ABSTRACT

A TRAINING WORKSHOP ON VETERANS AND COMPLEX TRAUMA POST TRAUMATIC STRESS DISORDER: A GRANT PROPOSAL

By

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The purpose of this project was to write a grant to create a workshop for service providers who work with veterans who suffer from complex trauma post-traumatic stress disorder (CT-PTSD) and locate a funding source. Since 2001, there has been an expansion as veterans have left the military. An issue facing veterans is how complex trauma interacts with PTSD. The agency chosen for the workshop is Veterans First in Santa Ana. The funding source is the Wounded Warrior Project. The project was designed to measure the skills and knowledge of service providers working with CT-PTSD. The workshop utilized pre and post surveys to monitor workshop effectiveness, provider understanding, and knowledge implementation. Currently, CT-PTSD is an under developed diagnosis that it is not recognized in the latest version of the *DSM-5*. With the help of workshops such as this, it is hoped that this will become a recognized veteran issue.

Keywords: Veteran, Complex, PTSD, Grant

Actual submission of and/or funding of the grant proposal was not required for successful completion of this project.

A TRAINING WORKSHOP ON VETERANS AND COMPLEX TRAUMA POST TRAUMATIC STRESS DISORDER: A GRANT PROPOSAL

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CHAPTER 1

VETERANS AND CT-PTSD

The U.S. military has been in a constant cycle of readiness and deployment since 2001. The day when the twin towers in New York fell was also the day the world's largest military-industrial complex was raised to full alert. Over the next few years, many new theaters of operation would be created. Within a month, the war in Afghanistan (Operation Enduring Freedom) would start. Less than 2 years later, Iraq (Operation Iraqi Freedom) would begin. Contributing to these major conflicts are even more "minor" or tertiary deployments throughout the world that have resulted in more combat exposures and potentials for life altering injuries and/or death (MacGregor, Heltemes, Clouser, Han, & Galarneau, 2014).

Post-Traumatic Stress Disorder

Of all the issues that face the U.S. military and veteran community, none is more prevalent than PTSD (Yarvis, 2011). Specifically, PTSD can be defined as a mental health condition created by a trigger event that was witnessed by an individual or experienced (American Psychiatric Association, 2013a). The resulting trauma can cause nightmares or night terrors, reliving the trauma, and/or feelings of uncontrollable anxiety. Military work often means deployments to overseas territories, often categorized as hostile fire zones. These work environments involve special dangers from either direct or indirect combat, culture shock, or environmental hazards. The results of these traumas

has also meant an increase in the numbers of Service Member Suicides (SMS; McCarl, 2013).

In many countries, the military is a reflection of the general population. Just as the public schools have unique cultural values and histories, so does the military. These cultures also change with the integration of new members and the exiting of older ones. Since 1973, the military has been an all-volunteer force (Wang, Brown, Spence, Adkins, & Elder, 2010). This shift away from a draft based service changed attitudes towards service. Similarly, views of military trauma from exhaustion to the more present PTSD have changed with cultural views of psychological health (Eagan Chamberlin, 2012). As the wars in Afghanistan and Iraq are de-intensified, the numbers of service members who are diagnosed with PTSD as a service connected disability have risen (Wisco et al., 2014). Additionally, as these service members return home and leave the military, greater numbers are using their educational and medical benefits. These post-services benefits have been described by some as a "camouflaged social safety net" (Wang, et al., 2010, p. 457).

General Problem Area

McCarl (2013) stated that the number of SMS has increased in the post 9/11 period compared to before the Global War on Terror. The result has been an increase in suicide prevention programs offered by the U.S. Department of Veterans Affairs (VA). One example is the VA's Crisis Hotline. Since its creation in 2007, it has received over 650,000 phone calls, and it has been reported to have saved more than 27,000 lives (McCarl, 2013). According to Wisco et al. (2014), PTSD, in addition to depression and substance use, is associated with suicidal ideation in veterans. A problem in the current

approach to helping veterans in crisis is ensuring that effective practices are in place (Creamer, 2011). If there is a way to improve outcomes and lower misdiagnosis rates, it would be more cost effective than intensive interventions or medication.

Specific Problem

PTSD is a complex issue as each person has an individual tolerance and adaptation level to traumatic stress. According to Youssef et al. (2013), complex trauma issues, such as child abuse, are linked to veterans' mental health status. Complex trauma is defined by Worthington and Langberg (2012) as "a history of subjugation to totalitarian control over a prolonged period of time involving danger, stress, and an inability to escape the situation" (p. 277). This can be a definition of child abuse in which dependency to a caretaker means that a minor cannot escape from the threat. In the modern military context, one would think that this definition only describes few situations, such as being prisoners of war. However, a more common occurrence of complex trauma in the post 9/11 military is the constant deployments, with ever present threats such as Improvised Explosive Devices (IED) and attacks from civilians who have become hostile. So the combination of long, repeating deployments and the ever-presence of danger can create a psychosocial environment in which a person feels confined by his or her situation and, therefore, experiences complex trauma.

