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The Experience of Disability Compensation for OEF / OIF Veterans

A dissertation submitted in partial satisfaction of the

requirements for the degree Doctor of Philosophy

in Social Welfare

by

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ABSTRACT OF THE DISSERTATION

The Experience of Disability Compensation for OEF/OIF Veterans

by

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Recently returned Veterans experience many health and mental health problems post deployment. These Veterans, also referred to as OEF/OIF Veterans, are applying and appealing for Veterans disability compensation (VDC) at rapidly increasing rates. Despite this fact, little is known about how Veterans experience the process. In-depth qualitative interviews were conducted with Veterans age 35 and under who were denied disability compensation by the Department of Veterans Affairs (VA). This dissertation follows a three paper format which explore various components of disability compensation as experienced by OEF/OIF Veterans.

The first paper describes how Veterans learn about VDC, motivations for applying and their experience with the process of applying. Veterans typically framed the approach to seeking compensation as deciding to finally get help from the VA in a general way. Overall, many felt that something was generally wrong, and pursuing VDC was a step to help them understand their health/mental health problems, and to ultimately get better. Many also perceived they would have access to better resources through the VA (e.g. priority appointments) if they were rated for a particular illness or injury. The actual process of applying was exhausting to many veterans, and involved significant work and commitment. Decisions made about applications were perceived by Veterans as confusing and arbitrary.

The second paper considers the process of symptoms becoming diagnoses for Veterans via the VDC process. Veterans arrived to the disability application process certain of their symptoms. Veterans and other entities involved in the VDC process then played a role in affirming, molding or diminishing those symptoms. Three key aspects of the VDC process are highlighted including the process of completing the application, getting evaluated through the compensation and pension exam and receiving a decision. These aspects are explored as key arenas were symptoms were molded, affirmed or diminished. In the context of concerns about Veterans malingering to receive disability compensation, these findings suggest a more complex and nuanced experience.

The third paper depicts the way that recent Veterans perceive themselves and other Veterans as deserving and undeserving of VDC. Their rationales considered three primary areas: (1) military and combat experiences, (2) specific conditions and (3) the motivation toward self-improvement and work. Veterans also grappled with their own sense of deservingness as applicants and recipients of VDC. Veterans applied these three rationales to themselves, and also

described the powerful role of military culture as a fourth factor that influenced their perceptions around deservingness.

The dissertation of Casey Roagan MacGregor is approved.

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Chapter 1: Introduction

Millions of soldiers were deployed to conflicts in Iraq, Afghanistan and other countries – as well as serving stateside – comprising the largest ground troop operation since the Vietnam War (Institute of Medicine [IoM], 2007). These soldiers, many below age 35, have transitioned into Veterans. Many of these Veterans are in great need of health, mental health and vocational interventions to ease the challenges of their transition. Identifying ways to help recently returned Veterans, or OEF/OIF Veterans, is a focus of many social service organizations, universities, corporations, foundations and perhaps, most importantly, the Department of Veterans Affairs (VA). The VA is the federal organization tasked with administering and overseeing healthcare and benefits for Veterans.

Veterans are currently eligible for a range of extra benefits administered by the Department of Veterans Affairs (VA) when their conditions are deemed connected to their military service. These benefits include health care, vocational rehabilitation and lifelong monetary “disability compensation” (VA, 2011). Eligibility for these benefits are determined and administered via distinct entities within the VA; a Veteran can receive free or low-cost health care for a condition with the health administration arm of the VA, but not be eligible to receive other benefits such as disability compensation through the benefits administration arm of the VA. Generally, the eligibility threshold is higher to receive monetary disability compensation compared to receiving health care coverage from the VA. For instance, most Veterans are eligible to receive low-cost health care and all OEF/OIF Veterans receive five years of free health care from the VA regardless of documented disability. But Veteran’s disability benefits in the form of monetary compensation require a separate application, lengthy waiting period and medical documentation.

Generally, unless a Veteran is medically discharged from the military, a Veteran decides to apply for disability compensation. The disability compensation application process involves the extensive use of medical records. Even if a Veteran has medical records from a private physician, the VA usually orders their own examination called a compensation and pension exam ("comp and pen"). The application is denied outright or a rating of 0-100 percent is assigned to a Veteran based on the degree of disability. Veterans typically receive the monetary compensation benefits for life. Monetary compensation is explicitly intended to cover loss of earning capacity and implicitly intended to cover the challenges and "quality of life" affected by a disabling condition (IoM, 2007).

Approximately 11 percent of all Veterans receive disability compensation (Bilmes, 2007). In 2012, the VA spent approximately $46 billion on disability benefits compared to approximately $15 billion in 2000 (Smith, 2012). The numbers of applications – and costs once disability is awarded – are rising due to the high numbers of two Veteran populations: OEF/OIF Veterans and Vietnam Veterans. Original first-time applications for compensation have approximately doubled from 2000 to 2006 which is assumed to be primarily OEF/OIF Veterans (IoM, 2007). The most recent estimate from data collected by the Associated Press (Marchione, 2012) suggests that close to *45 percent* of OEF/OIF Veterans are seeking compensation. Perhaps more noteworthy, OEF/OIF Veterans identify "eight to nine ailments on average" in their applications (Marchione, 2012). An older report identified that approximately 28 percent of OEF/OIF Veterans have applied for disability compensation thus far (IoM, 2007). Clearly, there is considerable growth among OEF/OIF Veterans applying for disability compensation from the VA.

Another element related to disability compensation is that Veterans have the legal right to appeal decisions as many times as they want (Board of Veterans Appeals, 2002). Veterans commonly appeal the first decision made on their application. For instance, of all claims received in 2006, 81 percent were reopened claims, often as appeals (IoM, 2007). According to the Board of Veterans Appeals (BVA), the two main reasons why Veterans reopen or appeal are a denial of any disability or the decision was not considered high enough for the veteran (Board of Veterans Appeals, 2002). Analysts identify the high cost and burden on the system related to appeal, expressing concerns about a system backlog (GAO, 2005).

Research about Veterans is often funded by the VA's research arm under the VHA: Health Services and Research Development (HSR&D). IN 2013, HSR&D had a research portfolio of approximately 90 million dollars and 245 ongoing studies about Veterans (HSR&D, 2014). Essentially, most research about Veterans starts with HSR&D funding. Perhaps because the vast majority of PI's are clinician-researchers who may not consider benefits issues, few HSR&D funded-studies have considered aspects of disability compensation. Research by Sayer and colleagues is the main exception; her contribution will be reviewed in other sections (Sayer, Spoont & Nelson, 2004; Sayer, Spoont & Nelson, 2005; Sayer, Spoont, Murdoch, Parker, Hintz & Rosenheck, 2011).

Of the scant research about Veterans' disability compensation, much has focused on concerns over malingering and over-emphasizing symptoms during clinical encounters to bolster their compensation claims (Frueh, Elhai, Grubaugh, Monnier, Kashdan, Sauvageot, & Hamner, 2005; Taylor, Frueh, & Asmundson, 2006). For instance, some research literature describes the disability compensation as an "incentive" that Veterans use to both mislead VHA officials about their health conditions and to not work (Frueh, Grubaugh, Elhai & Buckley, 2007). From a

clinical or medical model perspective, this concern matters for diagnostic errors – if Veterans are exaggerating symptoms or experiences to get financial benefits, it becomes more challenging to diagnose and treat them effectively.

In essence, disability compensation is largely unexplored in research literature and the qualitative perspective of Veterans in relation to disability compensation is virtually nonexistent.

Research Questions

This dissertation takes an exploratory qualitative approach to consider how younger OEF/OIF Veterans experience the disability compensation system. The following research objectives are addressed:

1. To explore and describe how younger OEF/OIF Veterans understand their decision to apply for disability compensation
    - How do they arrive at the decision to apply?
    - What does it mean to apply for disability compensation?
    - What does it mean to a Veteran to be denied or receive an unsatisfactory rating?

2. To explore and describe experiences with the application process
    - How do younger Veterans experience the process of applying for disability compensation? How might these experiences impact their health and mental health conditions?

3. To develop theories regarding health identities and perceptions of disability compensation
    - How does the involvement with the disability compensation process shape perceptions of other Veterans, the VA and Veteran-serving organizations, and other potentially important elements in a younger Veterans' life?
    - How do Veterans navigate their own health and mental health identities in relationship to the disability compensation process?

These research objectives are examined through three distinct papers.

Dissertation Model and Paper Summaries

This dissertation follows the three paper format, rather than chapters. Three distinct papers are offered, corresponding to Chapters 3, 4 and 5. The titles of the papers are as followed, and will be referred to throughout the dissertation as Papers 1, 2 and 3:

1. The Experience of Disability Compensation for Young Veterans
2. "I Know What's Going on With Me": Affirming, Diminishing and Molding of Symptoms into Diagnoses during the Veterans Disability Compensation Process
3. Deserving Veterans Disability Compensation

Paper 1 addresses research objectives 1 and 2, addressing Veterans' initial perceptions of disability compensation, how they decide to apply and their experiences with the process. Since Paper 1 speaks most to the Veterans' experience of the VA and aspects of military discharge in relation to disability compensation, a military health journal might be appropriate such as *Military Medicine*.

Paper 2 considers how Veterans negotiate their symptoms in relation to the elements in the disability compensation system. Elements such as advocates, clinicians, examiners and benefits determination letters affirm, diminish and mold the symptoms of Veterans into diagnoses. Veterans themselves reject or mold their own symptoms into diagnoses through the process of applying for disability compensation. An appropriate target journal might be *Social Work in Disability and Rehabilitation*.

Paper 3 draws upon theoretical frameworks in social welfare about the tendency for recipients of certain social benefits to divide others and themselves into categories of deserving and undeserving. Paper 3 also adds the element of considering how military culture affects

Veterans' perceptions of disability compensation, their own health issues and the issues of other Veterans. An appropriate target journal is the *Journal of Sociology and Social Work*.

Chapter 2: Background

OEF/OIF Veterans

Veterans of recent conflicts fall under Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF)[1], and thus are referred to with this label – OEF/OIF. As of September 2011, there were approximately 22 million living Veterans, with 12% or 2.6 million OEF/OIF Veterans (GAO, 2011). About 26% of deployed military personnel during the OEF/OIF era come from the National Guard and Army Reserve (Harnett & Gafney, 2011). There are more female OEF/OIF Veterans than from any other era, as almost 12% of all OEF/OIF Veterans are female (VA Womens Health, 2012). While the rates are disputed, both the Bureau of Labor Statistics (BLS) and the nonprofit group Iraq and Afghanistan Veterans of America (IAVA) assert that OEF/OIF Veterans under 35 have higher rates of unemployment than the general population (Bureau of Labor Statistics, 2012; IAVA, 2011). And of service members serving in OEF and OIF, the majority are white (66%), 16% black, 10% Hispanic, 4% Asian and 4% other (Armed Forces Health Surveillance Center, 2009). Blacks are slightly overrepresented among OEF/OIF military compared to the general population of the U.S., with whites and Hispanics slightly underrepresented (U.S. Census Bureau, 2010; IoM, 2010).

Research about this population is evolving, as conflicts are slowly ending. OEF/OIF Veterans have been identified as having extensive, and often co-occurring, physical and mental health conditions. In prior conflicts and wars, the casualty rates were much higher than these current conflicts. Unique to this group of Veterans compared to other wars, OEF/OIF Veterans

[1] Operation New Dawn (OND) was introduced in 2011, referencing the changed relationship for military in Iraq post-withdrawal. This proposal will only focus on OEF/OIF Veterans since the vast majority of research literature encompasses this population only.

comprise an all-volunteer army that have been deployed and redeployed, sometimes up to four or five times (IoM, 2010). Due to improved medical care in the field, OEF/OIF Veterans are now surviving injuries which once fell soldiers (Bilmes, 2007; Lew, 2005). As of April 2015, 6829 OEF/OIF/OND military personnel have been killed[2] and 52,312 have been officially wounded in action (Department of Defense [DoD], 2015).

OEF/OIF Veterans experience a range of disabling mental health conditions. Some OEF/OIF Veterans use the VA health system to receive treatment. As a snapshot of prevalent conditions, the top five mental health conditions treated at the VA among OEF/OIF Veterans in 2010 were adjustment reaction which includes PTSD (n=109,850), depressive disorder (n=57,639), episodic mood disorder (n=38,715), neurotic disorder (n=45,252) and substance abuse disorder (n=36,797) (GAO, 2011). Subcategories of OEF/OIF Veterans have been identified as facing particular mental health challenges. For instance, the National Guard and Reserve have been linked to higher rates of PTSD and depression (Milliken, Auchterlonie, & Hoge, 2007; Shell & Marshall, 2008). It is hypothesized that Guard and Reserve members experience more mental health challenges upon separating from the military due to their relative isolation from established military communities (Milliken, Auchterlonie, & Hoge, 2007; Shell & Marshall, 2008). Female OEF/OIF Veterans are also a demographic category with unique needs. In particular, female OEF/OIF Veterans experience disproportionate rates of military sexual trauma (MST), the official name for sexual harassment and/or rape while in the military, as well as disproportionate rates of sexual coercion (Lipari & Lancaster, 2003). According to Kang & Bullman (2010), OEF/OIF Veterans also have significantly higher suicide rates than the general population and the risk is higher for those who more recently left the military.

[2] This includes both hostile and non-hostile actions (e.g., accidents, suicides).

Many OEF/OIF veterans have conditions which are not easily identified and diagnosed after returning from service. The medical community and veteran stakeholders consider post traumatic stress disorder (PTSD) and traumatic brain injury (TBI) to be the two signature "invisible wounds" of these conflicts (Tanielian & Jaycox, 2008). PTSD and TBI often co-occur with other debilitating – and potentially invisible – conditions and experiences. There are various estimates of TBI among OEF/OIF veterans. The Military TBI Taskforce (2007) identified a 30 percent prevalence rate among OEF/OIF veterans of moderate and severe TBIs. Not all TBI's result in lifelong adverse results, but there is also much that is not known about this condition (Tanielian & Jaycox, 2008). Other conditions include musculoskeletal conditions and chronic pain. One recent estimate of overall prevalence OEF/OIF veterans suffering from chronic pain was 38 percent (Gironda, Clark, Massengale & Walker, 2006). OEF/OIF veterans with PTSD and/or TBI experience high rates of depression, anxiety, sexual trauma, somatic pain, and substance use disorder (Tanielian & Jaycox, 2008; Helmer, Chandler, Quigley, Blatt, Teichman & Lange, 2009; Hawkins, Lapham, Kivlahan & Bradley, 2010; Eisen et al., 2012).

There are many younger OEF/OIF Veterans, with a median age range of 25-34 in 2011 (Department of Labor [DOL], 2011). As Kelty, Keylamp & Segal (2010) identify, "military service is often a mission for the young" given the hierarchal nature of service and demand for physical fitness Younger OEF/OIF Veterans may be at a particularly high risk for developing mental health disorders. Exposures to direct combat correlate significantly with increased PTSD risk (Yehuda, 2002); younger Veterans are often at a lower rank and experience more combat exposure. There have also been suggestions that their relative youth renders them less experienced and able to handle the stress of warfare (Seal, Cohen, Waldrop, Cohen, Maguen, & Ren, 2011). One large-scale study identified 31 percent of all OEF/OIF Veterans seen at the VA

having mental health diagnoses and/or psychosocial problems (Seal, Bertenthal, Miner, Sen, & Marmar, 2007). This national study analyzed VHA utilization data for 2001 to 2005 and addressed the proportion of OEF/OIF Veterans who have received mental health diagnoses as well as the subgroups of OEF/OIF Veterans at high risk. Young age among OEF/OIF Veterans was highly correlated with mental health and PTSD diagnoses, with the youngest age bracket of 18-24 at highest risk. They were also at higher risk for alcohol and substance abuse (Seal et al., 2007).

Veterans Benefits

Veterans comprised one of the first groups to receive categorical social welfare benefits from the state (VA, 2010; Skocpol, 1992). There is a rich history regarding the development of various benefits to Veterans. From a comparative social welfare perspective, many Western countries offered assistance to military Veterans well before other social welfare benefits were institutionalized for non-Veteran citizens (Skocpol, 1992; Gerber, 2000). Since any semblance of a military system in the United States and before any formal establishment of the VA, a central federal body offered benefits to Veterans and their families. For instance, the Congress of 1776 established life-time pensions for disabled Veterans (Dickson & Allen, 2005). One of the earliest *formal* systems of social welfare in the United States were Veterans benefits, with their "record keeping, sorting, control, surveillance, and discipline of individual citizens; indexing needs of groups in the population; and maintenance of large permanent bureaucratic agencies" (Gerber, 2000, p. 16).

Veterans' benefits have historically been distinct and separate from other welfare benefits for the general public (Skocpol, 1992; Gerber, 2000). This may be due, in part, to the philosophy

underlying benefits to Veterans. This philosophy framed Veterans' benefits as an earned reward for service, rather than charity (Gerber, 2000; Woloch, 2000). Benefits also historically functioned to discourage desertion, and later to promote recruitment in a volunteer system. The boundaries of Veterans' benefit provision by category of Veteran have also shifted over time. For instance, Veterans with higher ranks were once offered distinctive benefits from those Veterans with lower ranks (Gerber, 2000).

The VA is divided into three parts: the Veterans Health Administration (VHA), the Veterans Benefits Administration (VBA) and the Burial / Memorial Services Administration. The VHA is the largest healthcare system in the United States and is essentially responsible for providing health care to Veterans who sustain injuries and illnesses via their participation in the armed forces (VA, 2010). The VBA is comprised of five principle units which administer various benefits to Veterans and their families: life insurance, vocational rehabilitation, education, home loans and compensation / pension benefits (VA, 2011). The VHA and the VBA intentionally operate as separate and distinct agencies from each other, with very different functions (Mental Health: Bridging the Gap Between Care and Compensation for Veterans, 2011).

