictly financial sense.⁴⁶ Rather, it represents something of the personal costs of war that reverberate through veterans' lives but are not easily captured in medical and psychiatric diagnoses. The military trains service members with skills that do not easily transfer outside of the military. Shortly after being in combat zones, after long periods of being isolated from civilian communities, veterans must navigate relocating, changing jobs and daily routines, unemployment, and/or starting college. The VA is tasked with assisting veterans through these "transitions," but the organization's effectiveness is often judged on the basis of healthcare outcome data alone.

⁴³ Lipton, E. (2010, December 8). Profits and Scrutiny for Colleges Courting Veterans. *The New York Times*. Retrieved from <http://www.nytimes.com/>

⁴⁴ United States Government Accountability Office. (2013, May 22). *VA Needs to Improve Program Management and Provide More Timely Information to Students [GAO-13-338]*. Washington, DC.

⁴⁵ It might be noted that efforts to account for and assess the effectiveness of veterans' benefits constitute a related category of government spending.

⁴⁶ This \$92.7 billion is an imprecise figure in another sense: it does not explicitly distinguish between services received by OEF/OIF/OND veterans and veterans of other eras, but it stands to reason that the VA's majority elderly population is not using these particular educational and employment services at the rate that younger veterans do.

My research shows that a VA hospital is not a hospital in the conventional sense. Both the symbolic work of the VA as an institution and the actual everyday work of VA clinicians exceed the bounds of what we typically imagine when we think of what goes on inside a hospital. Rather than thinking of the VA as a civilian hospital, we might think of it as an extension of the military. Doing so would suggest that we take the VA's role in veterans' "transitions" back to civilian life as seriously as the military takes the process of "transitioning" people into their roles as service members. The VA has moved toward institutionalizing meaningful support for "transitions." Under VA Secretary Robert A. McDonald's strategy for improving the organization, branded "MyVA Transformation," VA researchers listened to veterans' descriptions of their lives and their needs and conceptualized a map of veterans' "journeys" from joining the military to creating fulfilling civilian lives. If these recent projects materialize into formally organized, meaningful, sufficiently funded, and sufficiently researched programs to assist veterans in their "transitions," it would be a step toward taking veterans' own stated post-military social, educational, and employment needs as seriously as the military takes their training.

Physical and psychological traumas are arresting and disturbing; medical diagnoses and markers of recovery are easily coded and compared across populations and periods of war. However, many of veterans' post-military struggles in the civilian world are made up of experiences that are hard to describe, ambiguous in cause, transitory in nature, and therefore not easily categorized, counted, or fully resolved by a giant organization like the VA. The VA's educational and vocational rehabilitation programs cannot possibly resolve the nexus of physical, psychological, and social problems that make work and school challenging, nor can they resolve the incompatibility of military and civilian work experience, or the larger context of an economic recession into which they have returned. However, it is imperative that the multifaceted medical and social problems that returning veterans face be addressed by a multifaceted institution that bridges the medical and the social as well: the VA is in a position to address the consequences of creating a vast new generation of combat veterans, consequences that extend well beyond the prevention and treatment of combat-related physical and psychological trauma. As a society, we must invest in the provision of stability for post-9/11 veterans in the midst of their "transitions."

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