Complex trauma, while not a diagnostic category, has been proposed in the form of Complex PTSD (C-PTSD) for the World Health Organization International Classification of Diseases, 11th version, also known as ICD-11 (Cloitre, Garvert, Brewin, Bryant, & Maercker, 2013). By aiming at understanding and assessing for complex trauma, the treatment of PTSD will encompass a more holistic approach.

Prevalence

The prevalence of PTSD is more common among veterans of more recent wars (Vietnam and to the present day). In previous wars, the eras prior to the PTSD diagnosis, exhaustion, soldier's heart, shell shock, and combat fatigue were all used as terms for what is now considered PTSD (Eagan Chamberlin, 2012). The current diagnosis was a result of the post-Vietnam use of Evidence Based Practices (EBP) and the *American Psychological Association's Diagnostic and Statistical Manual for Mental Disorders* (*DSM*) for military pathology (Friedman, Resick, Bryant, & Brewin, 2011). The lifetime prevalence rate of PTSD for veterans of Afghanistan and Iraq is currently 14% and this percentage is expected to rise as the VA assesses more veterans (Belsher, Tiet, Garvert, & Rosen, 2012). A study of outpatient veterans with PTSD by Bormann, Hurst, and Kelly (2013) reported that recently discharged OIF/OEF veterans living in Southern California had double the occurrence of PTSD when compared to those who were currently serving on active duty. There are 43 military bases and training centers in California, with even more reserve and National Guard armories throughout the state. In the context of the veteran community, veterans tend to congregate into locations where there is a strong military or veteran presence (Teachman, 2013). In Southern California there is a need for veterans' services and to study the issues that are important in the veteran community. The National Center for PTSD, administered by the VA, reported that PTSD affects 3.6% of men and 9.7 % of women in the general population. In contrast, the estimated lifetime prevalence of PTSD in the veteran population is 30.9% of men and 26.9% of women (VA, National Center for PTSD, 2014).

Consequences of Not Intervening

Since the Vietnam War, the number of veterans as a percentage of the population has declined (Teachman, 2013). This is leading to an increasing isolation of the veteran population from the general population. There is also evidence that alcohol use disorders and PTSD have a strong association. According to research of by Capone, McGrath, Reddy, and Shea (2013), alcoholism is more strongly associated with the diagnosis of PTSD than the occurrence of combat exposure or combat hours in veterans. Additionally, PTSD is linked with a high likelihood of substance use disorders, and when a veteran is alcohol or drug dependent, there is a strong tendency for his or her spouse or partner to be an alcohol or substance user (Miller, Reardon, Wolf, Prince, & Hein, 2013). It has been reported that there is also a tendency to use prescription drugs among veterans diagnosed with PTSD. Some research has shown that there is a correlation between a diagnosis of PTSD and prescriptions of high doses of benzodiazepine, a drug used for anxiety and to aid in sleep (Hermos, Young, Lawler, Rosenbloom, & Fiore, 2007). There has also been an increasing amount of research indicating the high risk for suicide among veterans with a PTSD diagnosis (Wisco et al., 2014).

Importance of Intervention

The core purpose of an organization such as the VA is to provide the best possible outcomes and services for its target population (Kuehn, 2012). Benjamin Franklin stated "that an ounce of prevention is worth more than a pound of cure" (as cited in Kiel, 2011, p. 791). An important consideration in public policy is a cost benefits analysis of providing for veterans' healthcare given finite economic resources. Inefficiencies can occur when a serious mental health disorder diagnosis is missed, is inaccurate, or is

incomplete. The interconnection of PTSD and other health issues such as alcohol and drug use disorders and depression has been established (Wisco et al., 2014). When untreated, these disorders result in significant costs to affected individuals, their families, and society.

Goal

The goal of this project was to write a grant for a series of workshops to educate service providers who work with veterans about complex trauma and PTSD. These workshops will serve as a knowledge point in the veteran service provider community. It is necessary because the cost of not addressing complex trauma and PTSD is relatively high. The cost of these workshops is to remain low, so that they can be duplicated elsewhere.

Definitions

Complex Trauma (CT): "Complex trauma occurs repeatedly and escalates over its duration. …it is exemplified by domestic violence and child abuse …by war, prisoner of war or refugee status, and human trafficking…. to situations such as acute/chronic illness that requires intensive medical intervention…" (Courtois, 2004, p. 412).

Prolonged Exposure: defined as a type of therapy where as a trauma client is repeatedly exposed to thoughts, feelings, and situations that he or she has been avoiding in order to decrease the distress he or she has experienced (VA, 2014).

Post-Traumatic Stress Disorder (PTSD): included in the trauma and stressor-related disorders section of the *DSM-5* and it is defined a psychological distress that occurs following exposure to an actual or threatened death, serious injury, or sexual violence presenting with a varied clinical expression usually occurring within the first 90

days after an event but it may take years (American Psychological Association, 2013a, p. 271).