Research Paradigm

Symbolic interactionism

Symbolic interactionism helped organize theorizing about the data from my study. Symbolic interactionism emerged out of many philosophical camps. The philosophical approach of pragmatism is commonly viewed as an important precursor to formal symbolic interactionism (McCall, 2006). Pragmatism is many ideas; it includes the notion of open systems, truth

comprising of “what works” or what is happening in a moment rather than a reliance on an *a priori* system (Benton & Craib, 2001). At a basic level, symbolic interactionism is about recognizing that the self and experiences are contextual and “created” vis a vis interactions with society. Social roles are constantly negotiated in symbolic interactionism. There is a reciprocity between the self and others. McCall (2006) and Charon (2007) outline various tenets of symbolic interaction, synthesized here:

1. Man is constantly scheming, planning, constructing plans of action. Man is a thinking being who interacts with others and with himself constantly.
2. Things (e.g., symbols) have meanings in relation to plans. There are no things without our planning and interacting with these things. We are actively organizing and interpreting the things of our environment.
3. We arrive at shared meanings of the things in our environment.
4. We act toward things; man is not a product of his environment, but active and involved in creating it. Charon (2007) explains, “If we want to understand cause, focus on human thinking” (p. 29).

My three papers were guided by symbolic interactionism and thusly described in each paper. For example, Paper 1 considers the way that Veterans feel about aspects of the disability compensation process in relation to their own health conditions. The process is not neutral, but serves as a symbol affecting their sense of well-being and connection to the VA.

Study Methods

Recruitment and sampling

Following many qualitative methodologies and an exploratory approach, this study did not attempt to create a representative sample of OEF/OIF Veterans. The study used a purposive sampling approach. Purposive sampling approaches are appropriate when a specific population is sought (Rubin & Babbie, 2012). The sampling frame for this study included Veterans age 35 or under who applied for Veterans’ disability compensation and were denied disability

compensation or received a dissatisfactory rating. Morse (2007) explains, “qualitative sampling often begins by recruiting participants solely based on whether they have experienced the research topic in question” (p. 232).

One aim of the study was to learn about the experience of applying for disability compensation, from the perspective of returning Veterans. Another aim was to consider a subset of this population: namely, those who were denied or dissatisfied with the rating received. Considering this subset was relevant because of policy concerns about the high numbers of Veterans re-applying. Younger Veterans may re-apply over the course of their lives. There was also an assumption that these Veterans may have had challenges with navigating the disability compensation process. Understanding their challenges with the process was deemed important; Veterans who have challenges with the process are likely to be more at-risk for a range of negative outcomes, such as suicidality and substance abuse.

It was a sampling decision to not recruit Veterans with any one specific condition, disorder or diagnosis such as Veterans with PTSD or depression, for instance. This decision was made for a few reasons: pragmatically, it is difficult to recruit OEF/OIF Veterans in general. Narrowing the scope to one or two specific conditions would limit the pool dramatically. But more importantly, the study did not want to reify a particular diagnosis since an area of focus was the social construction of such disorders and diagnoses. This proved to be an appropriate decision since Veterans described the complexities around how other perceived their symptoms and diagnoses compared to their own experiences. As an exploratory approach to a topic with limited data, sampling only Veterans with a certain diagnosis made by a clinician would limit the study.

The sampling frame included OEF/OIF era Veterans age 35 and under. The study chose to select OEF/OIF and younger Veterans for a few reasons. Younger Veterans are OEF/OIF Veterans for the most part (even though this is changing as the years proceed). In other words, many Veterans under 35 are OEF/OIF era simply by default. As a group, these Veterans will potentially cost the disability compensation system more over the long term. OEF/OIF Veterans are frequently studied *as a group* given their particular stressors and challenges, such as repeated deployments, exposure to combat and invisible wounds (Kelly, 2011). The age of 35 is an appropriate yet arbitrary cut-off age, reflecting the research literature that many of the traditional adult achievements have been established or are well-underway (e.g., employment, training completion, marriage, parenthood) by that age.

The starting point for recruitment of Veterans were Veterans' organizations via snowball sampling techniques. Organizations included postsecondary student Veteran organizations, social service agencies, and other organizations in the community which were Veteran-identified. Over 35 organizations were contacted via email in the Southern California area and asked to distribute a study flyer and study information to their membership or clients. I also presented the study in-person to five Veteran student organization groups across Los Angeles and Orange County. Veterans interested in the study contacted me by telephone or email. All Veterans were pre-screened by telephone to establish eligibility. The advantage of this recruitment method is that the study was able to include Veterans who were not necessarily connected to the VA health system; as the VA has invested considerable efforts in outreach to Veterans in the community, this approach captured the perspective of those Veterans, albeit using nonprobability sampling techniques and thus non-representationally.

The demographic table in Appendix B describes the sample of 18 respondents. Thirteen Veterans from the sample had been deployed overseas. The average age was 24. All Veterans were male, except for two. Nine Veterans served in the Marines, five served in the Army and the other four were from the Navy and the Coast Guard. Most applied for compensation for both "physical" and "mental health" conditions, in the traditional sense. Four Veterans did not describe conditions considered mental health conditions, describing more "physical" illness and injury such as back pain and knee injuries. Four Veterans resided in a transitional homeless residence and learned of the study through the case manager of the residence. The majority of respondents contacted me via Veteran student organization recruitment efforts.

Data Collection

A total of 18 OEF/OIF Veterans were interviewed from February – July 2013. All semi-structured interviews were conducted in person. Seven Veterans were interviewed twice to better explore their experience. The determination for requesting a second interview was subjectively determined when situations were more complex and many questions remained. This flexibility in approach is consistent with some qualitative methodologies (Holloway and Todres, 2003). I had hoped to interview two additional Veterans a second time, but they did not return my calls and email requests, or were unable to schedule a meeting with me.

A semi-structured interview guide was utilized (See Appendix A). Questions were originally structured around three topic areas: 1.) Deciding to apply, 2.) Applying and 3.) The experience of being denied or given an unsatisfactory rating. The interview guide was refined over the course of interviews as issues emerged, following a grounded theory approach. For example, questions about accessing military records emerged as a problem for many Veterans and thus became part of the questions posed during subsequent interviews.

Veterans were provided with a $50 gift card incentive for participating as respondents. If Veterans returned for a second interview, they were offered a second $50 gift card. Most interviews spanned 1.5 hours. Interviews were conducted in private rooms within public settings such as library conference rooms and offices. Subjects were screened for cognitive impairment through the Mini-Mental Status Examination-II Brief Version (MMSE-II), a validated tool. No subjects were excluded for cognitive impairment. Consent was obtained verbally. The study was approved by UCLA Institutional Review Board. All interviews were recorded and transcribed.

Data Analysis: Grounded Theory

This study used a grounded theory approach to inquire about OEF/OIF Veterans and their experiences applying for disability compensation. Symbolic interactionism and grounded theory approaches pair well, particularly when a more constructivist grounded theory approach is adopted (Charmaz, 2005; Bryant & Charmaz, 2007). The introduction of grounded theory for qualitative research studies is attributable to Barney Glaser and Anselm Strauss, researchers who co-wrote The Discovery of Grounded Theory in 1967 (Bryant & Charmaz, 2007). Their original aim was to convince the social science research establishment that qualitative data could be analyzed with the same rigor as quantitative research. Through this effort, they partially reified a positivist top down approach to social science (Bryant & Charmaz, 2007). Over time, grounded theory was considered more aligned with other research influences such as social constructionism and symbolic interactionism. Bryant & Charmaz (2007) offer a description of a middle ground for grounded theory methodology to exist, between the objectivist /positivist approach versus the constructivist one; they describe it as a "repositioned" grounded theory methodology. This repositioned approach adopts a "fluid, interactive, and emergent research

process” and also “recognize(s) partial knowledge, multiple perspectives, diverse positions, uncertainties, and variation in both empirical experience and its theoretical rendering” (p. 51).

Following a grounded theory approach, the goal of the study was to represent the multiple realities of those being studied. Grounded theory allowed for inductively-derived “informal hypotheses and concepts”, but it was the data itself as the ultimate root of the study (Munhall, 2007). The development of my three papers followed this approach. Papers that I may have considered writing before collecting the data were markedly different after data collection. In other words, the data shaped the frameworks of the three papers.

This study also adopted certain heuristics and guidelines, attempting to follow the middle ground approach described above (Bryant & Charmaz, 2007). There are several heuristics and guidelines to using grounded theory as a methodological approach. First of all, analysis is ongoing as data is collected. Grounded theory is an inductive approach to addressing research objectives. There are two important methods to conducting analysis with a grounded theory study: coding and memoing (Strauss & Corbin, 1990; Lempert, 2007; Holton, 2007).

Data Analysis: Coding

My coding approach involved several steps, following grounded theory methodologies. The first step of coding my transcripts involved *initial coding* (Charmaz, 2006). Initial coding involves close textual reading, allowing for the quick identification of multiple topics and processes. In the tradition of grounded theory, initial coding began before all the data was collected and as soon as the first interview was transcribed (Bryant & Charmaz, 2007). Initial coding involved coding idea by idea – coding with gerunds that “reflect action” (Charmaz, 2006,

p. 48). For example, the initial coding of the following passage was coded as: "Comparing himself to other Veterans who have given up" and "Identifying that one has to fight".

> *BW: …it's kind of like how much wind do you have to fight because a lot of people just give up and they're like yeah, you know what, I'm done fighting. And then they just go with 50%.*
> *CM: Do you know people where that's been the case?*
> *BW: Yeah. I mean they just want to get on with their lives and that's what I want to do.*
> *CM: Why are you not giving up?*
> *BW: A lot of it has to do with principle.*

After initial coding, the next step involved *focused coding*. Multiple salient initial codes comprised focused codes. The point of focused coding was to identify frequent or significant codes (Charmaz, 2006). Categories are developed from focused codes through memoing and constant comparison of ideas. According to Charmaz (2006), rich and nuanced data from focused codes lead to category formation. Creating categories also involves the notion of describing its consequences and ultimately showing how the category is related to other categories. An examples of a category in this study is "Costs of applying". Another category is "Getting help with disability compensation". Papers 1 and Paper 3 followed this methodological approach and used that process for the basis of the analysis.

Paper 2 took the analysis one step further and attempted theoretical coding, a third step of rigour in the process. Theoretical coding involves identifying relationships between the categories identified via focused coding (Glaser, 1978; Charmaz, 2006; Holton, 2007). The synthesizing of coding in this way should offer an "integrated set of conceptual hypotheses that would explain what is really going on" (Holton, 2007, p. 274). The theoretical coding process elucidates clear and complex situation-specific theories or theory.

Data Analysis: Memoing

The use of memos are integral to any project using grounded theory. As Holton (2007) explains, the "basic goal of memoing is to develop ideas with complete conceptual freedom". Memos, in this study, allowed for both a gut reaction to an interview and summarizing of information. Memos are also spaces for reflexivity. Unlike other research studies where objectivity is the goal, this type of study requires self-awareness and awareness of self in relation to others. Memoing contributed to growth and insight regarding where "I stand" in relation to the study.

Memoing was also conducted via verbal recordings. The use of verbal memoing proved to be rich in a way distinct from the written word.

Use of Quotations

The three papers here involve extensive quotations. They are shared to best capture the voice of Veterans firsthand. Quotes were edited to make more readable. For instance, interstitial language (e.g., "you know"), was edited out in some places. Quotes were also shortened when conversations jumped around. Ellipses were used when a quote was edited. Ellipses were carefully chosen and care was taken to reflect the intent of the speaker.

Reflexivity

Reflexivity, or the idea of considering oneself in relation to the qualitative analysis, is appropriate with studies of this nature (Charmaz, 2006). The selection of papers and the analysis of data are certainly a reflection of my background and interest. My core beliefs include the idea that the government is not always transparent in its processes, and often fails in attending to the needs of people struggling, especially when significant sums of money are at stake. I also write these papers from the position of sympathy and concern for Veterans. My interests in the

concerns of Veterans grew out of my opposition to the wars following 9/11. Living in New York when the Twin Towers fell and seeing the way that the United States responded to the crisis by sending many individuals younger than myself at the time into combat operations for wars I did not support angered and saddened me. I do not think Veterans are helpless victims, but my view is that they struggle in systems beyond all of our control.

Prior to and during the study, I had many informal conversations with employees at the VA (Sepulveda Ambulatory Care Center) where I was a Research Associate. I also spoke with social workers and case managers working at different settings where I recruited respondents who shared their opinions and perspectives about Veterans seeking disability compensation. I finally spoke to Veterans under the guise of pre-research about their experiences. These conversations certainly shaped my perspective.

The fact that I am not a Veteran studying issues affecting Veterans – and personally interviewing them – created challenges and opportunities. I also interviewed mostly male Veterans. Based on what was learned about military culture, my not being a Veteran may have allowed to open up more than if I had been a Veteran. I think that being female may have also been helpful. While impossible to know for sure, male Veterans may have been more comfortable sharing certain details that exposed vulnerabilities.

Paper 2 discusses the social construction of diagnoses. When conducting interviews, I tried to stay aware of my own biases about diagnoses. My view is somewhat hostile to the medical model, while recognizing the vital need and function for diagnostic categories. Despite my attempts to stay aware of biases, I arrived at conclusions which reinforced the idea around the social construction of diagnoses.

My social welfare background undoubtedly shaped Paper 3 about Veterans' perceptions of deserving disability compensation. Ideas around deserving and undeserving recipients of benefits dates back to the Elizabethan Poor Laws of the 1600s and is etched into social work foundational curriculum. My background in welfare reform studies also contributed to this analysis.

Chapter 4: Paper 1

The Experience of Disability Compensation for OEF/OIF Veterans

Introduction

The Department of Veterans Affairs (VA) offers Veterans disability compensation benefits when a health or mental health condition is connected to their prior military service; benefits include monetary compensation. To receive Veterans disability compensation, Veterans complete an application which includes medical documentation of health or mental health conditions (VA, 2015). There are no time limits regarding when a Veteran can apply for disability compensation post-service (National Veterans Legal Services Program [NVLSP], 2011) and most Veterans apply for disability compensation after they have separated from the military (Military Advantage, 2015). Eligibility for disability compensation is established in two main ways: 1) a physical or mental health condition must be currently diagnosed, and 2) the condition must have a connection to military service (NVLSP, 2011) also known as "service connection". Veterans receive a percentage rating that determines the amount of compensation received (NVLSP, 2011). The percent rating determines the amount of money compensation; higher percentages allow for payments made to dependents and the waiving of medical co-pays among other benefits (VA, 2014).

Approximately 18 percent of all Veterans receive disability compensation from the Department of Veterans Affairs (VA) (Autor, Duggan, Greenberg, & Lyle, 2014). Original *first-time* applications for compensation have approximately doubled from 2000 to 2006 which is assumed to be primarily recent, or OEF/OIF, Veterans (IoM, 2007). The most recent estimate from data collected by the Associated Press (Marchione, 2012) suggests that close to 45 percent of OEF/OIF Veterans are seeking compensation. Perhaps more noteworthy, OEF/OIF Veterans

identify “eight to nine ailments on average” in their applications (Marchione, 2012). An older report identified that approximately 28 percent of OEF/OIF Veterans applied for disability compensation thus far (IoM, 2007). Disability compensation expenditures are rising: in FY 2013, expenditures were approximately $49 billion, compared to $46 billion in 2012 and $15 billion in 2000 (Smith, 2012; Autor, Duggan, Greenberg, & Lyle, 2014). Veterans commonly appeal the first decision made on their application. For instance, of all claims received in 2006, 81 percent were reopened claims (IoM, 2007). According to the Board of Veterans Appeals (BVA), the two main reasons why Veterans reopen or appeal are a denial of any disability or the decision was not considered high enough for the veteran (Board of Veterans Appeals, 2002). Veterans also have the legal right to appeal decisions as many times as they want (Board of Veterans Appeals, 2002).

National and state Veteran Service Organizations (VSOs) can play an important role in assisting Veterans to prepare for the application process. While a Veteran can apply for disability compensation on their own, a VSO can serve as the legal representative and submit the application on a Veterans’ behalf. VSOs also conduct training sessions for Veterans to learn about disability compensation (DAV, 2012). 85 percent of Veterans are assisted by a VSO in applying or appealing disability compensation (Shedd, 2013). Additionally, in 2007, a law was changed to allow legal representation of Veterans seeking compensation claims by private firms; at least 3200 firms are now accredited by the VA to provide representation to Veterans (Collier & Early, 2010). No studies have been conducted which consider the performance of VSO’s in relation to disability compensation for Veterans; some researchers identify the need for such data given the large role VSOs play in initiating Veterans to the disability compensation process (N. Sayer, personal communication, August 13, 2012).

According to one recent study, Veterans may not fully understand the eligibility rules around disability compensation. Meshberg-Cohen, Reid-Quiñones, Black, & Rosen (2014) focused on substance-abusing Veterans, analyzing perceptions about working and receiving benefits among Veterans who were already receiving disability compensation. Even though Veterans are typically allowed to continue receiving disability compensation if they work, a majority of surveyed Veterans in this study perceived that increasing work would negatively affect their disability compensation levels. Veterans also perceived that working would negatively affect medical benefits with the VA (Meshberg-Cohen, Reid-Quiñones, Black, & Rosen, 2014), even though working is generally allowed when receiving disability compensation.

