
Occupational Performance Needs of Young Veterans

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MeSH TERMS

- adaptation, psychological
- independent living
- motivation
- occupational therapy
- social participation
- veterans health

OBJECTIVE. We examined the occupational performance issues facing young U.S. veterans (aged 20–29 yr) who served in Iraq and Afghanistan. Perceived challenges in occupational performance, the most common mental health and brain injuries of war, and motivations for participation in daily occupations upon return to civilian life were identified.

METHOD. Thirty young veterans from Operation Iraqi Freedom and Operation Enduring Freedom were interviewed using the Canadian Occupational Performance Measure (Law et al., 2005). They were also screened for posttraumatic stress disorder, traumatic brain injury, major depression, and alcohol abuse or dependency.

RESULTS. The top five occupational performance challenges were engagement in relationships, school, physical health, sleeping, and driving. The health conditions screened positive for 23%–77% of respondents.

CONCLUSION. This study identified challenges faced by today's young veterans when reintegrating into the community and daily life. Strategies for occupational therapy practitioners to aid veterans in community reintegration are discussed.

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Veterans who return to civilian life after service in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) are at risk for experiencing disruptions in engagement in occupations of daily living. According to the most comprehensive study of the psychological and cognitive consequences of the wars to date, 1.64 million U.S. troops have been deployed for OIF and OEF since 2001 (Tanielian & Jaycox, 2008). Approximately one-third of these veterans will struggle with at least one of the following injuries: posttraumatic stress disorder (PTSD), traumatic brain injury (TBI), and major depression (Tanielian & Jaycox, 2008). A 2004 study of combat veterans who served in Iraq and Afghanistan indicated that alcohol misuse was significantly higher after deployment than before deployment (Hoge et al., 2004).

Although readjustment issues are not new to veterans, the current conflicts present unique circumstances that warrant further discussion. As of August 23, 2012, 49,214 service members had been wounded in action in OIF and OEF and 6,513 fatalities had occurred (U.S. Department of Defense, 2012). The difference between the number of wounded service members and fatalities demonstrates the impact of advancements in armor and medical treatment on survival rates of service members (Tanielian, Jaycox, Adamson, & Metscher, 2008). The large number of service members who survive serious injuries is one of many unique issues experienced by this generation of veterans. Another unique issue is the expansion of enemy and combat zones to include suicide bombers in towns and villages and improvised explosive devices (IEDs) on roadsides. As of February 2011, a cumulative 30,684 deaths and injuries (63% of the total) resulted from explosive devices (Defense Manpower Data Center, 2011). Explosive devices have contributed to the rising issue of blast injuries, which are the primary cause

of TBI among active-duty service members (Defense and Veterans Brain Injury Center, 2011).

In addition to the high rate of injury survival, expansion of combat zones, and use of IEDs, this is the first time the United States has been in an extended war with an all-volunteer military (Sollinger, Fisher, & Metscher, 2008). The current conflicts have a limited pool of people to fill the ranks. This situation creates three risk factors that may contribute to potential behavioral health issues among young veterans: (1) the length of deployment (sometimes 12–15 mo), (2) multiple deployments (some service members have been to Iraq three or four times), and (3) sleep deprivation (Office of the Surgeon Multi-National Force–Iraq & Office of the Surgeon General, U.S. Army Medical Command, 2008). Repeated exposure to extreme stress and the constant threat of trauma may explain why some veterans do not respond as well as non-veterans to exposure therapy (Creamer & Forbes, 2004), a well-established treatment for PTSD that involves re-experiencing a traumatic event to the point of habituating the anxiety-evoking response.

Veterans' ability to reintegrate into civilian life has an impact on their loved ones and greater society. Military suicides in Iraq have been identified as a significant problem; the rate of suicide is 21.5 per 100,000 service members (Office of the Surgeon Multi-National Force–Iraq & Office of the Surgeon General, U.S. Army Medical Command, 2009), which surpasses rates observed in the civilian population (in 2006, the civilian rate was 10.95 per 100,000; Centers for Disease Control and Prevention, 2009). Although reliably tracking suicide rates of veterans after military service is difficult, one can predict that the emotional burden and stress caused by war place them at risk and have a potential impact on close interpersonal relationships as well as society.