Trauma Focused Cognitive Behavioral Therapy: is a form of cognitive behavioral therapy with a specific focus on cognitive restructuring the client's thoughts surrounding the trauma (Bisson, Roberts, Andrew, Cooper, & Lewis, 2013).

Veteran: is defined as a person who has served more than 180 days in the military (active or reserve).

Veterans Service Organization (VSO): is defined as a non-governmental organization that acts as an advocate on behalf of veterans with the VA.

CT-PTSD Workshop

The proposed CT-PTSD workshops would fill a gap in an area that has not been recognized by the wider veteran provider community. PTSD can be the result of intensified or aggravated traumas from pre-service or pre-deployment life experiences also known as complex trauma. One of the main goals of the workshops will be to educate the service providers in how complex trauma interacts with and is often linked to PTSD. The current lack of a *DSM -5* designation for CT-PTSD suggests that there is not enough awareness of this issue. The design of the workshops will be primarily to increase the knowledge base and influence the attitudes of those who are involved in treating veterans suffering from complex trauma and PTSD. According to a report by the U.S. Government Accountability Office (GAO, 2011), the key barriers to veterans seeking and accessing mental health service were stigma, a lack of understanding about mental health care, and concern about healthcare within the VA. This program aims to

promote a modern view among service providers that complex trauma, like PTSD, is not a lifelong disorder with no hope of recovery.

A series of workshops based on education about complex trauma and its relation to PTSD in veterans has as its goal better treatment opportunities for veterans. Linking PTSD and complex trauma would raise awareness in service providers of another layer of complex interactions in the minds of veterans suffering from PTSD. The long-term benefit of this awareness maybe the inclusion of complex trauma/complex PTSD as a service connected disability. This is a long-term outcome that would require additional resources, service provider inputs, and time. This workshop would help to generate the awareness needed to make CT-PTSD stress disorder a separate service connected issue.

The CT-PTSD veteran workshops would target service providers working with veterans. The workshops would be using EBP in complex trauma to train the service providers in more effective practices when working with veterans with CT-PTSD. These workshops would be a place where service providers would be shown best practices in psycho-education about this condition.

Program Limits

As of 2013, CT-PTSD is not a recognized condition in the latest version of the American Psychological Association's *DSM-5*. There has been no decision as of 2014 as to whether it will be included in the next version of the *DSM*. The primary purpose of these workshops will be to raise providers' awareness of CT-PTSD as issue among. Resources provided in these workshops will include EBP for service providers of veterans with CT-PTSD related issues. There will be a bit of explanation that in the future this condition could be recognized in the *DSM* and in turn, recognized by the VA.

However, there will be special care taken to not let this be the primary focus of the workshops, since VA disability recognition is a long-term process. The goal are about raising service provider care and awareness, rather than veterans' compensation or pensions.

Cross-Cultural Relevance

Throughout most of the United States' history, to serve in the military was considered an honorable and socially responsible thing to do. However, by the time of the Vietnam War, questioning overseas intervention was not uncommon (Levy, 2013). In 1973, the U.S. military became an all-volunteer force. The result was that no more drafts were to be implemented. Instead, Selective Service registration for all males over the age of 18 became a requirement, and the draft has not been used since the Vietnam War. One of the side effects of this policy change was that recruiters were more likely to disproportionately target those who are minorities or otherwise disenfranchised. The greatest likelihood of going into the military comes from three factors: unfavorable circumstances, a lack of connectedness to others, and a history of fighting during adolescence (Wang et al., 2010).

Same sex oriented veterans were found to be 2 times as likely to commit suicide as their heterosexual peers (Blosnich, Bossarte, & Silenzio, 2012). Simpson, Balsam, Cochran, Lehavot, and Gold (2013) reported that findings from the 2000 U.S. Census revealed more than 50,000 active duty service members were in same sex relationships. Additionally, the researchers noted that more than a million veterans were in same sex relationships, and that the numbers were probably much higher than what was being

reported. These researchers also found an association between PTSD and a personal trauma in service related to veterans' sexual orientation.

Social Work Relevance

Today, the VA is the largest employer of social workers in the United States and according to its social work website: "the Department of Veterans Affairs is affiliated with over 180 graduate Schools of Social Work and operates the largest and most comprehensive clinical training program for social work students--training 900 students per year" (VA, 2012, para. 5). In Orange County, California, some veterans live with a comorbid state of PTSD and complex trauma. These veterans are a part of vulnerable population. Some of the issues they deal with include stigma from fellow service members, social isolation, and difficulties with alcohol and substance use. The National Association of Social Workers (NASW; 2008) core values include service, dignity and worth of the person, and the importance of human relationships. One of the primary missions of a social worker is to advocate for those who need help in improving services and advocating for themselves.