Other studies about Veterans disability compensation have focused on Veterans who seek compensation for Post Traumatic Stress Disorder (PTSD). This focus is likely because PTSD is the most common mental health condition that Veterans receive disability compensation for (Spoont, Sayer, Nelson & Nugent, 2007). Claims for PTSD disability have also increased much more rapidly than other conditions in recent years (Frueh, Grubaugh, & Buckley, 2007). There are various ideas about why PTSD claims are increasing. Due to improved medical care in the field, OEF/OIF Veterans are now surviving injuries which once fell soldiers (Bilmes, 2007; Lew, 2005). For example, as of May 2012, 5068 OEF/OIF military personnel have been killed in action and 48,083 have been *officially* wounded in action (Department of Defense [DoD], 2012). PTSD as a delayed-onset condition is another consideration, as well as the possibility of malingering (McNally & Frueh, 2013).

Sayer, Spoont & Nelson (2004) assessed the motivation for applying for disability compensation among Veterans with a PTSD diagnosis. They used the Disability Application

Appraisal Inventory, a scale they developed via literature reviews, focus groups with Veterans and VA representatives as a "self-report inventory developed to assess beliefs and attitudes about the disability application process (Sayer et al., 2004, p. 2136). One section of the scale focused on establishing the reasons Veterans seek disability, which included questions about *validation* (e.g., If I get disability for PTSD, I will feel that justice has been served for what I went through), *self-other acceptance* (e.g., If I am awarded service connected for PTSD, other Veterans will respect me), and *financial benefit* (e.g., I need to be awarded service connection for PTSD to pay my bills). Sayer et al. (2004) found that most Veterans agreed that getting disability benefits would allow validation and recognition from the government. Significantly, over half of Veterans thought that if they received Veterans' disability for PTSD, they could focus on getting better (Validation subscale).

More recent qualitative work of Sayer, Spoont, Murdoch, Parker, Hintz, & Rosenheck (2011) identified five key reasons that Veterans seek disability compensation. Using data from Veterans who applied for compensation with PTSD diagnoses specifically, the study identified: 1. Tangible needs, 2. Need for problem identification or clarification, 3. Beliefs that justify or legitimize disability status, 4. Encouragement from trusted others and 5. Professional assistance with application process (p. 702). This research was conducted among Veterans who had applied with PTSD diagnoses specifically. The 2010 National Survey of Veterans is another source of information about why Veterans apply; in this case, they queried why Veterans had *not* applied for VA disability benefits. The survey identified both a gap in knowledge and potential stigma as motivations in not applying: almost one quarter of Veterans were not aware of the VA service-connected disability program and another 14 percent identified not knowing how to apply, indicating a gap in knowledge. However, Veterans also responded that they did not apply

because their disability was not severe enough, they didn't want any assistance, they didn't need assistance, applying was too much trouble or they had never thought about it. These options were not mutually exclusive (Westat, 2010). These studies help us understand why Veterans ultimately decide to apply for disability compensation.

Many researchers and policymakers identify the disability compensation system as highly strained, inefficient, inaccurate, and overly bureaucratic (Sayer et al., 2005; Reed, 2011). Several large-scale research reports have described challenges with the system (Bridging the Gap Between Care and Compensation, 2011; IoM, 2007; Veterans Disability Benefits Committee, 2007). These reports, along with multiple U.S. Government Accountability Office (GAO) investigations, highlight some of the most egregious issues, including the lack of internal validity and reliability of ratings, extremely long delays in processing claims, antiquated screening processes, and inadequate medical examinations (GAO, 2002; GAO, 2007; GAO, 2010). The Institute of Medicine also criticized the way disabilities are evaluated under the rating schedule. In an era when mental health and physical conditions are frequently viewed in the context of each other – especially for populations like Veterans – the organization of the rating schedule is considered extremely outdated (IoM, 2007). Criticisms regarding the VDCP have also included the lack of coordination between the DoD and the VA. These reports are important, but neglect to capture the "voices" of Veterans experiencing such challenges.

Additionally, despite the growth and cost of the VA disability compensation program for recent Veterans, very little is known about how recent Veterans learn about disability compensation, their motivations for applying or their experience with the process. Prior studies address these questions, incompletely. For example, the work of Sayer et al. (2011) focuses on Veterans with PTSD only and the 2010 National Survey of Veterans (Westat, 2010) identifies

why Veterans do not apply for disability compensation. This paper uses a qualitative approach to describe Veterans' initial perceptions of disability compensation, their decision-making process in applying and how they feel about the process.

Methods

This study involved qualitative interviews with young Veterans, age 35 and under. The interviews explored several aspects related to Veterans' disability compensation including the decision to apply, the process of applying and the experience of receiving a decision about an application (Table 1). A total of 18 OEF/OIF Veterans were interviewed in-person from February through July 2013, with seven Veterans interviewed twice to better explore their experience. Thirteen Veterans from the sample had been deployed overseas. The average age was 24. All Veterans were male, except for two. Nine Veterans were Marines, five were Army and the others were from the Navy and Coast Guard.

OEF/OIF Veterans age 35 and under who had applied for Veteran's disability compensation and "had their application denied or received a rating they were dissatisfied with" were recruited through college Veteran organizations and Veteran Service Organizations (VSO's) in the Southern California area. Representatives of these organizations were contacted and asked to distribute a study flyer to anyone that might be eligible and interested. Because of the VA's strict rules regarding recruitment, no recruitment was conducted through VA organizations, including VA Medical Centers, Vet Centers or VBA offices. Interviews were conducted in-person, in private rooms. Veterans were asked to take the Mini-Mental Status Examination-II Brief Version (MMSE-II) before starting the interview, a validated tool to screen cognitive impairment (Mungas, 1991). No Veterans were excluded due to cognitive impairment. The UCLA Institutional Review Board approved this study.

All interviews were recorded and transcribed professionally. Following grounded theory methodologies, my coding approach involved initial coding and focused coding (Charmaz, 2006). Initial coding involves close reading of the transcripts, with an immediate identification of topics and processes. My initial coding process began during data collection following a grounded theory approach (Bryant & Charmaz, 2007). My initial coding process involved coding with gerunds that "reflect action", or idea by idea (Charmaz, 2006, p. 48). My second step involved *focused coding*. Multiple salient initial codes comprised focused codes to allow for identification of frequent and significant codes (Charmaz, 2006). From focused codes, I developed categories by the constant comparison of ideas and memoing which allowed a space for reflection and reflexivity (Charmaz, 2006; Holton, 2007). Two categories used in this paper were "Reasons for Initially Applying" and "Learning about Disability". Atlas.ti qualitative software was utilized to organize the data.

Results

Perceptions and Awareness of Veterans Disability Compensation Before Applying

Generally, Veterans knew little about disability compensation while they were in the military. Veterans heard of disability compensation, but "knew no details" and did not distinguish disability compensation from any other benefits they might receive after separating from the military. As one Veteran explained, "I had no idea about [disability compensation]. I had no idea there's people with service-connection…'What are you guys talking about?'…No one there talked about that". Another Veteran compared his initial understanding of disability compensation to worker's compensation:

> *People know that…if you get hurt, you get disability and that you get money for it. It's just as clear and concise as your first job and what the workman's comp process is. You don't really know what the workman's comp process is. You've heard about workman's comp and...your*

managers might be talking about workman's comp but you don't really understand the in-depth process behind it. That's the same thing with claims.

I asked about the value of any formal programs that are tasked with explaining disability compensation, such as Transition Assistance Program (TAPS), when they were separating from military service. Three Veterans did not think they took any TAPS outprocessing program. For others who did recall receiving TAPS, disability compensation was covered briefly with little explanation.

> *In TAPS we just learned ... it was real brief. It was like, okay, this is what a disability claim is, this is how you file the claim, these are the different ratings you can get, this is what service connected means. It was really brief and really generic…They said, 'hey if you feel like you think you might be eligible for disability, come fill out a claim'. That's all they said. They didn't go over the importance of it, they didn't do a great detail of it.*

Another Veteran was told during TAPS that he would have to stay longer in the military if he did apply for disability compensation. Because he was eager to leave the military, he perceived that this was told to him as a disincentive to apply. Only one Veteran described TAPS as helpful with disability compensation. This Veteran opted to take her TAPS class early as there is a 6-month window before separation to take TAPS; in her case, she was advised to apply for disability compensation while she was still in the military – advice she perceived as "good" and an option she pursued.

What little was known about disability compensation was initially negative and stigmatized. Veterans described initial perceptions that other Veterans were "gaming the system" or "sucking on the government tit". Initial perceptions of disability compensation were also linked to the stigma of being sick or ill, generally. This stigma was especially true among certain branches of the military (e.g., Marines). A Marine Corps Veteran shared that he had heard of a fellow Marine being "medically rated" for a hand injury while in the service:

They didn't even want us around him. We looked at him like, 'He's a bitch,' and he wasn't one of us…Because everything is always a big embarrassment, like you've got to run with the pack. They would say, 'Who's having a problem?' and God forbid somebody raised their hand.

Another Veteran from an elite unit explained that talking about any benefits related to health was considered like "cheating".

We are the elite, you're expected to deal with things in a type of manner. Like, 'Oh what, wait a minute, you got a cold? You got the sniffles? Get out there.' You know?…That's why it was rare that we talked about like, "Oh did you know that you can get this?" It looked to us that it was like cheating. 'Why are you going to cheat? You don't need that.' For God, for country, kind of a thing, so it was very ingrained in us in that sense. Yeah, there wasn't a lot of talk about it.

A few respondents received more favorable messages about disability compensation while they were still in the military. These messages emphasized the importance of documenting medical conditions.

I knew about [disability compensation] the whole time I was in…Well, I have lots of family members that are still currently in and everything, but I think it was just kind of told to us when we first got in. I don't remember who it was that said, 'If you have something, go to medical for it. Don't wait because if you don't have proof, then they're not going to help you.'

Finally, there was a lack of awareness that mental health conditions could factor into applying for disability compensation. As one Veteran described, "I had thought it was for wheelchairs and crutches."

The Decision to Apply

While most Veterans knew very little about disability compensation while they were in the military, they learned more details about it post-separation primarily through other Veteran friends or colleagues. Most typically, other Veterans encouraged the respondents in this study to apply. The one exception with this encouragement was when Veterans wanted to apply for

service connection related to PTSD. In this case, Veterans typically discouraged other Veterans claiming PTSD as a condition because of the perception that it could affect future employment opportunities.

Understanding of what disability compensation involved was learned about through Veterans at institutional or organizational settings, including Veteran Service Organizations (VSO's), Vet Centers and VA Medical Centers. The following Veteran received encouragement to apply via a social group at the Veterans of Foreign Wars (VFW), as he was suffering from various health conditions and living in a new city. He describes how the socialization led to discussion of "resources".

> *I would go to the VFW…They started bringing me to their house, treating me like family. I spent the holidays with them and to me, it was becoming more than a bar. It was like my social club, my family, and that's ultimately what it is supposed to be because they have dart night and they have potlucks, but then you get into resources…I started to come around these other guys and noticed that we had a lot more in common.*

Veterans reported getting encouragement to apply from employee and representatives from all three entities (Veteran Service Organizations, Vet Centers and VA Medical Centers). These employees and representatives were also often Veterans themselves, but not exclusively. Another example of this process involved a respondent initially being encouraged to apply by a Vet Center representative who suggested his "illness wasn't going away"; however he did not file an initial claim with the Vet Center because he experienced the representatives being too busy to help him and became frustrated. The following year he decided to apply and received assistance through a guest speaker brought to his informal Veteran social group.

Disability compensation was occasionally introduced to Veterans at VA Medical Centers after Veterans initially went for health and mental health care. But Veterans also went to the VA

for the first time interested in starting a claim for disability compensation, and enrolled in health care services after that initial visit. In this way, seeking disability compensation got returning Veterans to learn more about their health care and mental health benefits at the VA. One respondent explained, “I would have never even enrolled into the VA system had I not been seeking to apply for compensation and pension”. Another Veteran expressed that disability compensation drew him to the VA for the first time.

> *The first time I went to the [VAMC], I got processed in and learned that I got medical benefits. I also applied for disability. I didn't know that I got medical coverage. The main thing was the disability. I didn't go there for any other reason.*

I asked Veterans why they ultimately decided to apply. A primary reason was the lived experience of injuries and mental health conditions. All Veterans described extensive symptoms which were currently affecting their lives. Few participants could recall a distinct moment where a decision was made to apply. Instead, they typically framed the approach to seeking compensation as deciding to finally get help in a general way. Overall, many felt that something was “wrong”, and pursuing disability compensation was a step to help them understand their symptoms, and to ultimately get better.

> *When I got back from Iraq, I didn't feel like I was home. And so I went to the VA, and they threw me in vocational therapy just to talk to people and I got my diagnosis of PTSD, traumatic brain injury and then my case manager told me that I should apply [for disability compensation] because I fit the criteria for disability, for PTSD and everything.*

Health and mental health services were conflated with receiving disability compensation, over the course of the interviews. The following represents a Veteran merging the two distinct systems:

> *The only thing I'm looking for is basically help from the VA to help me deal with my mental and my injuries that I had while in the service. That's my biggest concern, you*

know. Like just help me with those things so that way I can transition and I won't have to be dependent on social service systems.

Several Veterans also described wanting to apply because they perceived that getting disability compensation from the VA would give them preferential treatment and better care at the VA. Further, many thought that the *higher* you were rated, the better care you would receive. One Veteran viewed the rating as an acknowledgement by the VA: "This being service-connected is probably the highest classification of being acknowledged through the VA." Another suggested that being rated allowed for special status within the VA:

> *I want [disability compensation] so that when I go for help or when I need it, I'm entitled to it. It's even put on the back of your VA card. That's one of the questions, 'Are you service-connected?' Because they need to know who they're dealing with in the sense of how you're ranked according to the VA.*

Ideas were expressed that receiving compensation, or being rated, would mean that the VA would view health and mental health conditions more legitimately.

> *It's like they're more willing to help you. What it seems like is comp and pen to them is like, "All right now, if comp and pen says you have it" -- then it's legitimate. You know if you just go in there and be like, "I've got this and I have these things," and it's almost like it's not as legitimate. At least, that is the feeling I've been getting from that.*

A few Veterans identified 100 percent as a goal.

> *At 100 percent, they take care of you a lot better…at 100 percent you get special privileges, you get first chances to be seen. Just different benefits that you get versus only having 90 and below…It's like a pecking order, it's getting that place and with 100 percent there are different benefits that you get.*

These views suggested an underlying concern that certain health needs would not be attended to at the VA without a disability compensation rating. Perceptions among Veterans included a strong link between receiving health care and disability compensation at the VA:

> *If they stop paying me, then they'd have to stop treating me. As long as they're giving me money, that means that I can go into the VA and they're going to look at any of my problems and deal with them. It might take a while, but they'll deal with them.*

Another Veteran suggested that he could get “flushed out” from the VA during a “purge” if his percentage was not rated higher than zero percent. (A zero percent is generally considered better than a rejection because the rating can increase at a later time). This Veteran suggested he learned this idea from a radio news program.

> *10% was to me, means I'm in that area. I'm not going to just get flushed out when they're getting rid of people in a quick purge. I heard about a lot of guys with 0% disability just getting dropped off the roster.*

Financial concerns related to health bills were also a reason for applying. One Veteran was being charged for medical care. With medical bills mounting, he decided to apply. He explained:

> *After I separated, nobody knew how to help me. I like asked everywhere in the VA. Because at the time when I got out, they didn’t even give you medical care as far I remember because they started charging me right off the bat for medical care at the VA.*

Deciding to apply for disability compensation was also a way for Veterans to try to plan ahead in the face of an uncertain health future. Almost all Veterans suggested they were expecting their conditions to worsen over time. No Veterans suggested that monetary compensation was a factor in the decision to apply. However, monetary compensation was indirectly discussed as allowing for health and mental health-related concerns to be addressed. A Veteran with back pain explained, “I needed to know that if something started acting up, I’d be able to go get it taken care of without having to worry about paying for it.” Another said he was told he would have problems with his back and stomach down the line, suggesting, “it’s like I am waiting for these problems to unfold.” Other respondents expressed similar ideas:

I applied to get disability just so maybe in the future I can collect the money to get another surgery or at least get care. That's all I really wanted, was just to get another surgery or corrective surgery or something like that.

Veterans also suggested they were not expecting disability compensation to be their sole income. One individual who was residing in a transitional housing center explained,

I understood [disability compensation] as help…To me, it's just pretty much getting back on my feet…a lot of people here are trying to be 100 percent because that's their life goal. I can't live off $2,000 [a month] for the rest of my life.

Finally, disability compensation was applied for in order to receive acknowledgement from the VA for conditions. One Veteran who had been raped while in the military was seeking compensation for military sexual trauma so that it would be "recognized" by the VA as having actually happened.

Process of Applying

Veterans shared extensive details related to their process of applying, including their feelings about the experience. Each offered what they considered to be their own "horror story" connected to the process of applying. Common experiences included medical documents never being received, calls not returned, applications being moved from one geographic area to another without informing Veterans, and incomplete or grossly inaccurate medical records being used to make determinations. The experiences with compensation and pension exams as part of the process was also shared. These exams involved Veterans being told diagnoses they did not agree with and being accused of lying or exaggerating symptoms. Veterans also struggled with "opening up" to examiners they perceived as "heartless" and uncaring.

Veterans were at different points in the application process, with some respondents having had appealed and some who had received decisions more recently. Per screening for the

study, all had “not been satisfied” with the rating they received on their application. Given those considerations, the process was experienced by Veterans as requiring a high level of “work” and commitment. The work of applying and persisting with the process was exhausting for Veterans. Many invoked fighting metaphors in their discussion of the process. As one Veteran explained in the context of applying, “It’s just whether or not you’re willing to put in the battle”. In addition to fighting metaphors, Veterans described being exhausted by the work of applying. The following describes the mental energy needed to apply:

> *Why is it such a hard time? Why do they give Veterans such a hard time to see these benefits that are for them? I don't understand. They made the process so you almost have to be a rocket scientist to crack the codes. There's people out there taking advantage of it and they cracking it overnight because they have the mental energy to figure it all out, how to get the loopholes and jump around and wait it out, say the right stuff at the right time so they get through the process seamlessly.*

The process of applying was linked with the exacerbation of their mental and physical health conditions. Most felt strongly that dealing with the bureaucracy of the process had a negative impact on their health. I asked one participant whether receiving benefits sooner than he had would have made any difference in his health conditions.