In addition to the emotional consequences, the economic consequences of invisible injuries of war are significant. The costs per individual associated with PTSD, major depression, and TBI are estimated to range from \$5,904 to \$383,221 (Eibner, Ringel, Kilmer, Pacula, & Diaz, 2008), calculated on the basis of lost productivity, treatment, suicide, and death; they do not include the costs of domestic violence, substance abuse, or homelessness.

The impact of war is substantial. The transition of a new generation of veterans to civilian life is important to consider because their well-being and ability to acclimate may be compromised. Therefore, the purpose of this study was to uncover young veterans' perspectives on their perceived problem areas, the presence or absence of mental health disorders and brain injuries, and their motivation

for participation in the occupations of daily life. The following research questions guided this study:

1. What are the daily life challenges that young veterans experience in the occupational performance areas of self-care, productivity, and leisure when reintegrating into civilian life?
2. What are veterans' current health statuses for the signature wounds of war—PTSD, TBI, depression, and alcohol abuse?
3. What do veterans identify as motivations for participation in the occupations of daily life?

Method

Research Design

We used a mixed-methods design to capture both the voices of young veterans' lived experience and quantitative information about health conditions. The study was approved by the institutional review board at the University of Wisconsin (Protocol 08.292).

Participants and Measurement

Participants were recruited on the university campus and through the state Department of Veterans Affairs. Inclusion criteria were service in OIF or OEF and being age 20–29 yr. We obtained demographic information through closed- and open-ended questions followed by a semistructured interview using the Canadian Occupational Performance Measure (COPM; Law et al., 2005), focusing on the 1st year back in civilian life (i.e., after service in a combat zone). Test–retest reliability for the COPM has been reported at .80, and it has been demonstrated to have content, criterion, and construct validity (Law et al., 2005).

Participants then filled out four brief health screening tools. The Primary Care PTSD Screen (PC–PTSD; Prins et al., 2003) identifies potential PTSD and has been shown to be psychometrically sound. The Brief Traumatic Brain Injury Screen (BTBIS; Defense and Veterans Brain Injury Center, 2007) identifies possible mild TBI among service members. Concurrent validity has been demonstrated (Schwab et al., 2006). The Patient Health Questionnaire–9 (PHQ–9; Ebell, 2008) measures the presence of depression. Convergent validity has been demonstrated with the Beck Depression Inventory–II (Dum, Pickren, Sobell, & Sobell, 2008); high sensitivity and specificity are reported (Gilbody, Richards, Brealey, & Hewitt, 2007). The Alcohol Use Disorders Identification Test (AUDIT) identifies excessive drinking (Babor, Higgins-Biddle, Saunders, & Monteiro, 1992). It

has been studied extensively and had yielded consistent findings of accurate screening for alcohol issues (Reinert & Allen, 2007).

Data Collection

Participants met individually with the first author (Heidi Lynn Plach) to complete the interview and health screenings during fall 2008 and spring 2009. Plach has extensive clinical experience in mental health occupational therapy, background that was essential because of the sensitive material and for strength of data interpretation. The process of data collection took approximately 1.5 hr per participant.

Data Analysis

Mixed-methods research combines both quantitative and qualitative techniques of data collection, data analysis, and interpretation (Creswell & Plano Clark, 2007). Credibility of qualitative research gathered from the COPM was attained through triangulation or use of a variety of means to gather data over time. Trustworthiness was ensured because the study's sample size supported findings, a group interview validated similarities with the individual interviews, and member checks took place throughout the interview and again before the completion of the interview (Merriam, 2002).