If this proposal is funded, the program will support the above NASW core values. It will provide a service by increasing the recognition of the link between complex trauma and PTSD, which would in turn mean a greater likelihood of correct diagnoses and better mental health care outcomes. The program will be using knowledge of complex trauma in veterans with PTSD, and show how early trauma is connected with comorbidity of different disorders including PTSD. Finally, the greater occurrence of PTSD and complex trauma in the veteran population will be addressed in a social setting.

In the long-term, this program might help service providers develop a broader and deeper understanding of complex trauma and its relationship to PTSD in veterans.

CHAPTER 2

MILITARY AND TRAUMA

The military has been dealing with trauma due to the rigors of war since almost the beginning of recorded history. Many of these injuries can also compound upon traumas that occurred during childhood development. As human society evolved, so too did the medical and social approaches to the traumas created by war. Military culture has shifted enough that the desire to change PTSD into PTSI (Injury instead of Disorder) is now being expressed within military journals (Levin, 2013). There are four interventions that are used by service providers working with clients who suffer from PTSD and other traumas. The interventions show that service providers can be trained to improve outcomes, attitudes, and patient engagement. Lastly, this article is an example of service providers seeking to learn how to more effectively treatments for PTSD and complex trauma clients.

History of Military Trauma

The idea of the complex interconnections between the mind and body is not a new concept. In the western philosophical tradition, the earliest mention of a psychological impediment due to combat conditions can be found in Homer's *The Iliad*, with its many vivid fighting scenes (Homer, 1951). In one scene, the character Patroclus was overcome with what could now be seen as PTSD. "Patroclus was stunned; his shapely legs refused to carry him; and as he stood there in a daze…" (Homer, 1951, 16.801-803).

Throughout most of antiquity, it should be noted that what might be considered psychological in modern practice was often interpreted as the works of supernatural entities or deities or the warrior's own spirit. In William Shakespeare's *Macbeth*, the main character Macbeth and his wife Lady Macbeth develop what appears to be PTSD after committing murder. In the case of Lady Macbeth, the mental trauma manifests as repeated hallucinations as she endlessly tries to remove imaginary blood from her hands. The doctor who is treating Lady Macbeth makes what might be the first clinical diagnosis of what would become PTSD by saying "…Unnatural deeds, Do breed unnatural troubles. Infected minds. To their deaf pillows will discharge their secrets…" (Shakespeare, 1993, Act 5, Scene 1). In Christian Renaissance England, this would most likely be seen as the result of an unclean soul due to violating one of God's commandments. During the European Renaissance, medical practitioners started to use the term *nostalgia* for soldiers experiencing war stress (Nash, Silva, & Litz, 2009).

Like most of fields of human knowledge, these views changed even further between 1750 and 1820 during the age of enlightenment (Dimitri, 1998). The idea that objectified facts mattered more than personal experience would lay the groundwork for all forms of modern science. During this period, there was also an increased awareness of battlefield actions taking a toll on the person. The initial reasoning of physical exhaustion was seen as a natural stressor of war; injury was seen as merely a lack of physical health. Eagan Chamberlin (2012) noted that soldiers suffered from "exhaustion," and the necessary prescription of the time was a day of rest before being returned to the front lines (p. 360). This time period was still heavily influenced by the idea of Aristotelian psychics. In ancient Greece, Aristotle had made the argument that

objects slowed down because they tired. This concept would influence how medical personnel at the time would look at these *invisible injuries* that are not easily apparent (Davis, 2005, p. 153). If a soldier is having trouble in war, it was because he or she was *tired*.

The enlightenment era led way to the industrial revolution in post 1820 America, which also saw an increase in the use of clinical and psychological definitions for battle field conditions (Dimitri, 1998). This was primarily due to the rise of medical and psychological type services becoming available with increased industrialization (Gochfeld, 2005). The condition known as *Soldier's Heart* entered into medical journals in 1870 (Bishop, 1942). A year later, Da Costa (1871) published his work with veterans of the American Civil War on what would become known as *Da Costa Syndrome*. These conditions included fatigue, night sweats, and losing consciousness, and were being noted as occurring even in non-military population who had experienced traumatic events (Lasiuk & Hegadoren, 2006). These conditions were considered favorable for the military service members, families, medical personnel, and military hierarchies because they allowed for a physical explanation of this *invisible injury*. A soldier would be able to serve honorably, a doctor would not have to diagnosis a personal failure, and military leaders would not have to worry about the breakdown of previously brave soldiers or questions about the wars themselves (Van der Kolk, Pelcovitz, Roth, & Mandel, 1996).

After the start of the industrial revolution, wars became increasingly modernized. Features such as large conscription armies, domination through new technologies, and massive causalities in terms of civilians and military personnel became the hallmark of military modernity. Increasing conflicts also meant more veterans with after service

conditions. World War I began on July 28, 1914 and lasted 4 years (Cooke, 2014). During this time, all the major powers of the world were involved in combat. As in previous wars, service members developed post traumatic illnesses; however, unlike in pervious wars, the technology of the era meant more casualties of all kinds, and more time in front lines.