> *[Getting it sooner] would have been less stressful for me because I would have realized it would have been something else that I can fall back on to if I fail. I would have been like, "O.k. I can focus on my medical issues and I don't have to worry about working or anything else. I can go deal with the medical stuff." No. I had to go work and hustle and this and that. I could not focus on taking care of me physically, mentally.*

Veterans struggling with mental health conditions such as depression, anxiety and PTSD expressed particular challenges.

> *I already have anxiety just with the different things that I have going on. [Applying] is adding to it and it's making my conditions worse because when you have issues like PTSD, any unknown…you just want answers and there's anxiety to get those answers.*

Another Veteran suggested that the long waits contribute to the high suicide rates among

Veterans due to the "unknown and the fact that it's drawn out for so long". Finally, the "tedium of compensation stuff" made one Veteran with a self-identified drinking problem as wanting to drink more.

There was an expression of confusion and frustration by extremely long waiting periods with limited or no access to check on the application status. Many described feeling "in limbo". One Veteran who waited over two years for a decision on his initial application described his feelings about waiting:

> *It kept getting postponed and they would send me apology letters. They would go, 'Sorry we are working on your claim. We'll be with you shortly.' They sent me four of those and then they'd send me, 'We need more information.' It would be the same package: 'Give us the date, give us the time, where were you at? Who else saw?' Just another story. To me, it becomes frustrating. Everything becomes frustrating when you keep doing the same thing. You feel like you're, I don't know, just arguing with somebody.*

Going through the experience of applying resulted in a deep distrust of the disability compensation system and its process. My interviews revealed specific examples of Veterans perceiving arbitrary decisions made during the process. Most felt their applications were not taken seriously. One Veteran suggested his application may have been used as a "napkin"; another joked that the reviewers read the first line and threw it out. A Veteran was waiting for a response to his application for at least two years and interviewed about his long wait by a national media outlet. He explained: "Once they got me the news interview, it took about a month [to get a response to his application]. Whoop-di-do. See how funny that was? It took a month after I got on the news and embarrassed the VA." He perceived the media attention expediting a decision on his application.

An overall distrust in the process was described, with the sentiment that the process was purposefully adversarial. For example, one Veteran said, "It's not disability assessment. They're

assessing their ability to discriminate against your disability. They're like, 'Okay, how can we not fund him?' That's really what they're doing." Other suggestions involved a quota that the VA operated under.

> *They're just legally looking for a reason based on the rules…I'm sure there is somebody that has a budget or something that they need to keep. That they have to keep under a certain amount of Vets from getting disability insurance.*

Another Veteran explained, "They make us go to all these appointments thinking we're lying about most of the stuff, but I think that having them believe me or believe a Veteran on the first try would be awesome."

The sample in my study were Veterans who had received a decision about their disability compensation, and were not satisfied with the decision. However, most Veterans in the sample had been awarded some compensation, typically 10 percent. The following Veteran was asked what it meant to him when he found out he was awarded compensation for a knee condition:

> *When I had even gotten my one knee [rated], I wanted to cry. I felt like I got some acknowledgement and that everything I've done and injuries I've sustained weren't in vain. That's what I felt.*

The feeling of relief was also expressed among those who were eventually given decisions. The decision to appeal or challenge the percentage rating often did not occur immediately, according to many accounts. Three Veterans, while dissatisfied with the decision, did not have immediate plans of appealing. All three suggested they did not have energy or "the drive" to commit to the effort, despite believing the decision was inaccurate.

Discussion

The findings in this paper have various implications for administration of the Veterans disability program and for health service delivery with returning Veterans. This research

suggests that returning Veterans knew very little about disability compensation while they were in the military. Many are learning about disability compensation after they separate from the military. The Transition Assistance Program (TAP) program that Veterans receive when they discharge from the military did not sufficiently prepare Veterans for the process of applying. This correlates with earlier survey research suggesting that less than half of Veterans thought that TAP was beneficial in learning about disability benefits (Westat, 2010). Thus, disability compensation is often introduced well after separation from the military. Veterans in informal settings, VSO's and representatives at the VA introduce Veterans to disability compensation. Given that many Veterans were unaware of benefits available to them and had misconceptions about types of conditions eligible for disability compensation, earlier and better education about these benefits may be needed. A recent report published by the USC Center for Innovation and Research on Veterans and Military Families (CIR) about needs of OEF/OIF Veterans in Los Angeles recommends the implementation of a transition mentor to assist with a variety of areas, including education about benefits (Castro, Kintzle, & Hassan, 2014).

Additionally, many Veterans in this study invoked a stigma when considering disability compensation while in the military. Disability compensation was associated with weakness. Any efforts of information dissemination about disability compensation to Veterans while in the military should consider this stigma and tailor messages accordingly. Further, the documentation of injuries and illness was not understood by Veterans as important, while they were in the military. The military should improve efforts to document illness and injury, while Veterans should receive better education about the crucial role of their medical records while they are in the military. The previously-mentioned CIR report suggests that "every separating service member needs to leave active duty with all the necessary documentation" to file an application

for disability compensation in case they decide to in the future (Castro, Kintzle, & Hassan, 2014, p. 52). CIR's recommendation is appropriate based on the data from my study. However, almost all Veterans in this study had grossly incomplete documentation for their health and mental health conditions from when they were in the military, as they had occurred. A frank consideration of why Veterans have incomplete medical documentation while in the military is relevant.

While some Veterans were able to articulate distinctions between the VA's disability compensation system from the health administration arm of the VA, many did not make such a distinction. The VA has invested considerable resources in promoting outreach efforts for returning Veterans to seek help from the VA (Erbes, Westermeyer, Engdahl & Johnsen, 2007; Amdur, Batres, Belisle, Brown, Cornis-Pop, 2011). Pursuing disability compensation was generally not considered distinct from getting medical / mental health care from the VA for Veterans in this study; Veterans perceived the two systems as intricately linked and one in the same. At the same time, the interest in applying for disability compensation may also be a primary motivator to get some Veterans to the VA in the first place. It is unclear whether the VA recognizes a Veteran's interest in disability compensation with their current outreach efforts. Further, efforts around getting returning Veterans to seek health and mental health care from the VA should consider the disability compensation experience as an important "critical time" when Veterans are first introduced to the VA.

In this study, I also identified the complexities around why Veterans decided to apply for disability compensation. In stark contrast to the idea that Veterans are malingering or exaggerating symptoms to get compensation (Taylor, Frueh, & Asmundson, 2007; McNally & Frueh, 2013), the decision to apply had little to do with receiving monetary compensation in my

sample. Veterans in this study described a process of deciding to apply for disability compensation as they were seeking help in a general way. In the course of seeking help, they were pointed to apply for disability compensation by other Veterans, VSOs and representatives from the VA. In other words, many decided to apply based upon the advice of others in the context of needing help.

In addition to seeking help in a general way, Veterans in my sample specifically wanted assurance that their health and mental health needs would be covered at the VA. Rules around eligibility and co-pays change; for example, OEF/OIF Veterans eventually were offered two years of free post-deployment health coverage which became extended to five years in 2008 (VA, 2014). Another example includes a 2010 policy change that allowed caregivers to receive special assistance and compensation. As some Veterans in this study understood, the VA does organize Veterans into distinct priority categories – and disability percentage ratings factor into which category the Veteran falls in. Eligibility around these categories have also changed over time. In 2003, Veterans with Category 8 status were excluded from any health benefit coverage with the VA; Veterans in this category have no service connection and incomes slightly above the poverty line (Priority Group 8 Veterans, 2007). Essentially, then, to understand why Veterans apply and appeal, we should consider the motivation of receiving quality VA health care. Veterans are covering their future health care options by applying for disability compensation.

In an uncertain healthcare coverage environment at the VA, with shifting eligibility rules – along with uncertainty about their future healthcare needs – getting a disability rating was a good idea for the Veterans in my sample. They described concerns about being “flushed out” of the VA health system and falling out of the “pecking order”; Veterans in this study were concerned they would not be attended to by the VA and expressed limited trust in the VA

meeting health needs in the future without a disability rating in place. Following Lipsky's (1980) conceptualization of bureaucratic encounters, various mechanisms occur to ration services in an environment of limited resources, including long waiting periods and triaging, or "differentiation among clients in people processing" (Lipsky, 1980, p. 106). While Lipsky was referring to the immediate triaging of individuals during bureaucratic encounters, Veterans in my study experienced being triaged within the VA through the disability compensation process. Whether accurate or not, they perceived the VA as having a quota system and limited resources. The resources Veterans were most concerned with was access to current and future healthcare. Future studies which consider the broadening of recent healthcare access under the Affordable Care Act in relation to disability compensation are warranted.

Finally, I identified how Veterans feel regarding the disability compensation application process. Veterans described exhaustion resulting from engaging with process. Aspects that felt exhausting to Veterans were the long waits for a response, the confusion over rules and policies, and the challenges in finding out their status. Applying required effort and energy that not all felt they could sustain into the appeals process. Some Veterans felt their health conditions to be further compromised via the process. Social scientists have offered the concept of "cooling out" as applied to educational and public welfare settings which reject individuals for various services or resources (Goffman, 1952; Clark, 1960; Sellerberg, 2008). There are many aspects to this theoretical idea which include the notion that systems with limited resources handle many rejections and maintain mechanisms that help soothe the process and minimize anger. An unanswered question is whether everyone can receive disability compensation who submits a legitimate claim. We know that in fact, many claims are rejected or receive lower ratings than they requested. Since there are no limits on Veterans applying and re-applying, mechanisms

which cause frustration such as long waiting periods and lost paperwork, then, may function to discourage Veterans from appealing. To support this idea, not all Veterans were planning on appealing despite the conviction that they had a legitimate claim. This experience potentially relates to other social welfare programs such as Supplemental Security Income (SSI), with long waiting periods and uncertain outcomes for applicants (Autor & Dugan, 2006; Keiser, 2010). Veterans perceive the disability compensation system as adversarial.

While reforming the entire process is outside the scope of this paper, it is important to consider the aspects of the process that are most challenging to Veterans, and specifically OEF/OIF Veterans. Given the anguish that many experience once applying, an easier way of ascertaining status is important. The disconnect between the VBA and the VHA could also be bridged: once a Veteran applies for disability compensation, outreach for treatment of health and mental health conditions could be activated. The journalist Aaron Glantz also offered a somewhat radical policy recommendation modeling the disability compensation on the system of taxation: benefits to begin upon submission of application with the *presumption* of accuracy (Glantz, 2008). While putting such a policy recommendation into practice would be challenging, efforts around reforming the system should continue a focus – even as the VA deals with numerous controversies with its health system.

Chapter 5: Paper 2

"I Know What's Going on With Me": Affirming, Molding and Diminishing of Symptoms into Diagnoses during the Veteran Disability Compensation Process

Introduction

There are over 2.6 million Veterans under Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) (GAO, 2011) and many have been identified as having extensive, and often co-occurring, physical and mental health conditions. While Veterans can be formally diagnosed with conditions during their time in the military or after they leave service, many OEF/OIF Veterans have conditions which are not easily identified and diagnosed after returning from service. As certain injuries and wounds such as amputations may be quite visible and somewhat easy to diagnose, many conditions remain "invisible". The medical community and Veteran stakeholders consider post traumatic stress disorder (PTSD) and traumatic brain injury (TBI) to be the two signature "invisible wounds" of these conflicts (Tanielian & Jaycox, 2008). Other typical conditions include musculoskeletal conditions and chronic pain. One recent estimate of overall prevalence OEF/OIF Veterans suffering from chronic pain was 38 percent (Gironda, Clark, Massengale & Walker, 2006). OEF/OIF Veterans with PTSD and/or TBI experience high rates of depression, anxiety, sexual trauma, somatic pain, and substance use disorder (Tanielian & Jaycox, 2008; Helmer, Chandler, Quigley, Blatt, Teichman & Lange, 2009; Hawkins, Lapham, Kivlahan & Bradley, 2010; Eisen et al., 2012).

Veterans are currently eligible for a range of extra benefits administered by the Department of Veterans Affairs (VA) when their conditions are deemed connected to their military service. These benefits include health care, vocational rehabilitation and lifelong monetary disability compensation (VA, 2011). Eligibility for these benefits are determined and administered via

distinct entities within the VA; a Veteran can receive free or low-cost health care for a condition with the health administration arm of the VA (VHA), but not be eligible to receive other benefits such as monetary disability compensation through the benefits administration arm of the VA (VBA). Generally, the eligibility threshold is higher to receive monetary disability compensation compared to receiving health care coverage from the VA. For instance, most Veterans are eligible to receive low-cost health care and all OEF/OIF Veterans receive five years of free health care from the VA regardless of documented disability. But Veteran's disability benefits in the form of monetary compensation require a separate application, waiting period and medical documentation.

There is considerable growth among OEF/OIF Veterans applying for disability compensation from the VA (IoM, 2007; Marchione, 2012). Generally, unless a Veteran is medically discharged from the military, a Veteran decides to apply for disability compensation. The first step of the process involves the completion of an application. These applications can be filled out by anyone and are typically completed by a Veteran themselves or an advocate. The advocate can be an employee of the VA, or external from a Veteran Service Organization (VSO). The disability compensation application process involves the extensive use of medical records, if available. The second step involves an examination called a compensation and pension exam ("comp and pen"). Even if a Veteran has medical records from a private physician, the VA orders this examination by doctors from the VA, or contracted by the VA. After the exams are complete, the application is reviewed. The application can be denied, or given a rating of 0-100 percent based on the degree of disability.

Study Context

Research around Veterans pursuing disability compensation is an emerging area. Of studies that do exist, many focus on the issue of symptom malingering and exaggeration to bolster claims for compensation (Frueh, Elhai, Grubaugh, Monnier, Kashdan, Sauvageot, & Hamner, 2005; Taylor, Frueh, & Asmundson, 2006). While there is scant data about the experience of completing an application and receiving the decision, the role of the compensation and pension exam has received some empirical attention. One study identified the compensation and pension exam as stressful, confusing and upsetting for multiple conditions, both health and mental-health connected (Sayer, Spoont & Nelson, 2004). In a published editorial, Rosen (2010) described his experience as a physician in the VA. He identified how compensation and pension exams are often performed in the VHA setting (e.g., health clinic), thus potentially causing a confusing situation and suggests there is a “missed opportunity” for health treatment since the goal of a compensation and pension exam is primarily one of data collection and evaluation (Rosen, 2010).

In this study, I set out to learn how Veterans navigate the disability compensation system at three key points in the process: completing an application, getting evaluated through the compensation and pension exam and receiving a decision. This paper focuses specifically on how Veterans navigate their own symptoms within a system that utilizes a medical model approach.

Sensitizing Concepts

I used a grounded theory approach to analysis, described in the methods. I did not begin with a theoretical framework dictating analysis; instead the data shapes the analysis (Charmaz, 2006). But there are several ideas that assisted in the theory-building process as *sensitizing concepts*. Sensitizing concepts, as Blumer (1954) described, are as they sound: concepts that

“gives the user a general sense of reference and guidance in approaching empirical instances” (Blumer, 1954, p. 7). They are to be contrasted with the idea of a definitive conceptual framework which presupposes how the data will be viewed (Charmaz, 2006).

Several sensitizing concepts influenced analysis. The social construction of diagnoses and literature connected to that idea is the first concept to consider. As a starting point, the Veterans disability compensation system follows a medical model, similar to other rating systems of disability (e.g. Supplemental Security Income). While there is no singular definition of the medical model (Nessee & Stein, 2012), it typically includes dualistic ideas that one is healthy or ill; diagnoses are central and arrived at through a scientific approach; a diagnosis is present or absent based upon differential criteria; and a doctor or professional is central in making the diagnosis or diagnoses (Gabe & Monaghan, 2013). Critics of the medical model consider diagnoses to be social constructions with significant grey area (Goffman, 1961; Kleinman, Eisenberg & Good, 1978; Kleinman, 1980; Estroff, Lachicotte, Illingworth & Johnston, 1991). Critics also point to the enormous power of a diagnosis and by default, professionals asserting the diagnosis (Kleinman, 1980). A medical model approach to this study might have identified Veterans with particular diagnoses at the outset. Instead, this study – and paper – is about the Veterans’ process of negotiation of symptoms and diagnoses rather than assuming their presence or absence.

The specific medical and mental health diagnoses and their corresponding ratings that the VBA uses are not fixed, in part, because medical knowledge evolves. Traumatic brain injury (TBI) is an example of a newly identified condition which both constitutes a diagnosis and which is connected to military service. In 2008, TBI became a diagnosis allowed to be compensated up to 100 percent, years after the VHA and other medical communities recognized the disorder

(Maze, 2008). Prior to 2008, the VBA typically did not rate it as an impairment beyond 10 percent. In another recent shift, diabetes mellitus (diabetes) became a presumptive condition in 2000 after the National Academy of Sciences identified a limited relationship between the Agent Orange exposure of Vietnam-era Veterans and the development of diabetes (Singleton, 2009). In 2008, the level of impairment also changed for PTSD. All PTSD diagnoses now receive a minimum of 50 percent disability rating. Therefore, formal policy around what should be service-connected and how impairing a condition may be is iterative.