The COPM data for all challenges were analyzed as follows: (1) Using the individual COPM assessment forms, all challenges were listed under the occupational performance areas of self-care, productivity, and leisure; (2) the participant's confidential number was listed next to the challenge to capture an accurate number of how many veterans had a challenge in a certain category; and (3) challenges were reviewed and combined when appropriate. A second analysis was completed to determine the top five challenges reported in Step 3 of the COPM. Data from the health condition screenings and the demographic questionnaire were analyzed with descriptive statistics.

Results

Participants

Thirty young veterans participated, 28 current students and 2 alumni. Twenty-six were male (87%) and 4 were female (13%); 9 (30%) were ages 22–25, and 21 (70%) were ages 26–29. A total of 28 (93%) were White and 2 (7%) were Hispanic. All branches of the military were represented (Army, $n = 14$; Marines, $n = 6$; Navy, $n = 5$; Air Force, $n = 4$; and Coast Guard, $n = 1$). Most participants were

single ($n = 26$); 3 were divorced and 1 was married. The majority were employed ($n = 23$; 77%).

Twenty-one (70%) veterans had *engaged in enemy combat* (defined as having been fired upon, having returned fire, or both), and 22 (73%) received at least one honorary recognition related to combat. Fifteen (50%) had received mental health treatment since their return. The amount of time since the participants left active duty ranged from 3 mo to 5.5 yr; 16 veterans (53%) had been back for 2–3 yr. When asked, "What was the greatest thing about returning home?" more than half (53%) indicated it was their freedom, not any tangible object or possession.

Occupational Performance Challenges

The first research question identified the daily life challenges that young veterans experience in the occupational performance areas of self-care, productivity, and leisure when reintegrating into civilian life. Step 1 in the COPM helped participants fully explore their daily life challenges in their 1st year back as veterans. Most life challenges fell into self-care performance (see Table 1). Driving was the most frequently reported challenge (70%) in self-care, followed closely by sleeping (67%). In the occupational performance area of productivity, almost all participants

Table 1. Challenges Identified on the Canadian Occupational Performance Measure ($N = 30$)

Challenge	n	%
Self-Care		
Driving	21	70
Sleeping	20	67
Eating, weight gain	17	57
Finances	15	50
Physical health	15	50
Community interactions	10	33
Mental health	9	30
Hygiene	3	10
Dressing	3	10
Navigating health care	3	10
Fear of dentist	1	3
Productivity		
School	28	93
Work	15	50
Household management	6	20
Leisure		
Relationships	24	80
Drinking (excessive)	11	37
Balancing time	9	30
Emotional desensitization	6	20
Exercising	3	10
Finding meaning	3	10
Feeling guilty	2	7
Coping with loss	1	3

(93%) reported challenges surrounding the occupation of school. In leisure performance, 80% of participants struggled with relationships in their 1st year back from service.

Many participants found Step 2 of the COPM, rating the level of importance of each challenge on a scale ranging from 1 to 10, to be difficult. They indicated that they would rate the importance level as a 1 during their 1st year back because they were apathetic or lacked insight into these challenges. However, in retrospect, they realized that these challenges were far more important to address than they originally believed. The results of Step 3 identified the top five most important challenges as relationships, school, physical health, sleeping, and driving (see Table 2; note that challenges are listed under the larger occupational performance areas of leisure, productivity, and self-care). Within those occupations, major qualitative categories emerged.

Leisure. The occupation of socializing and participating in relationships was identified as the most significant challenge; 77% reported this as one of their top five. The emerging theme centered around difficulty relating to others outside of one's military peer network, resulting in isolation. One veteran summed up the experiences of many:

I think that there are some issues with society in general. They didn't understand, and you just can't describe what you've been through and what you're feeling when people ask those questions. The worst question that is just appalling to me is, Did you kill anybody? That's asking probably one of the most offensive questions that you can ask because there is just so much to that question. It's very disturbing. Being with the veterans or the people you served with and being in that network, all of those questions are eliminated and they're more geared on towards what are you doing now and what did you do yesterday? It's more living again and starting over and starting new because you don't have to talk about what you've done, where you've been. When you do and you resurface on old times, they're usually on good memories.