Within 6 months, a new phrase, *Shell Shock*, had replaced soldier's heart. Charles Meyers, a physician in the British Expeditionary Force concluded that blood vessels breaking in the brain were resulting in mental breakdowns of soldiers (O'Brien, 1998). However, this did not account for soldiers who were suffering from these same psychological symptoms when not exposed to direct combat. There is documentation reporting lines of soldiers, marching for miles, to be treated for confusion and light headedness, symptoms associated with chemical or artillery attack (O'Brien, 1998). These men, however, had not been in combat. In response to these cases, Meyers named another condition: *shell concussion*, a psychological condition brought about by the intense and dangerous conditions in war (Lasiuk & Hegadoren, 2006).

After the war, Abram Kardiner (1941), an American psychoanalyst who had studied with Sigmund Freud, first coined the term *war neurosis*, believing that this trauma was a psychological injury rather than a physical injury. The U.S. military during this period also began to integrate psychological screenings for new recruits and draftees. It was also during this interwar period, between WWI and WWII that the idea of earlier traumas as a factor in more complex psychological trauma was considered (Marlowe, 2001). There was also some preliminary work done to understand how external stimuli

to the brain could create a physiological condition which would in turn alter the individual's state of mind.

Europe was thrown into another World War in 1939 and across the Atlantic the United States began to prepare for military entry. In the psychological arm of the military, psychiatrists began to heavily influence the screening process for new recruits and inductees (Pols, 2011). The military, often because of their prejudices, screened out minorities believing that in doing so they would only have the fittest and smartest serving (Dwyer, 2006). Additionally as the war against Germany took off in North Africa (Tunisia Campaign), the rate of mental breakdown was as high as 35% of all the wounded, contrasting to 2% during United States involvement in WWI (1917-1918) and a 12% average of mental breakdowns during WWII (1941-1945; Pols, 2011).

During this time, Spiegel (1944), an American psychiatrist, noted that units with high levels of camaraderie experienced very low percentages of mental causalities while units with low levels of cohesions had higher numbers of service members with psychological issues. Spiegel would later go on after the war to publish books and articles that brought forth the idea that a trifecta of individual relations between soldiers, group relations to their unit, and relations to their leaders provided the greatest buffer against psychological breakdown (Owens & Edna, 1947). It was also during this time period that American neurologist, Alexandra Adler, published works on similarities between those with psychological traumas and those with injuries to the brain (Andreasen, 2010). When World War II ended, the interest in combat stress did not end with it. The interest in and funding for military psychology increased and led to the front line therapy that would dominate during the cold war.

In the Korean War (1950-1953), the practice of front line psychiatry was used extensively. This therapy relied on three factors: proximity, immediacy, and expectancy (Van der Kolk et al., 1996). Psychiatrists worked within front line medical facilities such as Mobile Army Surgical Hospitals (MASH) to ensure that a service member was not permanently separated from his or her unit. These front line sessions were short and would only focus on current problems with the idea that the combatants would be returned to their unit as soon as possible (Spiegel, 1944). It was during this era that several new developments impacted the treatment of service members. The first was the short-lived use of early psychotropic drugs used to treat psychological disorders. The initial use of the drugs in the military context was treatment based on a disease model of psychiatric issues. However, it was found that the medication did not work effectively when there were multiple causes for a mental health disorder.

During this time period, there was also a rising awareness of the importance of psychosocial support for victims of any physical trauma (Hamburg, Artz, Reiss, Amspacher, & Chambers, 1953). The result was a new conceptualization of stress as being a synthesis between the environment and the person (Marlowe, 2001). The final development was the creation of the *American Psychological Association's Diagnostic and Statistics Manual of Mental Disorders* (*DSM-I*) in 1952. In this first edition, all of the prior combat-stress related conditions could be diagnosed under the condition *gross stress reaction* (Saigh, 1999). Gradually, the cold war era faded into the Vietnam War Era and the methods of military deployment served to add another layer of stress for the service members. When a service member was killed or removed from service, a

replacement would be sent to fill the position within 24 hours of arriving in country (Moskos, 1975).

It was during the United States involvement in Vietnam that many other facets of what would be later known as PTSD were considered. In the United States, studies of how industrial accidents could lead to psychological conditions were being published (Nemiah, 1963). Psychiatrists working with Holocaust survivors had noted that some psychological injuries appeared many years after the traumatic event (Krystal, 1968). It was during this time that experiencing a traumatic event outside of combat became viewed as sufficient to cause the type of psychological trauma that would become PTSD. It was also being noted by the psychiatric field that there was a lack of standardization for the criteria of these traumatic conditions. This was probably a result of the *gross stress reaction* diagnosis being dropped entirely from *DSM-II* in 1968 (Saigh, 1999). As the war proceeded, there would have to be a more uniformed standard for diagnosing service members, perhaps included in a newer *DSM* (Horowitz, 1974).