Two conditions that tend to affect OEF/OIF Veterans are not eligible for direct service connection. Chronic pain is highly correlated with various conditions that tend to afflict OEF/OIF Veterans, including traumatic brain injuries and PTSD. A recent estimate of overall prevalence OEF/OIF Veterans suffering from chronic pain was 38 percent (Gironda, Clark, Massengale & Walker, 2006). However, Veterans cannot seek a direct service connection for chronic pain; rather chronic pain must be linked to another diagnosis. Veterans also cannot receive compensation for substance use disorder (SUD) as a primary condition. However, SUD qualifies as a secondary disability and can be connected to conditions such as PTSD or cirrhosis of the liver.

Many theorists have written about the social construction of illness (Goffman, 1961; Kleinman, Eisenberg & Good, 1978; Kleinman, 1980; Estroff, Lachicotte, Illingworth & Johnston, 1991; Charmaz, 1995). Kleinman (1988) and others have demarcated illness from disease where illness is the lived experience and disease is that which is identified by experts. Other theorists have considered the distinction between symptoms and signs (Goffman, 1961; Aronowitz, 2001). Symptoms are often associated with the subjective reporting of a patient's illness, while signs are considered objective bio-markers of disease than can be measured by

experts. Much has been written about diagnoses or “putative” conditions where few tests are available and are primarily arrived at via reported symptoms from a patient (Brown, 1995; Dumit, 2006; Miles, Curran, Pearce & Allan, 2005). These conditions include chronic fatigue syndrome, multiple chemical sensitivity and to a large degree, chronic pain. Most mental illnesses are also “conditions” which people struggle to get recognized and verified.

Stone (1984) offers an important element to the consideration of illness and specifically, disability. She suggests that disability being determined via clinical or medical technologies is are recent artifact of history – in prior eras, priests or others might determine a person’s disability and importantly, legitimacy to not work. Her historical assessment of the concept of disability asserts that determining disability has always been challenging, with inherent concerns about deception due to the nature of what disability measures and assesses. She identifies that disability is both an administrative category which confers benefits, along with a clinical medical definition (Stone, 1984). She also identifies the way that subjective interpretation play a role in determining disability and illness; she suggests, “despite tremendous intellectual efforts by physicians, lawyers and program administrators to transform such experiences as pain, fatigue, and shortness of breath into objective phenomena, determinations of disability are still highly dependent on the subjective reports of individuals, as well as their willingness to tolerate various forms of discomfort” (Stone, 1984, p. 146). Analysis for this paper was strongly influenced by these ideas.

The findings of this paper also offer a model with other concepts, operationalized here. First, affirmation as a concept is defined as “emotional support or encouragement” (Merriam-Webster's online dictionary, n.d.). In a therapeutic context, affirmation is a strategy used to both recognize and sympathize with the other. Self-affirmation theory suggests that people are

protective of their self-integrity, have multiple selves and identities to preserve (Steele, 1988); relevantly, self-affirmation theory identifies the effort that people make in defending and restoring their self-worth (Steele, 1988). Self-affirmation interventions often involve an assertion of values or competence in the face of a situation that is not affirming (Sherman & Cohen, 2006). An example might be affirming a person's coping skills despite recently losing a job. Affirmation, as applied here, can also happen internally through self-talk.

Molding is another concept to consider. Molding is the notion of shaping something. To mold something, it begins as one entity and ends up something else after the act of molding. There is an assumption of malleability in regards to molding; the entity is not fixed or frozen. This paper discusses how Veterans and others molded symptoms into particular diagnoses to fit the needs of a situation.

Diminishment is the final concept that influenced by analysis. Diminishment can be considered the opposite of affirmation and is defined as "the act of making a person or a thing seem little or unimportant" (Merriam-Webster's online dictionary, n.d.). If affirmation validates and acknowledges, diminishment invalidates and ignores.

Methods

Qualitative interviews were conducted with 18 young OEF/OIF Veterans, age 35 and under. The interviews explored several aspects related to Veterans' disability compensation including the decision to apply, the process of applying and the experience of receiving a decision about an application. A total of 18 Veterans were interviewed in-person over February through July 2013, with seven Veterans interviewed twice to better explore their experience. Thirteen Veterans from the sample had been deployed overseas. All Veterans were male, except

for two. Nine Veterans were Marines, five were Army and the others were from the Navy and Coast Guard. The average age was 24. Veterans received $50 gift cards for each interview they participated in. Appendix B offers the demographic information for the sample.

Recruitment involved contacting college Veteran organizations and Veteran Service Organizations (VSO's) in the Southern California area. Contact individuals were asked to share the flyer with their membership to anyone that might be eligible and interested. The study flyer advertised for OEF/OIF Veterans age 35 and under who had applied for Veteran's disability compensation and "had their application denied or received a rating they were dissatisfied with". Because of the VA's rules regarding recruitment, no recruitment was conducted through VA organizations, including VA Medical Centers, Vet Centers or VBA offices. All Veterans were interviewed in-person, at public settings in private rooms. Veterans took the Mini-Mental Status Examination-II Brief Version (MMSE-II) before starting the interview, a validated tool to screen cognitive impairment (Mungas, 1991). No Veterans were excluded after meeting initial criteria. The UCLA Institutional Review Board approved this study. All interviews were recorded and transcribed professionally. Veterans are referred to throughout the paper by pseudonyms.

Analysis

There were several steps to coding with this study, following a grounded theory approach. (Glaser & Strauss, 1967; Bryant & Charmaz, 2007). The first step of coding involved *initial coding*, with close textual reading, allowing for the quick identification of multiple topics and processes (Charmaz, 2006). In the tradition of grounded theory, initial coding began before all the data was collected and as soon as the first interview was transcribed (Bryant & Charmaz, 2007). Initial coding involved coding idea by idea – coding that "reflect action" (Charmaz,

2006, p. 48). After initial coding, the next step involved *focused coding*. Multiple relevant initial codes comprised focused codes. The purpose of focused coding was to identify frequent and significant codes (Charmaz, 2006). Then, categories were developed from focused codes through memoing and constant comparison of ideas. According to Charmaz (2006), rich and nuanced data from focused codes lead to category formation. Creating categories also involves the notion of describing consequences and ultimately showing how the category is related to other categories. The final step involved *theoretical coding*. During theoretical coding, I identified relationships between categories (Glaser, 1978; Charmaz, 2006; Holton, 2007). In this study, “affirming symptoms”, “diminishing symptoms” and “molding symptoms” were all categories. Relationships between these categories were identified to create the theoretical model in Appendix D.

Following a symbolic interactionist approach, I considered the notion that symptoms and diagnoses were socially constructed objects which functioned in various ways (McCall, 2006; Charon, 2007). Symbolic interactionism as applied here is the idea that diagnoses are “co-created” vis a vis interactions with society. Symbolic interactionism identifies that people are thinking beings who are constantly interacting with others and themselves to makes sense of their world (McCall, 2006; Charon, 2007). Also key to symbolic interactionism is that things have meaning in relation to plans; there are no “things” without our planning and interacting with these things. We are active organizers and interpreters of our environment using this framework (McCall, 2006; Charon, 2007). For this paper, diagnoses have meaning in relation to how the diagnose will be used pragmatically.

The guiding research question of this paper was: How do Veterans navigate their own health and mental health identities in relationship to the disability compensation process?

Findings

The table in Appendix C depicts the conditions that Veterans identified with at the present time and considered connected to their military service. The most common conditions are offered, along with a narrative column. The table is created based upon Veterans' perceptions; no formal screenings for diagnoses were conducted. Veterans arrived to the disability application process certain of their symptoms. Additionally, some Veterans expressed confidence in the diagnoses associated with the symptoms prior to involvement with the application process. Veterans interacted with clinicians, examiners, VA representatives, VSO representatives and others who played a role in affirming, molding and diminishing those symptoms in relation to the disability compensation process.

The diagram in Appendix D depicts the process of symptoms becoming formal diagnoses via the disability compensation process. There are many aspects to the disability compensation process, but three key ones are highlighted here. The process of completing the application, getting evaluated through the compensation and pension exam and finally receiving a decision are explored as key arenas were symptoms were affirmed, molded or diminished as conditions and diagnoses. These experiences were not mutually exclusive; as an example, the same Veteran experienced affirmation and molding of symptoms during the application process.

Completing the application

Veterans approached the application form for disability compensation on their own or received assistance from advocates. About half of respondents originally filled out the application on their own or with minimal assistance, even though some later appealed with assistance. A common experience was a process of affirmation through the completion of the application themselves, expecting to be taken "at face value". For example, Marcus had worked

as a medic in the Army and felt familiar with medical terminology. He described how he did not know all the diagnoses for his symptoms, but felt confident that he knew what had occurred while he was in the military. He explained, "I wrote up pages. Pages of stuff. And, I'd write next to it 'I'm not sure of the date'. Because they want specifics. I don't know what the doctor's diagnosis was, but this is what happened." The process of writing out their symptoms and stories allowed affirmation for him.

Veterans received help from various advocates and representatives who assisted with what diagnosis to put on their applications, in connection to their symptoms. Many Veterans reported to me that they were simply asked what they "thought was wrong" in regards to diagnoses to claim, rather than relying on clinical sources. Roberto described working with his case manager to decide what to put on his application:

> *First, he asked me what I felt I acquired over my period being in the Marine Corps and during the war and everything and then after I told him that, he just asked me what else hurts, what else. Then I would name stuff and he would write it all down.*

Ken shared a similar experience as Roberto, as he completed his application with assistance. (Ken could not recall whether the individuals who helped him were from the VA or another organization.)

> *I remember I had two meetings. One with the guy who said, okay what do you want to claim? And then there was another one like just, here's the paperwork you got to fill out. Filled it out and he goes, okay. You'll hear back from them in 4 to 5 months.*

While not every encounter with completing the application allowed for affirmation, Veterans suggested that listing symptoms felt "good to get it out".

Advocates and others who helped Veterans occasionally suggested diagnoses to put in the application process, helping to mold symptoms into diagnoses. These suggestions occurred when

Veterans were sharing symptoms with advocates; suggestions also occurred based on other contextual factors. A typical example of a suggested diagnosis was tinnitus, or ringing in the ear. Veterans frequently talked about the diagnosis of tinnitus as one that they were advised to identify with on their application. One Veteran described it as a “gimme” because he was told during his outprocessing program (TAPS) that it was hard to prove or disprove. Johnny was a jet mechanic in the Navy with a severe hand injury that had not been documented while in service. He was also concerned about his exposure to asbestos affecting him in the future. He received advice from a family friend about putting tinnitus on his application:

> *When I told her I was a jet mechanic, she said go in for tinnitus because they can't say whether you do or don't. And you definitely have hearing damage from the military. You were around jets, you definitely have it.*

Johnny suggested he had some hearing loss, but was not sure whether it was at the level of the diagnostic criteria for tinnitus. In sum, tinnitus was an example of a symptom that was molded into a formal diagnosis in the application form.

Deciding to pursue disability compensation was also an opportunity for Veterans to refine their diagnoses based upon their symptoms. The process of applying compelled Veterans to think about what was occurring and what diagnosis might correspond to their symptoms. They also received diagnoses from the people assisting them. Pedro had previously been diagnosed with panic disorder by a private non-VA doctor, but was eventually diagnosed with PTSD by a VA doctor as he was planning to apply for disability compensation. I asked Pedro whether he agreed with the new diagnosis.

> *Yeah, because it made sense. All the stuff I saw, the symptoms, everything that one goes through, it just made perfect sense. It made a lot more sense than panic disorder with agoraphobia because I wasn’t that scared of people…After I found that out, I started learning more about post-traumatic stress syndrome (sic). I started doing research on it and*

> *seeing how it just makes a lot more sense to how I feel and how I act and why I react that way.*

In Pedro's experience, one diagnosis made more sense than others. His experience of being told a few different diagnoses was reflected in other Veterans' experiences, as well. The diagnosis itself was not always evident when Veterans entered the application process. For example, Peter was residing in a transitional shelter and had recently applied a second time with the assistance of a legal advocacy group. He was denied for all conditions the first time he applied and was unsure why he was denied. He described that the second time around felt "more accurate". He described the two times he met with the legal advocacy group representative as involving the interpretation and molding of his symptoms into diagnoses for the application form.

> *The first time I went down there, I went down to talk, and I was like I can't sleep, I can't eat, I need to be isolated, I keep having these recurring feelings and constant arousal every time I'm somewhere. He's like okay, you have PTSD, sleep insomnia, lower back, tinnitus and something else. So then I'm like okay…[The legal advocacy group representative]asked, "Well, when you were in the service did you have these things? How did they affect you in the service?" And so I was like, "Okay, when I was in the service I was suffering from alcoholism because I was self-medicating because I couldn't deal with the pressures of what was going on there and the other stuff. Like I had a mental breakdown." They said, "You do have PTSD," because that's what that is. They gave me the information so I could read about it.*

During the two interviews, Peter shared numerous anecdotes with me about his severe challenges related to his symptoms, including several incidents of street homelessness in his twenties. As Peter explains, he is clear about his symptoms to the legal representative helping him process his application. But it is the representative who names the diagnoses required for the application.

Veterans also engaged in diminishing symptoms, purposefully omitted certain mental health diagnoses that they thought could affect employment opportunities. Four Veterans described leaving off PTSD from their disability compensation application because of this concern. Sergio

was starting a job in the public sector and explained in regards to claiming PTSD, "In my line of work, everybody's like, 'Oh, don't do that, man. Don't put that down. You're ruining your opportunity of getting any work anywhere.' In this way, Veterans were selective about what diagnoses they included on the application, choosing to diminish ones that they perceived as affecting future employment.

Getting evaluated

After Veterans submitted applications, they were asked to attend compensation and pension exams. Veterans described their symptoms being diminished by examiners during the compensation and pension exams. Examining clinicians who perform the compensation and pension exams are instructed to not share diagnostic conclusions. Despite this formal policy of the VA, some clinicians who performed the compensation and pension exams shared opinions about the presence or absence of particular conditions that Veterans were being examined for. Roberto was told by an examiner, "I don't think you have PTSD". Roberto told me he just "blew him off" and said, "I don't care what [he] thought." Eric had been diagnosed by his VA doctors with various conditions, including a traumatic brain injury. He explained of the examining clinicians, "I kind of expected them to be more like my regular doctors. But some were more like accusatory of me lying". He depicted a specific example about an examiner suggesting he was lying about having short-term memory loss. In this way, diminishment of his symptoms occurred.

Veterans' symptoms were occasionally affirmed by the examiners in the compensation and pension exam process. For example, one Veteran was told outright by an examiner that he had PTSD and that he should seek help. Ben shared another story where he was told by an examiner that he definitely had PTSD, but to not expect it to get compensated by the disability

compensation system because every applicant gets “lowballed” the first time they apply. In other situations, Veterans were told by private or VA doctors that they had certain conditions and particular diagnoses, while examiners conducting the compensation and pension examination shared conflicting diagnostic opinions to a Veteran. One Veteran described how surprised he was to be told by an examining psychiatrist that he did not have PTSD during a compensation and pension exam, even though he had been told that he did have PTSD by his VA doctor.

A few Veterans described a process of exaggerating symptoms to fit particular diagnoses specifically during the compensation and pension exam. For example, a Veteran who had severe back pain described a process where he told the clinician during the compensation and pension exam that he was in severe pain, even though he was not feeling severe pain at the time of the exam. He felt that this was not a lie, because he did feel severe pain depending on the day. More typically, Veterans told me about future plans to mold their symptoms when they were evaluated again. For example, Derek experienced chronic back pain and was encouraged by a VSO representative to throw his back out before the exam. He recalled thinking it was “dumb” to throw one’s back out before an exam. He ended up not getting rated for his back concerns. He explained that in hindsight,

> *If I was evaluated again, I would walk in and when they told me to stand up, I would say, “I can’t, my back hurts.” When they tell me, “Can you bend down and touch your toes?” I would just look at them straight in the face and be like, “No, I can’t, my back hurts.” [If they asked] “how much does it hurt?” I’ll just say, “It hurts like a 10. It’s excruciating pain. Write that down.” I don’t know, what do you want from me? Because if I tell you the truth, you’re just going to be like, “You’re fine.”*

Eric also experienced physical pain. He described a recommendation from his mother to “milk it for all its worth”. He explained the rationale around his final decision to not lie or exaggerate.

Eric: Like she said if I have pain in my left leg, then tell them it's a 10 if it's like a 4. She said just go all out because either way you're going to get a rating. If I say it's a 10, I'm going to get like a 4 or something.
CM: She said they're going to under do it anyways?
Eric: They're going to undermine me anyways so might as well go big or go home.
CM: Did you take her advice?
Eric: No. No.
CM: You felt like you were being honest?
Eric: I was very honest with them…
CM: Why didn't you lie?
Eric: I don't know. There's no point in really lying because if I lie about one thing, how do they know that I'm not lying about everything else?

In Eric's case, he was encouraged to mold his symptoms to better fit the diagnostic criteria, as several other Veterans were also planning to do so in future evaluations.

Finally, Veterans thought their ailments and conditions were not taken seriously by examiners during the compensation and pension exams, resulting in perceived diminishment. In a similar vein, examiners were described as cold and unfriendly by several Veterans. Examiners were described as "closed off" or "heartless". Eric suggested it was very challenging "to open up" to the examiner, potentially compromising the diagnostic process. Several Veterans also felt that the exams were not thorough enough to fully capture their psychological or physical conditions. Others expressed frustration when they were not told any information about diagnoses. Nico shared struggles with his vision and knee pain. He said,

Nothing the [Examiners] did gave me any clue that…whether or not my pains were actually real or not or whether I was going to get any kind of compensation for them. They just checked me out and, said, 'okay, take it easy.'

Several Veterans discussed this experience, suggesting the expectation to be affirmed during the process only to learn little to no information about their diagnoses.

Receiving a Decision

Veterans were offered decisions about their applications which primarily diminished particular symptoms. The experience of diminishment occurred via conflict between what they claimed on their application, and what was accepted by the claim process as a diagnosis. Diagnoses were diminished on the basis of not being connected to military service and/or not enough evidence of the actual condition.