Productivity. School challenges were reported by 70% of veterans (28 were students). Two categories emerged: (1) relating to younger classmates, given the veterans' life experience, and (2) having the essential skills for the academic environment (i.e., difficulty concentrating, relearning skills, and being overqualified for required course work). The following comment captures this sentiment:

I think it would be really helpful if they [faculty] would look at the experience and training that veterans get, especially those who have been deployed to a combat zone because you get so much more advanced training. . . . The basic entry medical stuff, how to take a blood pressure on people, how to hang an IV bag, how to give an injection or how to read a monitor, vital signs over 2 days or how to administer medications. That's all stuff that I've been doing for a long time. I taught IVs in the military to people who have never done it before, and here I am practicing on a rubber arm. . . . Try doing this with stuff blowing up around you instead of being in a lab.

Self-Care. Physical health, including eating and weight gain, was a challenge reported by 50% of veterans. The predominant issue was indulgence in food and consequent weight gain. Many veterans believed the amount of free time, lack of structure, and access to food were contributing factors to negative nutritional habits. This young veteran's experience reflects the overall issues within this area:

The first 3 months back I probably put on 35 pounds. . . . I just came back and ate as much as I could and drank as much as I could. It was access. Eating all of the things that you missed. Also, I had the time. I wasn't working. I wasn't in school yet. You're like, Why wouldn't I go out again or have a big dinner 4 days in a row where you wouldn't do that normally? You're not in a routine.

Sleep disruption was listed as one of the top five challenges by 37% of those interviewed. All participants shared an explanation for their sleep challenges without

Table 2. Top Five Occupational Performance Challenges (N = 30)

Top Challenge Areas	n	%	Challenges Captured by These Categories
Leisure			
Relationships	23	77	Managing social interactions, finding meaningful relationships, belonging, isolating, being desensitized emotionally, reconnecting
Productivity			
School	21	70	Transitioning to the student role, being older and having served overseas or conveying experiences, having to take basic courses, relating to classmates, concentrating
Self-care			
Physical health	15	50	Physical injuries, limited activity, weight gain
Sleeping	11	37	Poor sleep hygiene, inadequate rest, nightmares
Driving	10	33	Reckless driving, discomfort, impatience, heightened alert

prompting from the interviewer. The sleep disturbances were physically rooted, psychologically rooted, or both. The veteran quoted next identified both potential causes and the challenge to readjust once home:

It seemed like I had to drink alcohol to get a decent night's sleep. For one, having been on a completely different time schedule, it's hard enough to adjust to because for over a year, you're used to certain sleep schedules . . . transitioned between first, second, and third shift. On top of that, then there's the emotional problems from being overseas, anything from post-traumatic stress disorder to readjustment disorders. . . . I have nightmares, waking up, thinking about things to death. Not being able to sleep for several hours, just lying there and thinking about it.

The occupation of driving or riding in vehicles was identified as a top five challenge by 33%. The recurring description included feeling anxious and uncomfortable (i.e., panic attacks, flashbacks, hypervigilance) in a motor vehicle and how their experiences affected their behavior on the road on their return (e.g., reckless speeding, ignoring traffic signs, avoiding parked cars). A study participant's comment illustrates the challenges to the individual and, potentially, to other motorists:

There would be roadside bombs, so you drove straight down the middle of the highway. Just different behaviors that were suited towards that environment, and obviously driving in conditions that were always tense at a higher level of alertness because you had in the back of your mind that you could be entering a scenario that was going to be violent or potentially lethal. So there is a transition period of going back to civilian domestic driving. I sped a lot. There was one instance in particular when I was driving home . . . and I had kind of a panic attack. I was in my truck and I had a quick moment of panic because I honestly thought that I lost my weapon. I said, "Oh my god. Where's my weapon, where's my rifle!"