As the Vietnam War wound down, the military attempted to quantify trauma in order to identify individuals and units that were particularly vulnerable. At the time, it was believed that there must be either a direct connection or strong association with direct endangerment in a combat zone as a necessity for a trauma to be diagnosable (Egendorf, Kadushin, Laufer, Rothbart, & Sloan, 1981). Instruments to evaluate trauma were shifting to take into account the intensity of combat, forming a hierarchy based on the number of events and chronology of the patient combat history (Lund, Foy, Sipprelle, & Strachan, 1984). All of this was building up to the creation of a new diagnosis, PTSD, in the *DSM-III* in 1980.

Two issues were present in the treatment of veterans returning from Vietnam. First, many former service members were being treated in clinical settings without disclosing their military history to clinicians. Second, a general apathy towards veterans, which was due in part to the Vietnam War's unpopularity in the general public, leading some clinicians to not solicit information (Wilmer, 1982) or ignore a service member's military history. Consequently, by the late 1970s, there was a groundswell from veterans and clinicians to get a psychological diagnosis in the *DSM* for the traumatic experiences of the many veterans coming home from Vietnam (Eagan Chamberlin, 2012).

New concepts such as *Post-Vietnam Disorder* were being researched and published in medical and psychological journals during the 1980s (Amen, 1985). There was not enough evidence for this condition to be a separate psychological disorder, so more inclusive criteria were examined. The initial concept of PTSD was a psychological diagnosis from a traumatic event that was outside the normal range of human reaction. This was the first appearance for this type of military-related trauma in a *DSM* for 22 years. As years went by, the definition was expanded to include longer and longer delayed onsets of symptoms, and as a result, a diagnosis that was considered uncommon during a peace time started becoming more common (Andreasen, 2010). As the military and veterans communities continued to evolve their views on military trauma, the psychological and neurological diagnosis for trauma changed.

In *DSM-III-R* the stressor was redefined. A stressor now had to be outside the range of human experience enough to cause distress in anyone (American Psychological Association, 1987). There was also a refocusing on the psychological aspects of the trauma rather than previous physical proximity. This was coming at time when research

estimated that about 15% of all Vietnam veterans had PTSD (Barnes & Harvey, 2000). The *DSM-IV* was changed again to recognize a broadening of stressors. It was now no longer necessary for the service member to have been in physical danger involving a traumatic event. The threat of danger was enough for the diagnosis (American Psychological Association, 1994). The history of exposure, three clusters of symptoms, duration, and life significance were needed for diagnosis. In the *DSM-5* the symptom cluster of avoidance/numbing was split into two separate clusters: avoidance and persistent and negative alterations in cognitions and mood (American Psychological Association, 2013a). The text was also changed, requiring a reaction from an individual during the event was removed. In addition, a recurring exposure to a trauma (i.e., for police and first responders) as well as sexual assault were added to traumatic stressors.

Military Stigma

The Roman poet and historian Pliny the Elder once said in his work *Naturalis Historia*, "there is nothing more miserable and proud than man" (De Botton, 2001, p. 118). There is an underlying social issue when wars are over. The soldier is typically worshiped in times of war, but forgotten in times of peace. It is from this attitude that stigma is developed about veterans. According to Goffman (1963), stigma is "an attribute that is deeply discrediting" (p. 13). This tendency to discredit is not just restricted to individuals, but is applied across whole social constructs. In societal perceptions outside the military, policy makers can hold conflicting beliefs about veterans with PTSD. This form of cognitive paradox is defined in two ways. First, there is the belief that PTSD is not well defined, which results in over diagnosis. Second, despite over diagnosis, veterans are not reaching out enough to get diagnosed (Fisher, 2014).

This kind of mental somersaulting is not uncommon when discussing past wars and veterans, especially when a war is lost or unpopular.

The most common manifestation of cognitive dissonance about military and veterans is to re-frame a past conflict in a socially constructed form that aligns with the national interest. Post World War II Germany was flooded with narratives of being stabbed in the back by German minority groups, as a way to deal with the cultural trauma of losing the greatest conflict up until that point (Geyer, 1992). For an occupied Japan, it was the idea that they were conquered by the last "European" power trying to impose the last of the *white man's burden* (Dower, 2000). During the Vietnam conflict, there was the idea that if the commanders in Vietnam were more like the generals of World War II, the war would have been different (Beidler, 1995). These grand constructed narratives can be useful in understanding group decisions and consciousness. PTSD, however, is entirely an individual diagnosis, which opens two questions: How is an individual supposed to react to a trauma in his or her life? How are social groups supposed to react to an individual with a PTSD diagnosis?

PTSD has gone through many forms before its current appearance in the *DSM-5*. In the *DSM-5*, a person can be diagnosed with PTSD if he or she meet the criterion. This creates a problem in diagnosis among service members, because in order to be diagnosed with PTSD, it is necessary to manifest significant symptomology. This is undermined by the desire to not appear weak and therefore liability to one's unit (Britt, 2000). Furthermore, adding to the issue of addressing PTSD and stigma is the concept of bracket creep. This phenomenon of bracket creep in psychological science is the expansion of a condition into broader and broader categories. This creates difficulties because it blurs

the lines in identifying the mechanisms that cause the trauma symptoms, as the causal stressor of the condition becomes less significant (McNally, 2009).