Diego shared his experience after he had been trying to get compensation for a traumatic brain injury (TBI) and PTSD, among other conditions after his time serving as a Marine. He was first denied outright and offered no accompanying explanation in the letter he received. He appealed, and later received service connection for a knee injury, but still not TBI or PTSD. He described talking with his doctor at the VA during a medical visit, in reference to both TBI and PTSD. He explained, "I had a [VA] doctor walk in and go, "How come they're not paying you?" Just straight up like that. I was like, 'You tell me. He's like, 'You need to stay on top of this.' I'm like, 'All right.' " In this example, Diego expressed feeling diminishment by the disability compensation decision, but affirmation by his doctor at the VA.

In addition to diagnoses not being identified via the process of receiving a decision about disability compensation, Veterans were given diagnoses they did not agree or identify with. Upon receiving determination letters from the VBA, Veterans were surprised to find they were diagnosed with conditions they never knew they had. For example, Marcus had re-applied several times and was eventually rated for PTSD, even though he never thought he had that diagnosis, or had put it on his application. Sara was rated for an "adjustment disorder with anxiety and depressed mood", a diagnosis she did not think she had been evaluated for, and had even never heard of. She was disappointed because she was not rated for the military sexual

trauma, a diagnosis that she *did* identify with. (Military sexual trauma is a formal diagnosis, typically connected to a sexual assault which occurred during an individual was in the military.)

Diego shared his feelings about the experience of his conditions, compared to what the compensation system determined them to be. He described his persistence and determination in the face of bureaucracy, after appealing a second time (describing himself in the third person):

> *Then you persisted and they're like, "Let's screen you again, but for real this time. You got a little something." Then you're like, "No, I think got more than what you think I have." And they're rating me for the knee that doesn't even hurt me nearly as bad as the other one! The one that I feel is really injured. So I don't know what they were basing their judgments off of. I know what's going on with me. I disagree with it.*

Diego describes diminishment via the process of receiving a decision.

Most Veterans assumed the discrepancies were due to the bureaucratic nature of the process. Veterans also described themselves as "naïve" or "green" for believing that their symptoms would be "taken at face value". Even though Veterans considered the bureaucracy to be at fault, diminishment remained a painful experience described by Veterans. One Veteran described feeling "written off and overlooked". Ken shared the following reaction to receiving a zero percent rating that did not affirm the diagnosis regarding his damaged wrist:

> *It definitely hurts. It's not like I'm faking. But, I notice it more now. And it's not just annoying because it's painful but it's also, I get frustrated because I'm like, the freaking Army screwed me. Every time I feel the pain, it's a reminder that they screwed me, or at least so far… So now every time my wrists hurts, I perceive it as more annoying than it actually, than perhaps I would have before.*

Despite feeling diminished, Veterans continued to believe in their symptoms and, when appropriate, diagnoses. All respondents were asked if they felt differently about their symptoms after receiving a compensation decision. While Veterans had a range of ideas regarding why

certain symptoms were not formally recognized as diagnoses – including the notion that their applications were not really reviewed or that the VA rejects most applications to save money – the compensation decision appeared to have little bearing on the belief that their symptoms were real.

Discussion

Ultimately, the disability compensation process involves “bureaucratic encounters”. Hasenfeld, Rafferty & Zald (1987) suggest, “the bureaucratic encounter is both an information exchange and a negotiation and conflict management process through which the applicant's normative framework and expectations are brought in line with the organization's” (p. 402). One question is what this means for Veterans in relation to disability compensation. Veterans negotiated their symptoms into medical diagnoses (or not) as part of the normative framework, or administrative expectations, of the program.

This qualitative study sought a more nuanced understanding of how Veterans experience the Veteran disability compensation system and their own symptoms in relation to it. In line with symbolic interactionism, the diagnosis was a socially co-constructed object. The application itself was also not a neutral object, but a space for their story to be told. While many studies focus around whether Veterans are malingering or not, this qualitative study suggests that such a question does not fully address the complexity of what goes into the process for Veterans. In accordance with a medical model, a diagnosis is either present or not; there is no grey area. The results of this study suggested that the process of diagnosis – whether self-diagnosis or diagnoses by others – can be ambiguous.

Veterans and their advocates avoided diagnoses they were uncomfortable identifying with (in the case of PTSD) and included diagnoses that they thought they had a good chance at receiving (e.g. tinnitus). At the same time, Veterans made good faith efforts to share their understanding of their symptoms in the application, with the assumption that they would be affirmed by others. Veterans began the process of disability compensation with a sense of self-integrity and thus, self-affirmation. They were confident of their symptoms.

The experience of affirmation and diminishment emerged as a theoretical process because Veterans I interviewed believed their symptoms were real. In other words, affirmation and diminishment can only occur for someone if they hold a core belief to be affirmed or diminished. When symptoms needed to become diagnoses for purposes of the disability compensation system, Veterans had their symptoms affirmed and diminished from the beginning of the application to the end of the process when they received a rating for the application. Through the compensation and pension examination, Veterans were told by certain examiners that did or did not have certain diagnoses; other examiners did not offer affirmation that Veterans were seeking. Veterans participated in the process by diminishing stigmatized symptoms (and presumed diagnoses such as PTSD) or molding their symptoms to better meet the expectations of the compensation system's medical model. While Veterans expressed hurt feelings about diminishment by the disability compensation system, they did not doubt their symptoms.

Veterans going through the disability compensation process receive diagnoses and, occasionally conflicting conclusions, via several different sources and exchanges. First, many Veterans have doctors within the VA or via private health insurance diagnose them. These providers are not formally connected to the disability compensation system. The second area where Veterans get diagnosed through applying for disability compensation is via the

compensation and pension exam process. Most of the Veterans in my study were eventually assisted by representatives from Veteran Service Organizations (VSO's). These representatives often determined which illnesses and injuries to put on the application for the Veterans they were serving. The determination of benefits, shared via mailed letter, offered a fourth version of diagnoses. Veterans also received "informal" diagnoses from peers, primarily other Veterans. The Veterans in my study were not always willing to agree with diagnoses given to them, including by expert clinicians. The diagnoses conflicted at times. In line with prior research, Veterans also did not make clear distinctions between the VHA and the VBA despite their distinct functions. Some also did not fully understand that VSOs were distinct from the VA. As the VA spends considerable efforts on reaching Veterans and gaining their trust, conflicting diagnoses and experiences undermine such an effort.

The compensation and pension exams are an area for scrutiny. These exams are increasingly considered a "missed opportunity" for health outreach to Veterans. Rosen (2010) argues that OEF/OIF Veterans who are applying for disability compensation for PTSD should receive an automatic referral to a VA healthcare provider during the C&P. Rosen (2010) discusses the evaluation process as one where the goal is to collect data with little empathy – an experience that can be counterproductive or damaging to Veterans who may have had limited treatment opportunities. Interviews conducted for this study confirm such an experience. Veterans initially approached the compensation and pension exam with the intention of sharing their experiences in an honest way. Their experiences of diminishment prompted them to consider their future examinations with some Veterans suggesting they would tell the examiners what they needed to hear – or what the diagnosis required – in order to have their symptoms affirmed. This is arguably different than malingering; all Veterans experienced real symptoms as

relayed to me. Stone (1984) considers the way that people are evaluated when applying for Social Security Disability Insurance (SSDI) as a "strategic presentation", a marked distinction from cheating (p. 145). Strategic presentation involves "doing all one can to get certified when one believes one has a legitimate claim" (p. 145). It is also important to note that few Veterans had "exaggerated" during compensation and pension exams and instead were planning to do so in future evaluations.

The people who affirm or diminish Veterans are also not "neutral". Each function in a particular way, as their diagnoses function in unique ways. The VA physician who offers a diagnosis of PTSD to a Veteran may not feel the same pressures that an examiner has. It is conjecture to suggest that an examiner is pressured to "under diagnose"; however, at least one study has identified that diagnoses and ratings are applied differently across states and that, "for certain claims, different raters could reasonably arrive at different results (Hunter, Boland, Guerrera, Rieskts & Tate, 2006, p. S-3). Veterans often entered the disability compensation with little understanding about how the process works. Better preparation around the role that each clinician plays – including the compensation and pension examiner – is warranted. Advocates who assist Veterans with applications may consider having better diagnostic processes when working with Veterans. Veterans also should be prepared before separation around what is expected with an application for disability compensation.

Chapter 6: Paper 3

Deserving Veterans Disability Compensation: A Qualitative Study of Veterans' Perceptions

Introduction

Social welfare programs and policies are created and maintained for intended categories of individuals and groups (e.g., domestic violence survivors, Veterans, addicted adults, refugees) (DiNitto & McNeece, 2008). Eligibility requirements for these programs and policies range widely, as well as the effort expected to prove eligibility. The United States has typically enacted social welfare policies which require extensive verification processes at the front end – especially for programs and policies targeting low-income individuals and families (Handler, 1972). While not static, certain categories of individuals and groups have historically been considered by society as more deserving of social aid than others; children, the severely disabled and the elderly all might be considered deserving, while the "able-bodied" are considered less deserving of social aid (Katz, 1989; Midgley, 1995).

Veterans in the United States were one of the first categories of citizens to receive social welfare benefits from the government (Skocpol, 1992). Veterans' benefits have historically been distinct and separate from other welfare benefits for the general public (Skocpol, 1992; Gerber, 2000). This may be due, in part, to the philosophy underlying benefits to Veterans. This philosophy framed Veterans' benefits as an earned reward for service, rather than charity (Gerber, 2000; Woloch, 2000). Benefits also historically functioned to discourage desertion, and later to promote recruitment in a volunteer system. Veterans disability compensation (DC) is a Veterans' benefit receiving significant attention by policymakers and others. DC provides monthly cash payments to disabled Veterans. The program in its current iteration is not means-

tested and according to the Institute of Medicine (2007), intends to compensate Veterans for their average impairment in earning capacity as well as "non-economic losses, such as loss or loss of use of a limb or organ that may not affect ability to work, but reduces the quality of life of the Veteran". (p. 28).

Original *first-time* applications for DC have approximately doubled from 2000 to 2006 which is assumed to be primarily recent, or OEF/OIF, Veterans (IoM, 2007). The most recent estimate from data collected by the Associated Press (Marchione, 2012) suggests that close to 45 percent of OEF/OIF Veterans are seeking DC. In 2012, the VA spent approximately $46 billion on disability benefits compared to approximately $15 billion in 2000 (Smith, 2012); in FY 2013, DC expenditures were approximately $49 billion (Autor, Duggan, Greenberg, & Lyle, 2014).

Eligibility for DC is based upon two primary eligibility areas: 1) a disability or disabling condition must be currently present, and 2) the condition must have a connection to military service (National Veterans Legal Services Program [NVLSP], 2011) also known as "service connection". When Veterans are determined to be eligible for monetary DC they are commonly referred to as service connected.[3] To verify service connection, Veterans who apply for DC after they are discharged undergo a compensation and pension exam by a clinician, as well as submit medical records. Connecting the condition to military service for purposes of DC can occur a few ways. The first way is direct service connection where evidence can establish a condition being directly related to something that occurred while in service (NVLSP, 2011). The second way to establish service connection involves a secondary disability caused by a direct service connected disability. This secondary disability is also referred to as a "proximate" disability, as it is

[3] A potential misnomer, service connected does not necessarily mean better connected to services offered by the VA. In this context, a service connected Veteran is a Veteran who was determined to both have a disabling condition and have that condition connected to their military service, thus receiving monetary compensation for that condition.

proximate to the service-connected one. One example could be developing heart disease years after an amputation of a leg (Congressional Research Service, 2010). The third way of establishing service connection is when a condition is *aggravated* by military service. In this case, the Veteran must have documentation of the condition by the military before they entered service to establish a "baseline" for the condition (Congressional Research Service, 2010). The fourth way of establishing service connection occurs when a condition fits the presumptive category (NVLSP, 2011). The presumptive category involves several illnesses and conditions that automatically qualify for DC and are dependent upon the war-era served (Congressional Research Service, 2010). So, for instance, certain cancers and leukemia are linked to Agent Orange exposure and thus, apply to Vietnam-era Veterans. A fifth important way that Veterans can receive DC is when a disability occurs "at some point in time between [the] beginning and ending dates on active duty" (NVLSP, 2011, p. 68). For example, an injury that occurred via participation in a recreational game could qualify for DC under the VBA parameters if that person was on active duty.

This study offers insight into how Veterans perceive DC. While the general public may have little understanding about Veterans DC, policymakers, Veteran advocates and Veterans themselves likely have specific perceptions of the program. These perceptions have not been explored in research literature with the exception of one study. Sayer & Thuras (2002) identified that clinicians held negative perceptions about Veterans in their care who were seeking DC compared to those who were not. My research question asked how Veterans perceive themselves and others in relation to disability compensation. What this paper offers is the social construction of a "target population" for a social program – in this case, Veterans DC (Schneider and Ingram, 1993). I examine the social construction of Veterans who apply for and receive DC as perceived

by Veterans – the target population – themselves. Specifically, this paper describes how recent (OEF/OIF) Veterans view issues of deservingness for DC. It addresses how Veterans construct notions of deserving applicants to and recipients of Veterans DC, and where they place themselves in the process.

Methods

This study utilized qualitative interviews with OEF/OIF Veterans, age 35 and under. The interviews explored several aspects related to Veterans DC including the decision to apply, the process of applying and the experience of receiving a decision about an application. A total of 18 Veterans were interviewed in-person over February through July 2013, with seven Veterans interviewed twice to better explore their experience. Thirteen Veterans from the sample had been deployed overseas. The average age was 24. All interviewed Veterans were male, except for two. Nine were Marines, five were Army and the others were Navy and Coast Guard.

OEF/OIF Veterans age 35 and under who had applied for Veteran's disability compensation and "had their application denied or received a rating they were dissatisfied with" were recruited through college Veteran organizations and Veteran Service Organizations (VSO's) in the Southern California area. Representatives of these organizations were contacted and asked to distribute a study flyer to anyone that might be eligible and interested. The VA has strict rules about recruitment; thus, no recruitment was conducted through VA organizations, including VA Medical Centers, Vet Centers or VBA offices. Veterans were interviewed in-person, at public settings in private rooms. Veterans took the Mini-Mental Status Examination-II Brief Version (MMSE-II) before the interview, a validated tool to screen cognitive impairment (Mungas, 1991). No Veterans were excluded due to cognitive impairment. The UCLA

Institutional Review Board approved this study. All interviews were recorded and transcribed professionally.

The analysis in this paper used a grounded theory approach (Bryant & Charmaz, 2007). Following grounded theory methodologies, the analysis of this paper was led by certain “sensitizing concepts” (Blumer, 1954). In contrast to quantitative studies where hypotheses are tested, sensitizing concepts assist in the theory-building process. Sensitizing concepts, as Blumer (1954) described, are concepts that “gives the user a general sense of reference and guidance in approaching empirical instances” (Blumer, 1954, p. 7). They are to be contrasted with the idea of a definitive conceptual framework which presupposes how the data will be viewed (Charmaz, 2006). Ideas about deservingness related to applicants and recipients of Veteran’s DC were an unexpected development. During my analysis, certain sensitizing concepts grounded in social welfare theory were “activated” and contributed to my analysis and initial theory construction. One sensitizing concept was the idea of stigma around social programs that provide monetary benefits. The notion that recipients of social programs which provide direct cash assistance can be easily stigmatized is a strong idea in social welfare theory (Katz, 1989; Popple & Leighninger, 2005) and is a part of my own academic orientation. A related sensitizing concept is that there are deserving and undeserving applicants and recipients of social programs.

As typical with a grounded theory approach, analysis and initial coding began after the first few interviews were conducted. This process allowed me to note that Veterans were making judgments about the legitimacy of other Veterans applying and receiving DC. Thus, subsequent interviews probed around how Veterans considered the legitimacy and deservingness of other applicants and recipients of DC when it arose during the course of the interview.

After all interviews were conducted, analysis began around the *basis* for delineating deserving and undeserving Veterans and three themes emerged, as described in the results. The interviews were about Veterans' own decisions to apply and experiences with applying, yet many respondents spontaneously shared ideas about others; specifically, the types of Veterans who should be applying and receiving it and those who should not. A category emerged around "Deserving DC". This category had several features, outlined in the results. Then, the category of "Deserving DC" was connected to another category via the process of memoing and analyzing the data: the category of "military culture" seemed to connect to the idea of Deserving DC. Military culture was another area that was not part of the initial study focus. However, respondents talked about military culture in interview after interview. The results describe how military culture is linked to delineating deservingness for DC.

Finally, Veterans had ideas around deservingness in regards to both applying and receiving DC and did not disentangle the two distinct aspects of the program. Therefore, applying and receiving Veterans DC are not separated in the analysis for this paper.

Results

Returning Veterans were interviewed about their decision-making around and experiences with applying for DC. Throughout the interviews, Veterans delineated who they considered more – or less – deserving of Veterans DC based on several rationales. Their rationales considered three primary areas: (1) military and combat experiences, (2) specific conditions and (3) the motivation toward self-improvement and work. Veterans also grappled with their own sense of deservingness as applicants and recipients of DC. Veterans applied these three rationales to themselves, and also described the powerful role of military culture as a fourth factor that influenced their experiences.

- **Delineating Deservingness: Combat**

Whether and how a Veteran participated in "combat" was an important feature of delineating deserving from undeserving applicants for DC. Veterans had general comments about the role of seeing combat in determining the deservingness of an applicant. Veterans more readily identified other Veterans who they felt did not deserve DC compared to Veterans that they felt did deserve it based upon combat participation. They shared several anecdotes about other Veterans they knew who felt did not deserve compensation.