Health Status

The next research question identified the veterans' current health status for PTSD, TBI, depression, and alcohol abuse, the signature wounds of OIF and OEF. Of participants, 23% screened positive on the PC-PTSD. Although this percentage is about one-quarter of those interviewed, 40% of veterans answered "yes" to the question, which asked whether in the past month they had been "feeling numb or detached from others, activities, or surroundings."

The BTBIS results indicated that 40% of veterans screened positive for a possible mild TBI. Of participants, 30% reported experiencing physical symptoms, including

headaches, dizziness, memory problems, balance problems, ringing in ears, irritability, or sleep problems.

Results for the PHQ-9 showed that 77% of veterans screened positive for potential depression. Almost half (40%) indicated that they had little interest or pleasure in doing things, and 30% had felt down, depressed, or hopeless in the past 2 wk. Results on the PHQ-9 supported the COPM results, because 53% of veterans indicated having trouble with sleep and 47% had a poor appetite or were overeating. Of those who indicated having a problem in at least one area on the questionnaire ($n = 23$), 40% indicated that those problems had made it difficult to participate in work or home tasks or to get along with others.

The AUDIT revealed that 53% of veterans screened positive for problem drinking. A deeper interpretation of the AUDIT results indicated that 93% of participants engaged in hazardous drinking; 66% used alcohol in a manner that was harmful emotionally or physiologically, and 43% might be dependent on alcohol.

Motivation for Participation in Life

The final research question asked the veterans to identify motivations for participation in the occupations of daily life using an open-ended question; that is, we asked what motivates them to stay well and active in life, despite their challenges. Achieving their goals (such as graduating from higher education) was one of the main driving forces for 77% of respondents, and spending time with loved ones (family and friends) was a motivating factor for 50%.

Discussion

This study is the first to use the COPM with a veteran population. However, the results of this study's occupational performance challenges with respect to relationships, school, and physical health are similar to those reported by shelter and homeless populations (Munoz, Garcia, Lisak, & Reichenback, 2006; Tryssenaar, Jones, & Lee, 1999). Using the COPM, both the homeless population and veterans in this study prioritized their challenges and identified interpersonal relationships and pursuing an education or returning to school as among their top eight issues that needed addressing (Munoz et al., 2006; Tryssenaar et al., 1999). One of the homeless populations identified physical health as one of their top four challenges (Munoz et al., 2006), which is also consistent with the results of this study. Although many differences exist between the needs of veterans and the homeless population, whose basic living requirements

(shelter, income, etc.) are absent, the challenges of driving and disruption in sleep appear to be unique to the veteran population, which is understandable given their experience and exposure to the repeated traumas of these wars.

Although many service members return to civilian life without mental health disorders and brain injuries, our study population had a higher reported incidence of the invisible wounds of war than those in the RAND Study (Tanielian & Jaycox, 2008). This higher incidence may be explained by a positive testing effect, because we used a 1.5-hr, face-to-face interview during which time rapport was built, whereas the RAND results were acquired by phone.

Veterans have a lifetime membership in a unique culture that is <1% of the population. Hasselkus (2002) noted that the key to understanding a culture comes not only from considering the similarities between groups but also from recognizing the differences or idiosyncratic features of a group that are unlike those of other groups. The life experiences of this generation of veterans are vastly different from those of the average 20- to 29-yr-old. As this study has indicated, those differences make reintegration into civilian life a challenge. Occupational therapy practitioners have historically played a vital role in enhancing veterans' well-being (Vogel & Gearin, 1961). However, it has been more than two decades since a large veteran cohort has returned from war. Considering the needs of this new generation is timely.

It has been noted that "caring for these wounded often requires an intensive mental health component in addition to traditional rehabilitation services" (Tanielian et al., 2008, p. 6). This need can be effectively answered by occupational therapy practitioners with strong roots in both psychological and physical rehabilitation. Researchers and clinicians alike are encouraged to be innovative in the fight to sustain veterans' independence.