Stigma in war is often focused on the concept of cowardliness. In World War I England, there were semi-official organizations such as the female Order of the White Feather. This organization was dedicated to humiliating men who were seen as idlers during wartime (Gullace, 1997). These women would go around looking for men who looked healthy enough to serve in the military. If the young men were *perceived* as not willingly serving, the women would throw white feathers in the man's face. Such organizations suggest that an individual's gender plays a part in how PTSD is viewed. In a 2008 study by Arbanas, young females were assessed to evaluate their attitudes about mental illness. When compared to their male counterparts, young females in the study showed significantly higher stigmatizing attitudes towards PTSD than other mental health disorders.

The military itself is sometimes described as a "cult of masculinity" with the aggressive and virile male raised up to the ideal archetype (Dunivin, 1994, p. 536). There was yet another example of social stigmatization during the Second World War when a new term for the fear of military service, *lack of moral fiber* (LMF) was first introduced in Britain (Trainer, 1994). This was a term implemented in 1940 following the British evacuation of Dunkirk. The perception was that fear was contagious and that questioning the war or one's commander was treasonous. The LMF label on a service record meant that the British government enforced a deliberate denial of psychiatric and therapeutic aid (Trainer, 1994). In some of these cases, the desire not to fly was a result of the bombing

(intentional or otherwise) of civilian targets during air raids. The extent in which stigma can affect veterans is not limited to times of war but can also be inter-generational.

There is a noted perception about the World War II generation of veterans. They are known as the silent generation, who lived through the great depression and won the war against tyranny (Fontana & Rosenheck, 1994). In one aspect, the silent generation label may be true when it came to PTSD. The World War II cohort showed an under reporting of psychological symptoms and lower numbers of those seeking help for issues related to the military. This group of veterans was followed by the Korean War veterans who showed the highest rates of suicidal ideation and mental distress (Fontana & Rosenheck, 1994). This was possibly a result of the unpopularity of the Korean War and the false reporting that many captured veterans had "converted" to communism. Just as military rituals have carried over the years their positive associations (Trice & Beyer, 1984), so too has the negative stigma of seeking mental health services.

During the Vietnam War, the military had adopted a policy of individual rotations of service members into the combat zone and their fighting units within 24 hours of arrival. This in essence meant that the war was being fought privately by each individual. Unfortunately, this meant a privatization of the stigma of fighting in an increasingly unpopular war (Segal & Segal, 1983). From the very beginning of military service, new recruits were labeled with the title FNG (Fucking New Guy) and would be hazed or ostracized unless taken under the wing of a more senior individual or having gained trust in other ways (Bey, 1972).

In the 1990s, U.S. service members came back from deployments to the Balkans as part of UN peace-keeping operations. In a study by Britt (2000) of 708 veterans

returning from Bosnia, the service members were more stigmatized for admitting to a mild psychological injury or condition than seeking services for even a minor physical injury. In an article by Hoge et al. (2004), service members returning from Afghanistan and Iraq reported that they felt they would be treated differently by unit commanders if they reported symptoms of PTSD. The same service members also stated that their own teammates would try to distance themselves if they told them they had PTSD.

Military indoctrination starts the process of stigmatizing the desire to seek help from the beginning of basic training. The military mindset is created in basic training to get the individual to accept a standardized set of values and social norms (Keats, 2010). There is also an idea that one will be stigmatized by going to seek help from service providers, known as Anticipated Enacted Stigma or AES (Hoge et al., 2004). This is based on the personal belief that a person will receive a hostile reaction or attitude from his or her social peers as a result of seeking help. Active service members about to deploy are the most likely to report AES according to a study with 240 Active National Guard (ANG) service members (Blais & Renshaw, 2013), but many veterans and their social networks carry over these attitudes out of the military into civilian life.

There is also a possibility that a veteran's own family could be a source of AES if the veteran seeks services in the military or from the VA after leaving service (Stecker, Fortney, Hamilton, & Ajzen, 2007). This can mean that the veteran population is especially vulnerable to social pressure to fulfill a socially constructed super masculine role. Since the military is supposed to be strong and ready for action, so are the veterans expected to be strong and ready to serve their country, even in the civilian sector. Service members returning from a military deployment under reported distressing conditions

(Gray, Bolton, & Litz, 2004). This could be a result of AES but may also be a desire by a service member to finish his or her time in service without further delay; reporting symptoms of PTSD or any other health problems could delay discharge.