> *One of the Marines I used to work with broke his leg on a…trailer. And then he kind of just went crazy and then got kicked out. And he was only in for maybe two years. And he's rated 70% and like he's undeserving. Like he didn't do anything. He was in the communication shop the whole time. Never deployed. Always in trouble. And I felt like he shouldn't apply, because he doesn't deserve it.*

The above-description identified someone who did not deploy and was perceived as working in a non-demanding setting. For the respondent, this was a type of Veteran who should not be legitimately receiving DC. Many Veterans also identified an injustice when they felt the wrong individuals were getting DC. The following respondent delineated "paper pusher guys" from friends who had been in multiple instances of combat.

> *I have just seen a lot of paper pushers get more disability compensation than some of my friends that have been blown up multiple, multiple times…It upsets me tremendously. The reason why some of those paper pusher guys got it is because the military has let them into the military and they have already had psychological problems when coming in. It either made it worse or kept the same. Just because they let them in, now they are responsible.*

Respondents suggested other Veterans were "working the system", delineating them from Veterans who had been in combat. The following excerpt describes a perception of the government as being less responsive to Veterans overall because of the Veterans who were abusing the system for DC.

I could also see how the VA or the government is being more difficult with service connects now because I can see here and other places that I go to and from the stories that I hear how people are trying to work the system. I can see how they're trying to manipulate it, because I hear guys are 100%. They didn't even go to combat, you know what I mean? They didn't go through some of the things that some of us went through. But I guess they learned to work the system. As long as we have people doing that, then it's going to make it more difficult for the people that do need it, because I also know guys that got blown up more than once and they can't work. They still have to wait as long as the guy that's cheating the system.

Other respondents also expressed concern about combat Veterans who needed DC. For example, one respondent compared a Veteran who was receiving compensation due to a technical error to homeless Vietnam and OEF/OIF combat Veterans. He said of the latter, "they can definitely use it because they're on the streets down on Skid Row suffering."

In addition to perceptions about others, Veterans identified their own deservingness as applicants in relation to participation in combat and serving overseas. Veterans who had not been in combat described their struggle in feeling like a deserving applicant. One Veteran from the Coast Guard had injured his back and knee during search and rescue missions while in service. During the interview, he described a perception that he shouldn't apply for compensation based upon mental illness disabilities, as he perceived his branch as less deserving than other branches due to the Coast Guard's smaller role in combat.

FO: I was in the Coast Guard. I feel like me compared to a lot of other Veterans I don't really have a reason to[apply for mental illness-related disabilities]. It feels dirty.
CM: That would feel wrong?
FO: Yes, it would feel wrong. Out of respect for the people, out of respect for the Veterans who were blowing fucking babies up, it would feel wrong.

Another Veteran who had not been deployed and involved in combat operations described discomfort with applying for DC when compared to Veterans who had been deployed and in combat.

> *There is that kind of a moral fiber in me or that little bit of me that says that obviously the combat Vets who are getting disability deserve it a lot more. And, if it came down to me and some other guy who got hurt in Iraq, Afghanistan, they deserve it more obviously.*

This quote is in line with other respondents who considered the deserving of disability compensation to involve a "moral" judgment.

- **Delineating Deservingness: Conditions**

The specific conditions of Veterans emerged as an area where deservingness was delineated. Veterans shared stories about other Veterans who had conditions deserved of compensation, but were not rated fairly. One Veteran had a friend who had spent years trying to get DC for back pain. She explained,

> *Somebody having two discs in their back from being deployed and you barely get 20 percent disability and they were months unemployable because of their back and all they're getting is 20 percent? It just makes me wonder, how do they base these percentages?*

While Veterans identified others as having legitimate conditions deserving of DC, they also questioned certain conditions that seemed disconnected from military service and thus less deserving. The following quote suggests a judgment made about the cause of a particular condition, chronic back pain.

> *I've seen a lot of cases where people got out and didn't really have a bunch of problems. They had chronic back pain, but that's because they were fat, stuff like that. They would get huge checks every month because of their disability. It might be because you don't know the full story of their injuries, but if the squeaky wheel gets the oil kind of stuff, they worked the system in their favor and ended up getting disability…A friend of mine down in [city], she's really heavy, overweight and never exercises and then wonders why she has back pain. It's like, "I know why you have back pain. It's because you're carrying 100 extra pounds and you play video games all day." They're using it to milk the system, whereas some people that need it are turned down.*

Other Veterans perceived undeservingness around conditions that could not be easily verified. For example, one Veteran talked about the conditions that people applied for that were considered “gimmes” because they could not be verified. He was critical of those who claimed such conditions: “Tinnitus was a big one. Sleep apnea. It seems like a lot of stuff to where you could get something out of it and no one could really like test you for it. If you can live with yourself saying that, go for it.”

Veterans also questioned the rationale for specific percentages related to various conditions. Losing a finger seemed to not justify full disability according to one Veteran, “If you lose a finger, you’re not 100 percent disabled. That person is not 100 percent disabled, but they’re getting a lot of money for it.” Alternatively, others considered limb loss as the ultimate disability deservingness of 100 percent. For example, a Veteran compared himself to Veterans who lost limbs, suggesting his mental health conditions from combat were not as severe as those who suffered limb loss.

> *People are now learning that psychological health problems, mental health problems are very disabling. But it’s tough when you’ve seen the stuff I’ve seen and see also the mental thing that they got to go through. Like guys that are losing their legs, losing their arms. It’s not just the fact that they have to learn without them. It’s just the fact that they have to psychologically go through that also. It’s like a double whammy on them, so it’s hard for me to put myself on the same breath as them or to say that I deserve 100 percent. I’m thankful I came back a lot healthier than a lot of guys that I know.*

Another Veteran suggested that there was a “stigma” in receiving DC if conditions are not visible: “There is a stigma with a lot of the guys. It is like I got both of my arms, I have got my legs, I got all my fingers, all my toes. That is the stigma. It is like, ‘You don't need it. You've got everything on you. You don't need that disability.’ Issues around visible conditions and

deservingness emerged in the following exchange where the respondent explained the perceived value of a missing limb, comparing it to himself.

CM:	*Do you have a sense of why you were denied?*
FG:	*I was denied because…of the paperwork and because it wasn't serious enough. I don't know.*
CM:	*What does that mean? To you, what does that mean?*
FG:	*The guy that was helping me only had one leg.*
CM:	*What does that mean to you?*
FG:	*Maybe you're supposed to be missing a leg to get disability insurance. I don't know.*
CM:	*Did you feel like you shouldn't pursue it then because of that or was it or?*
FG:	*No. I'm sorry he lost his leg and I'm glad that didn't happen to me. I obviously think that he's probably going to get maximum disability…He's fine, he lost his leg, at least he's walking around. I don't want that much. I just want whatever is supposed to be compensating for my back. At least if I get 10 percent compensation for my back and my back starts getting worse, they can raise that claim depending on my back's hurt.*

Finally, another Veteran put missing limbs and hearing problems as the more deserving condition compared to his own: "I have 10 percent disability. It's probably not the highest I can get, but there are guys that have a lot worse than me. Guys that are missing arms or missing all their hearing."

- **Delineating Deservingness: Motivations**

The third main area where Veterans perceived deservingness was in the area of motivation for applying and receiving DC. Veterans delineated between those who were trying to be self-sufficient versus Veterans who were not. Respondents generally felt that Veterans should be working hard toward employment and independence if they were pursuing DC. For many of the respondents, there were Veteran "types" as examples they did not want to follow. The following respondent compares Veterans interested in "sucking on the government tit" versus those trying to "move forward".

There's a whole part of me...I hate saying this and I mean this goes to Social Security and everything else. There are guys who just want to suck on the government tit…And I almost think that there should be rewarding of people who constantly try to move forward and do better in their lives versus the guys who sit around doing nothing and they just want a hundred percent compensation and all this other stuff.

A few Veterans suggested older Veterans from other eras were "cautionary tales" of how they did not want to end up themselves. According to the respondents, these older Veterans did not work and had lives they considered unsuccessful. The following quote depicts a respondent describing other Veterans he had encountered at the VA addressing their DC.

You have the guys that were lifers that were Vietnam Vets or whatever. Those are the ones like in my opinion, I don't know them. They may be great people, but they came off to me as the we-work-the-system kind of people. I'm not saying Vietnam Vets in general, but they were older gentlemen, older than myself…They looked like they had been taking advantage, or maybe not advantage…they had looked like they had been doing those programs but they hadn't gotten anywhere, so it was very discouraging. I was like, "Well, this guy looks like he's not doing anything with his life." He doesn't have a job and he's using all these things. I'm like, "Do I want to go down that road?"

As with the discussion about combat participation and severity of conditions, Veterans identified themselves and their own motivations toward applying and receiving DC. Respondents were asked questions about why they were applying for DC. These questions frequently evoked descriptions of their own plans for becoming self-sufficient. One Veteran suggested he would eventually donate his DC:

I just want all of the bills that have stacked and have gained interest. I just want those things to be covered. I don't care for the monthly. I'm going to figure out a way to make it myself. But at the same time, if I don't appeal and protect my future, who knows where I'll end up being? So I mean, ultimately what my ideal future would look like is that I have a nice career and I take the VA disability and donate it.

Another Veteran described his motivations toward applying and receiving DC, suggesting he did not want any "materialistic things".

First I would just try to maintain my apartment. Then, just put the rest away, save it just until I needed it. I don't really have any wants or needs as far as materialistic things, but if I had to go to the doctors for anything. If I had to get surgery or something like that I can actually pay for it now.

Respondents also had strong beliefs about finite resources in the government and the sense of limited monies to go around. As one respondent said when talking about how his Veteran colleagues perceived DC: "they don't want to get it because they have that feeling like they're trying to take money away from other Veterans".

Influence of Military Culture on Delineating Deservingness

All interviewed Veterans – despite branch -- talked about the culture of the military where individual need and vulnerability were expected to be suppressed in service of the larger group needs. In this culture described by respondents, declarations of bodily and psychic discomfort were stigmatized and discouraged. This was discussed in particular by Veterans who had been overseas and in combat. Veterans recounted the lingering effects of military culture influencing how they approached DC after they left the military. Military culture seems to have influenced perceptions of their own deservingness in seeking DC as Veterans. Moreover, military culture appears to have been a cause of distress and discomfort in asserting their deservingness as applicants and recipients.

One Veteran felt uncomfortable telling his former unit about applying for DC, comparing it to being a "leaf-licking hippie".

SW: I don't want them to think I'm some leaf licking hippie, tree-hugging type…That's the level of where they're at and you need to be in that mindset, they're still doing work. Some of them are in Special Forces, some of them are secret service agents, some of them are doing high level stuff. So for what they're doing, to an extent, they still have to have a certain mentality. But I'm just like, "Dude, be open."

CM: Tell me about the connection of leaf licking hippie and disability compensation. What's that?

SW: It's like this idea that I'm taking advantage of stuff, like, "Oh, how can you not handle that appropriately?" Like, "Dude, get out there, get a good job, get your medical and do your thing."

The above-quote also invokes the idea that getting DC is an inappropriate response to issues, while a job is the "appropriate" way to handle it. Another Veteran suggested he would be trading "money for pride" by pursuing DC. The excerpt below is an exchange following up to a question about whether the respondent told others he was applying. He asserted it was embarrassing to apply and something he did not want to take advantage of.

CM: Do you think it's a cultural thing a little bit?
RT: Yeah or maybe just a military thing. Just suck it up, you know. Suck it up.
CM: So military culture?
RT: Yeah, maybe just because like it is asking for money for pride…
CM: It sounds like you're a little bit ambivalent about deciding to apply.
RT: Yeah. It's like one of those kind of things, like, I wouldn't mind. Yeah, sure, give me money. But at same time...I don't want to take advantage either. It's one of those where sometimes I'm conflicted, you know. Like, you're asking for money. Well, you actually are in pain. But, you're not in constant pain.

Veterans suggested military culture required independence and, in the following excerpt, the "ability to deliver". Applying and receiving DC were considered actions which went against the culture.

CM: Did you think when you were in that you were going to apply for disability compensation?
DR: To me, it's dishonorable and that's part of what, I think, took me so long… because the whole 'death before dishonor' in the Marines.
CM: What is dishonorable? What do you mean by that?
DR: That's just a saying, basically you'll be a bitch, you'll be a broke dick, a light duty commando…and you could see these guys in boot camp, at least the way the Marines conduct their business….
CM: You were saying that it felt dishonorable … to what? To apply?

DR: Yes, because I think it's part of the training. It's just that mentality. They make such a big deal out of everything, but now that I think back on it, it's the training. If you told somebody you were going to be somewhere, you need to be there. You need to deliver.

One respondent, a former Marine who had been suffering from debilitating panic attacks and pain, described an ambivalent response to applying for DC, suggesting he did not fully deserve it because he had ultimately decided to join the military in the first place. He delineated himself from Veterans who thought that the "government owed them", as well as from Veterans who had been drafted. He articulates a logic that if one chooses to join the military, the government does not owe that person.

PH: It's help. I'm thankful for it, but at the same time, I'm not going to sit here and be, like, "Oh, I deserve it. It's mine." I'm the one that signed on the dotted line.
CM: What does that all mean? What do you mean by all that?
PH: Because I guess people believe that things are owed to them, and yeah, we did go and we did do certain things, but we signed ourselves up. We weren't drafted to go there. I just see that attitude around here and other places that I go to where they are now, "The government owes me. The government owes me." I think that's just a negative attitude to have, because you signed to go there. What did you expect to happen? I can understand for the Vietnam Vets, they were drafted. They were forced to go over there. They have the right to say that.

In sum, Veterans were strongly influenced by the institutional "logic" of military culture which expected suppression of health and mental health problems. The logic of this culture affected how they viewed their own deservingness as applicants and recipients. While Veterans were distressed and embarrassed to apply and receive DC, they also depicted processes of distancing themselves from the ideologies around suppressing vulnerability and need. Accepting that something was wrong was described as part of this process.

Recently, I've come to terms, like I really sort of say that I was wearing a cape thinking I'm a superhero and there's nothing really wrong with me. But as you get older, you got to admit your faults and you got to admit what you are capable and not capable of. And I

admit to myself, I got some problems, maybe I should go and see if I can get some sort of help or something.

The same Veteran who first described being concerned about seeming like a leaf-licking hippie explained later in the interview that he was consciously rejecting the idea that one needs to "work through their injuries", a sentiment encouraged while in the military.

> *CM: I see, and you don't think that yourself? Do you think you're taking advantage of the system?*
>
> *SW: No, I think that does happen, but I think that for people like me and others similarly, that's why it was set up, so that it could be used. This is not [identifying division] again where it's like, yes we have a hospital but you are not to use it because we are training and you will work through your injuries. It's like, no, that's bullshit. That gets people more hurt, more injured. I'm like, "No, I'm not doing that anymore." I'm not subscribing to that way of thinking. It worked to an extent, but not anymore…it's not like I'm sitting at home eating bon bons. I'm trying to get through and get myself to a certain level in life, so that I can start contributing. I want to put back into the system, but I can't if I have all these things going on. I don't think they're open to that or realize that.*

Even though most interviews suggested that Veterans delineated between legitimate and less legitimate Veterans, many were able to describe why they personally were justified to apply. The following quote depicts the idea that DC is compensation for a job, even though the idea was challenging for the respondent to accept.

> *But at the same time, as my peers say, my coaches all say, 'Hey, this is your job in the Army. This is what you were told by the Army to do. And you injured yourself doing it, whether it's here, there, wherever, it's still a job you did for the Army and they should compensate you for that'.*

Veterans articulated the ambiguity involved in their own process. The Veteran who shared the following quote had served state-side and developed several conditions related to her skin and digestion. She identifies herself as being "equally deserving" to another Veteran who spent years overseas and in combat. She also articulates the challenge of having conditions that are not

visible or easily identified.

> *I've heard that some Veterans believe that you went and you served in the war and you had this and these things and so you deserve it more, but I don't think it should take away from the other Veterans who have served just as equally. They weren't in combat and they did not witness such traumatic experiences. However they went through all of the same training that this individual did, to a certain extent. They went through the same basic training. It's like, they're both equally deserving of compensation because that person that deployed has no idea of what that person that didn't deploy did. You may know some of what happened to that person that deployed but you don't know all of it, you only know stories and bits and pieces. For example, somebody that didn't deploy and were perfectly healthy as myself before they went into the service and now they have all of these different problems and you're 22 with all of these problems -- is that to say that they're not as deserving as someone who spent 6 years in Iraq? I think they are both equally deserving…The level of compensation is different, but they are both equally deserving.*

This long quote depicts the process of coming to terms with the idea that other Veterans have debilitating conditions in relation to herself. She is suggesting that there are Veterans who were "in combat" and had "traumatic experiences" compared to others like herself; despite this, they do not need to be mutually exclusive in regards to who deserves disability compensation. In her estimation, both groups deserve compensation.

Discussion

Veterans interviewed for this study offered several ideas about who deserved DC. They also shared their process of considering their own deservingness as an applicant and recipient. In this way, they socially constructed a deserving and undeserving Veteran as an applicant and recipient. Common themes emerged from these ideas about deservingness, including military and combat experiences, experiences of conditions and the motivation toward self-sufficiency. Veterans who had participated in combat were more deserving than those who had not. The visibility and cause of conditions mattered, as well. Visible disabilities, such as limb loss,

suggested more deservingness, for respondents. Motivation toward employment and the intention of eventually not needing DC was also an area that respondents distinguished deservingness. Veterans struggled with their own sense of legitimacy around applying and receiving DC in all these areas.