Implications

Mental Health

Occupational therapy practitioners who specialize in mental health can play a significant role in directly addressing veterans' needs. The occupational performance needs and diagnoses explored in this study are areas that mental health occupational therapy practitioners are skilled in addressing. For example, veterans can be reassured that major depression is treatable. The most frequently prescribed mode of treatment is psychopharmacology; however, as a psychotherapy option, cognitive-behavioral therapy has also been demonstrated to be effective (Young,

Weinberger, & Beck, 2001). As part of that therapy, behavioral techniques such as scheduling mastery and pleasure exercises, self-reliance training, and role playing are used to help treat the symptoms of anhedonia, social withdrawal, and concentration difficulties. Young veterans have also been reported (Reger & Moore, 2006) to benefit from groups on stress and anger management, relaxation training, and sleep hygiene.

If a veteran is experiencing the debilitating symptoms of depression, it is understandable that his or her occupational performance would suffer in areas such as self-care (weight, hygiene, sleep), productivity (work, school, and household management), and leisure (activity tolerance and isolation). A veteran articulated how psychological symptoms hindered participation in life as follows:

Just finding a reason to carry out your day is the biggest challenge. When I came back and when I got out, I was in complete disarray, mentally, psychologically, and my entire life was just absolute chaos. . . . The capstone of challenges is finding a logical reason to continue to exist despite your experiences. . . . It's just panic attack after panic attack.

Physical Rehabilitation

This generation of veterans seeks treatment beyond the walls of Department of Veterans Affairs (VA) hospitals; therefore, one can anticipate that occupational therapy practitioners will have multiple opportunities to work with them. A strong association between PTSD and physical health symptoms, including pain in arms, legs, or joints, has been shown for 50.2% of service members who reported pain (Hoge, Terhakopian, Castro, Messer, & Engel, 2007). Because occupational therapy practitioners often treat pain, learning about early detection of PTSD and relevant treatment procedures to address it is critical.

Holistic Approach

Regardless of setting, occupational therapy practitioners typically establish a trusting relationship with their clients, which provides a comfortable context in which a veteran may disclose mental health symptoms. It is essential for occupational therapy practitioners working with a trauma survivor to know that asking someone to reveal details of his or her trauma can potentially cause further trauma and distress. Use of basic attending and listening skills and avoidance of questions that force memories are key. The study of manualized mental health treatments and training and certification in trauma counseling and psychological first aid are advanced skills available to occupational therapy

practitioners (Briere & Scott, 2006; Cahill, Pontoski, & D'Olio, 2005).

Occupational therapy practitioners also have a role in the identification and treatment of alcohol and other drug abuse. The U.S. Preventive Services Task Force (2004) has found brief counseling or advice (5–20 min) from a primary care provider to be efficacious for patients who misuse alcohol. A VA study found that the likelihood of receiving advice increased when providers used measures such as the AUDIT to flag high use (Burman et al., 2004), a result suggesting that occupational therapy practitioners can incorporate alcohol screening and brief counseling into sessions to help motivate veterans to address alcohol problems.

Despite the results of the AUDIT, in which 92% of respondents were identified as engaging in hazardous drinking, only 27% reported alcohol use as one of their top five challenges. This finding may reflect a lack of insight into the role that drinking plays in the occupations of daily life such as struggles with fulfilling responsibilities or maintaining positive relationships. Veterans may minimize alcohol's role because of the perception that binge drinking is a reward for serving even if they recognize the reckless behavior associated with it. A veteran acknowledged this dilemma as follows:

I was drinking and making decisions in ways I never did before. One time I woke up on the sidewalk. . . . I just lived through a war and had an inflated sense of self-privilege that was above moral standards.

The results of all health screenings help explain why being a student was the second highest challenge among veterans. Because 40% screened positive for possible mild TBI, reports of some form of interference with cognitive functioning in the context of school are not surprising.

Lack of access to mental health treatment has been a common barrier to service members and veterans seeking mental health assistance and may be related to stigma within the military and among health care providers and a potential contributor to suicide (Hoge et al., 2004). To address suicide rates, occupational therapy practitioners could learn to use a gatekeeper training program on suicide prevention such as Question, Persuade, and Refer (QPR; Tompkins & Witt, 2009; Wyman et al., 2009). QPR has growing evidence that learning these techniques helps increase the rate of appraisal, knowledge, and access to service. The National Alliance on Mental Illness often provides this training at no cost.

Finally, it is important to consider the relationship between motivations and obstacles to engage in daily life among young veterans. The top two challenges identified by veterans (school and relationships) were, interestingly,

closely linked to the top two motivators (achieving goals and spending time with loved ones). If a veteran is failing to succeed in an occupational performance area that also drives him or her to persevere and stay well, intervention may be needed to prevent loss of optimal functioning. As these veterans identified, the best thing about returning home was their freedom. Unfortunately, their *occupational freedom*, a term introduced here, meaning “the opportunity and ability to choose and participate in activities that are meaningful to an individual,” may be compromised as they reintegrate into the civilian world after service.

Implications for Occupational Therapy Practice

Young veterans can be found in the workplace, community settings, and institutions of higher education. These sites are suitable for implementation of manualized interventions focusing on targeted interventions for individuals and groups as well as opportunities for peer support and a sense of belonging.

- Supporting veterans' health and well-being is imperative for clinical practice and research in all occupational therapy settings (e.g., mental health, physical rehabilitation, pediatrics, older adults, ergonomics).
- The therapeutic relationship provides an avenue for recognizing the signature wounds of war, as presented in this study. Occupational therapy practitioners should address these wounds as appropriate, get trained in areas in which they are less familiar, and refer clients to specialists when the concerns extend beyond their scope of practice.
- The traumas of war have implications for all members of a veteran's family. For parents of young children, for example, the occupational therapist in pediatric or school-based settings can play a vital role in recognizing how transitions and loss contribute to behavioral or learning challenges.
- The inception of occupational therapy practice began with veterans. Occupational therapy practitioners can continue to uphold this history by researching interventions, disseminating the results, continuing their education, and applying their skills to aid in successful, healthy transitions for veterans and their families.

Limitations

This study has some limitations. Most participants were White men, so the views of women and those from diverse ethnic backgrounds may differ. The amount of time that had elapsed since the veterans' 1st year back varied. The

screening instruments looked at participants' current status, whereas the COPM focused on their 1st year home. Step 2 of the COPM, in which participants identified on a scale ranging from 1 to 10 the importance of each challenge, was difficult. Problems associated with Step 2 and numeric ratings were also reported in a study looking at the homeless population (Tryssenaar et al., 1999). A limitation may also have occurred with the use of the PHQ-9. Some veterans may have been reserved in their response to an item about self-harm; they were all informed before the study that if their safety was potentially in danger, confidentiality would be broken to access help. Last is the issue of the positive testing effect. The screening instruments were administered after a 45- to 60-min interview, which may have caused the participants to feel more open and comfortable with reporting problems; however, it also suggests that the responses were more valid.

Conclusion

Many service members return to civilian life without psychological and cognitive injuries of war; for some, however, hidden wounds include PTSD, TBI, depression, and alcohol abuse or dependency. The needs of young veterans are vast and range from self-care to interpersonal needs. With the persistence of overseas operations, the problems identified in this article will continue as current and future service members become veterans.

Occupational therapy practitioners are uniquely positioned to serve veterans in all adult practice settings. The ultimate achievement would be to offer veterans hope and skills for occupational freedom. Future research on this topic may include problems related to substance abuse. The next step in addressing the needs of young veterans will be the development of occupation-centered interventions to supplement current services. ▲

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