Important questions connected to this discussion are: why do Veterans need to delineate deserving from undeserving Veterans in the first place? In other words, why delineate at all? As illustrated earlier, Veterans' benefits were developed as distinct from other benefit systems. It may be that Veterans feel the need to be protective of a program that is distinctly intended for them. There may also be a keen sense of finite resources, as my results described. But the emotions around these issues were strong, suggesting a deeper concern from Veterans than "good government" functioning. The psychological theory of projection may be appropriate to consider (Freud, 1894). This familiar concept of projection involves one "projecting" undesirable feelings or thoughts on someone else (Fenichel, 1946). Veterans seemed to have internalized undesirable feelings and thoughts about their own sense of deservingness onto others. That process of identifying where they fit on the continuum of deserving disability compensation may have been transferred or projected readily to the situation of other Veterans.

Another important question to consider is why Veterans delineated around these specific areas. While there is no way to verify, certain possibilities are considered which also factor in ideas about internalizing challenging feelings. Further, these challenging feelings do not arise in a vacuum; they have a specific context and are potentially created by dominant cultural ideas which then become internalized to one's self, and projected on to others. This concept has been applied to sexist and racist ideologies (e.g., women putting down other women for perceived gender transgressions) (Foster, 1993).

In terms of Veterans and DC, there were several areas of delineation. In regards to combat participation, combat implied a bigger sacrifice for Veterans. The role of conditions as a point of delineating deservingness can also be considered. Limb loss and other visible injuries have historically been considered signature injuries of combat veterans – again implying sacrifice. As Gerber (2000) suggests, "visible injuries have tended to become the primary way in which they general population of disabled Veterans often seems to have been conceived in the minds of experts, artists, and the general citizenry" (p. 2). Getting hurt while serving the military versus "breaking your leg on a trailer", as one Veteran recounted, reflects two distinct types of sacrifices in the eyes of Veterans. Ideologies around visible wounds having more legitimacy may have been internalized. Also, most Veterans in my sample did not have visible injuries that I was made aware of. If ideas around disability provoke discomfort and confusion because of their imprecise "measurement and definition" (Stone, 1986; Berkowitz, 1987), Veterans may also have been delineating deservingness and undeservingness because of discomfort with their own disability status.

The focus on individual behavior and motivation toward self-sufficiency is a familiar one in American social welfare policy (Popple & Leighninger, 2005) and an area that Veterans may have internalized. Beliefs about motivation and self-sufficiency applied to DC resemble studies of other benefit systems, primarily welfare and means-tested programs. Recipients of other social welfare programs identify and delineate deserving and undeserving groups often around motivation and work ethic. In one study, Temporary Aid to Needy Families (TANF) recipients maintained negative views of those receiving TANF, while considering themselves to be exceptional or distinct from those they considered gaming the system (Seccombe, James & Walters, 1998). Many Veterans felt that there were appropriate and inappropriate motivations for

seeking DC. The appropriate motivation included the notion of getting back on one's feet" and moving forward. A few Veterans went as far as not wanting to keep the monetary compensation from the DC, seeking to donate it or return it when they no longer needed it. It is worth noting that DC is not supposed to be determined around whether a Veteran can work or not; unlike programs such as Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI), a Veteran can work a full-time job and receive DC at 100% based on injuries. Despite this policy structure, Veterans still gravitated to this concern.

While programs have formal rules about eligibility as described in the introduction, all eligible individuals do not necessarily apply to such programs. For the Veterans in my study, deciding to apply was not easy. This potentially reflects other social welfare programs. For example, in numerous studies about worker's compensation (Spieler & Burton, 2012) individuals with work-related injuries do not apply for worker's compensation in which they are entitled. Also, for means-tested programs, a high percentage who qualify do not apply (Blank & Ruggles, 1996). There are many reasons why people do not apply to programs for which they are qualified for, including lack of knowledge and understanding. Another theoretical frame suggests that organizational mechanisms function to discourage people from utilizing certain programs, especially those high in demand (Lipsky, 1980; Hasenfeld, Rafferty & Zald, 1987). These mechanisms can result in programs being stigmatized.

These interviews also suggested a factor that may be unique to Veterans: the influence of military culture. Military culture, like all cultures, are complex and cannot be summarized easily. However, aspects of military culture were quite salient for respondents: namely, health and mental health needs were suppressed and stigmatized. If welfare is stigmatized because poor people are stigmatized, DC is possibly stigmatized within the military because of its association

with vulnerability. Veterans articulated a conflict between the expectations to suppress their health needs while in the military, and then to later acknowledge problems and disabling conditions. Ultimately, the latter is about expressing their own vulnerability and deservingness. They projected this conflict to assessing the deservingness of others, while also applying it to themselves. Future studies might consider how the military maintains one set of institutional logics, while the VA system employs a conflicting set (Thornton & Ocasio, 2008).

Despite institutional logics undergirding military culture, the Department of Defense and other governmental bodies have undertaken significant efforts to remove stigma from help-seeking within the military (National Center for PTSD, 2014). Many of these efforts are recent and may not have reached the Veterans in this study. This study has implications for the important role of military culture in shaping Veterans perspectives, years after they separate from the military.

Compared to other beneficiaries of some social programs, Veterans arguably enjoy a high political status and have significant lobbying power, with powerful representative groups (Hamilton, 2014). How Veterans consider themselves and other Veterans in relation to a costly social program is important. Veterans and other representatives have publicly criticized other Veterans for malingering and not being deserving of DC and other benefits (Bridging the Gap Between Care and Compensation, 2011). Promoting stigma around the program may result in Veterans who qualify for the program to not apply. More perniciously, Veterans may be less likely to receive needed medical and mental health treatment care for themselves, as data is emerging around the notion that Veterans often first visit the VA in order to apply for DC (Sayer et al., 2009). Finally, when Veterans parse out among themselves, they may become less of a unified front threatening their force as a lobby and undermining their interests being served.

Chapter 6: Conclusion

This study was conducted because, while there is a strong body of research about Veteran health and mental health conditions, there are few studies about the relationship that Veterans have to their federal benefits and specifically, disability compensation. As an exploratory study, the three papers offered in this dissertation represent distinct aspects of the disability compensation process experienced by young OEF/OIF Veterans.

The findings in Paper 1 identified several important aspects of the disability compensation process. Veterans often do not know what they are eligible for and how the process works, in practice. Preparing Veterans for what disability compensation is and what is needed to complete an application is recommended for well before Veterans separate from the military. Seeking disability compensation for younger Veterans occurred when Veterans decided to pursue help generally for their mental health and health care needs. This is very important, as the pursuit of disability compensation occurs at the same time that health care is pursued. In line with Rosen (2010), seeking disability compensation should be viewed as a critical juncture for health outreach purposes and a time of "introduction" to the VA. Younger Veterans were also very concerned with securing their health insurance futures by applying for disability compensation. Young Veterans in this study were uncertain that they would be cared for in the future; the motivation of applying was partially to ensure their health and mental health needs would be met currently and in the future.

Paper 2 proposed a scenario where symptoms were affirmed, diminished or molded for Veterans via the disability compensation process. Three points in the process were considered including the application, the compensation and pension exam and receiving a decision. The framing of a Veterans' diagnosis as a socially co-constructed idea is something counter to the

disability compensation system. Rather than focus on whether Veterans are malingering or not, the paper's purpose was to show that Veterans symptoms are quite real to them. No interviewed Veteran doubted their symptoms. However, Veterans' diagnoses appeared to function in certain ways connected to the disability compensation process. Scenarios were described where Veterans perceived negative outcomes from identifying with certain diagnoses and diminished them on the application form. Veterans were told by clinicians a diagnosis (affirmation) and then told by other clinicians something quite different (diminishment).

The way that Veterans separated and categorized themselves and others was not anticipated as an area of inquiry, shared in Paper 3. The idea of deservingness is a deeply rooted concept when it comes to social welfare benefits. While disability compensation is intended to serve as compensation, it may be treated like means-tested public assistance when Veterans delineate rationales for who deserves it (Popple & Leighninger, 2005). Also in relation to public assistance, many disability compensation applications are denied (or lowly rated). Paper 3 identified three key areas that Veterans used when identifying deservingness around disability compensation. The extent of a Veterans combat experience mattered. The actual conditions mattered, as well. For example, limb loss was perceived as more deserving than a condition such as pain. Veterans identified the importance of motivation toward working in delineating who deserved disability compensation. Veterans applied these three rationales to themselves, and also described the powerful role of military culture as a fourth factor that influenced their perceptions around deservingness.

There are several important themes regarding the study as a whole. Veterans in this study struggled with the decision to seek help for their health and mental health conditions. It was not an easy decision for many of them. A result of the decision to seek help generally included

applying for compensation, in addition to seeking treatment and assistance. Veterans arguably experienced vulnerability when deciding to apply. Veterans seemed to emerge from the disability compensation process with anger and distrust of the process itself. Many things happened before and during the process, but a common theme from all the interviews was the experience of diminishment – described most fully in Paper 2. Once Veterans made the decision to get help, it seemed many were surprised at how challenging it was to receive such help. As media reports identify long waiting lists, these interviews reveal the lived experience of bureaucratic encounters. In this context, Veterans finally sought help and were confronted with processes that challenge and frustrate them.

Veterans also received assistance throughout the process. It is other individuals, often Veterans as friends or representatives from the VA or VSOs, who initiate them around the process for pursuing disability compensation. Assistance and advice shaped perceptions of the system and their place in it, in various ways. Understanding their perceptions will contribute to better mechanisms for supporting Veterans. For instance, understanding the perceptions held about deserving and undeserving Veterans can help the VA and other organizations tailor messages that recognize such perceptions. Understanding commonly held misconceptions is also relevant here. The compensation system has garnered significant attention for its backlog of claims. If the primary motivation of seeking disability compensation for some Veterans is enhanced health care as their illnesses and conditions become debilitating with age, as these interviews suggest, perhaps a more nuanced approach to offering care should be adopted.

The Veterans as part of this study were all young and represent the future clients, patients and customers of the VA. As the VA seeks to improve outreach and health services for returning Veterans, the disability compensation process should be considered.

Limitations

There are several limitations to this study. A key limitation of this study overall is in relation to the findings is that all respondents were recruited as individuals who were not satisfied with their disability rating. Thus, these are Veterans who are potentially already displeased with the process. However, considering that nearly 80 percent of Veterans appeal (IoM, 2007), the experience of dissatisfaction with a compensation rating is likely not a unique experience.

Another key limitation is related to the issue of recall bias and selective memory. Veterans may have shared stories which make their decisions and perceptions seem more favorable during an interview. Also, the experience of a process is difficult to capture retrospectively, and cross-sectionally. To better understand the process, a longitudinal study which includes observational techniques is warranted.

Future Research

As an exploratory study, more questions are raised than answers given. Findings from this study suggest that future research could be conducted around specific Veteran populations. For example, combat Veterans specifically seemed to experience more stigma around asking for help with their applications than Veterans who had not experienced combat. Veterans who experience military sexual trauma (MST) are another group that should be considered in relation to disability compensation. While only one respondent had experienced MST, the experience described suggested special concerns when trying to "prove" a sexual assault has occurred in the context of compensation. Comparing the experience and perceptions of older Veterans with younger ones would be a next step in the context of this study.

Appendix A: Interview Guide Domains

Deciding to apply:

1. Tell me about your decision to apply for Veterans' disability compensation.
    a. How did you first learn about Veterans' disability compensation and being service connected?
    b. When did you first consider applying? Who, if anyone, encouraged you to apply? Did anyone encourage you not to apply?
    c. What do you think motivated you to apply?

Applying

   d. Tell me about the process of applying. How did you begin the process of applying? What were your first steps?
   e. Did anyone help you with the application process? If yes, what did they do to help? How did you connect with them – what brought you to them or them to you?

2. Tell me about the compensation and pension exam. What happened when you arrived? What was it like?

    a. What did you expect the compensation and pension exam to be like?
    b. How did the person who did the compensation and pension exam interact with you?

Experience of being denied and/or dissatisfied

3. Let's talk about what happened when you found out about the decision regarding your service connection. How were you first told of the decision?

    a. Do you have a sense of why the decision was made? What were you told? Who told you? Did you talk to anyone from the VA? Anyone else?
    b. How did you feel when you found out the decision? How do you feel about it now?
    c. Do you know why your application was denied or not rated highly? What do you think?

4. Have you felt differently about any of your health or mental health conditions since starting this process?

Appendix B: General Demographic Table

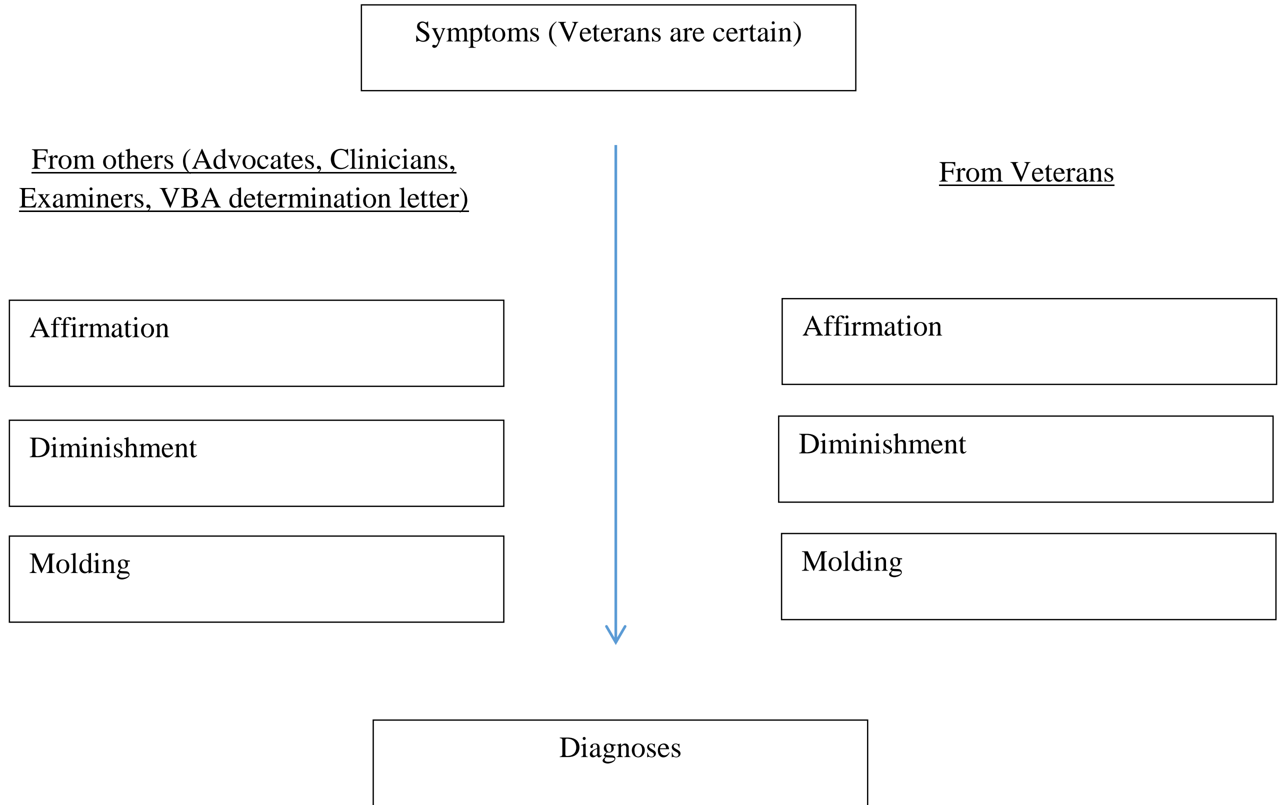
Pseudonym	Follow-up interview	Gender	Race	Military Branch	Age	Deployed in Combat Overseas
Ben	Yes	M	White	Marines	28	Yes
Roberto	Yes	M	Hispanic	Marines	32	Yes
Ken	No	M	White	Army	27	No
Derek	No	M	White	Marines	28	Yes
Eric	Yes	M	White	Marines	25	Yes
Marcus	Yes	M	White	Army	32	Yes
Doug	No	M	White	Army	24	Yes
Peter	Yes	M	AA	Navy	28	Yes
Sara	No	F	White	Marines	28	Yes
Lance	No	M	White	Navy	35	No
Johnny	No	M	White	Navy	31	No
Pedro	No	M	Hispanic	Marines	30	Yes
Sergio	Yes	M	Hispanic	Army	35	Yes
Freddy	No	M	White	Coast Guard	28	No
Sherry	No	F	AA	Marines	22	No
Nico	No	M	White	Army	32	Yes
Diego	Yes	M	Hispanic	Marines	33	Yes
Jasper	No	M	White	Marines	26	Yes

Appendix C: Self-identified Conditions Affecting Functioning and Well-being

Pseudonym	Pain (e.g., back pain, knee pain)	Post-traumatic stress disorder (PTSD)	Substance abuse	Other conditions
Ben	×	×		Reaction to anthrax vaccine which included weekly vomiting blood; tinnitus
Roberto	×	×	×	Chronic skin rash; knee injury; high liver enzymes
Ken	×			Repeated broken nose affecting breathing
Derek	×	×		None mentioned
Eric		×	×	Traumatic brain injury; tinnitus; leg muscle damage
Marcus	×	×		Nerve issues; tinnitus; severely broken wrist
Doug		×	×	Memory loss; anger issues; cardiac arrhythmia
Peter	×	×	×	Seizures; anxiety attacks
Sara	×	×		Military sexual trauma; migraines
Lance	×			None mentioned
Johnny				Hand injury; tinnitus

	×			
Pedro		×	×	Panic attacks; traumatic brain injury (TBI)
Sergio	×	×	×	Kidney issues
Freddy	×			None mentioned
Sherry				Skin condition
Nico	×	×		Vision issues
Diego	×	×		Traumatic brain injury (TBI)
Jasper	×			None mentioned

Appendix D: The Process of Symptoms becoming Diagnoses with the Disability Compensation System



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