Hopefully, this culture of stigma around military trauma is changing. The military has been going through faster cultural shifts since the end of World War II. When looking at the military from an objective standpoint and using Maslow's (1943) hierarchy of needs, it is possible to see maturing shifts in the military response to combat trauma. The military has moved from bare survival during the first 150 years of the United States' history to a stage in which survival is almost completely assured. As a consequence, the military has moved away from more primary needs (such as survival) into more professional services (Segal & Segal, 1983). This would partially explain why the military culture has changed to allow these issues to become addressable.

Recently, the military has expressed a desire to change the post-traumatic stress disorder to post-traumatic stress injury (Levin, 2013). If this change occurs, it is hoped that less stigma will be applied to the condition. Subsequently, AES may also be reduced as service members are able to seek services without the stigma of a lifelong debilitating disorder. Having peers and higher ups in the chain of command talk about post-traumatic stress disorder is also therapeutic. In workshops that explain how post-traumatic stress disorder is not a black and white issue, many veterans express a shock that the person giving talks or information about post-traumatic stress disorder has suffered from the condition (Collier, 2010). There has also been more impetus to create veterans specialty courts since 2001. These courts address veterans who are affected disproportionally by criminal justice and homelessness issues (Walls, 2011). These courts also place a special

emphasis on issues of post-traumatic stress disorder and traumatic brain injury. As a result these courts are known to have positive effects on outcomes for veterans. Focus groups created by the Department of Defense showed that service members and veterans were open to receiving psychological help (Manning, 2009). This was on the condition that the service provider be a real veteran with military experience. The use of workshops as a bridge to break stigma and engage veterans will now be presented in more details.

Interventions

This section outlines four different workshops and how they could be used as examples in working with veterans who suffer from CT-PTSD. Karlin et al. (2010) conducted a follow-up survey of VA health care sites 3 years after 4-day workshop, a training for using Cognitive Processing Therapy (CPT) and Prolonged Exposure therapy (PE) for the treatment of PTSD. The project involved providing training to 1,100 mental health staff. The results of the survey revealed that after 3 years, the majority of the facilities were providing these empirically supported therapies and the veterans who were treated had a significant reduction in their PTSD symptoms. The authors emphasized the importance of follow-up consultation in achieving their success.

In another workshop-based training, Jensen-Doss, Cusack, and De Arellano (2008) also reported that workshop training is necessary but insufficient for disseminating evidence-based practices among providers. They provided training on Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) for 66 mental health practitioners. The researchers found that following the workshop, the clinicians were not often putting what

they learned in training into practice. Instead, only the clinicians' attitudes were improved regarding TF-CBT.

Cucciare et al. (2012) looked at workshops training staff at the VA on Motivational Interviewing (MI) to improve the outcomes when helping veterans. The training was a half-day workshop, which was then followed by a 1-hour online training and ended with a second workshop. The researchers studied 229 primary care clinicians who reported that the MI training did lead to greater knowledge and self-reported usage. There was also a change in attitude and the clinicians preferred MI to more traditional advice giving formats. The clinicians also responded with more engaging interactions with client vignettes after the workshop.

In other research, Frueh, Grubaugh, Cusack, and Elhai (2009) observed the co-morbidity of Severe Mental Illness (SMI) and post-traumatic stress disorder. The group found that therapy based on evidence based practices is critical to a patient's outcome but that there was a lack of implementation in public sector clinics. The article also noted that evidence based practices was especially important in regard to post-traumatic stress disorder and trauma. One of the major barriers to implementing evidence based practices was the lack of motivation and resistance to change among service providers. The authors surveyed public sector clinic staff's attitudes in treating dual diagnosed patients. Their findings showed that only about 30% of providers had received 6 hours or more of training on PTSD or trauma during their entire career. The same clinicians also reported they did not have the necessary skills or training to address post-traumatic stress disorder or trauma-related issues. One of authors proposed solutions is to provide clinicians with

additional specialty training to help keep clinicians stay current with findings in post-traumatic stress disorder research.

Theses interventions show that training for service providers working with clients suffering from post-traumatic stress disorder can have a significant impact. The first intervention indicates that the practices put in place were almost fully integrated by 3 years later. The second intervention shows that attitudes of the service providers were significantly changed. The third intervention made the observation that providers were more engaged with their clients after learning new therapies. The last intervention also noted that service providers were not getting enough training to feel effective in providing adequate psychological support.

Conclusions

This chapter was a review of literature for a grant for a CT-PTSD workshop. The history of post-traumatic stress disorder dates back to antiquity and has evolved through the pre-enlightenment, industrial, and modern eras. Views of post-traumatic stress disorder evolved from physical impairments to mental and physiological conditions. As the medical side of military physiological conditions has changed so has the stigma surrounding the conditions. The military has also shown a greater desire to change the stigma surrounding conditions such as post-traumatic stress disorder. The interventions showed that practices could be put in place to improve patient outcomes. There also appears to be a genuine desire from service providers to get more training on psychological conditions such as CT-PTSD.

The proposed workshop will help to provide further education for service providers who treat clients experiencing the symptoms of CT-PTSD. The training will

involve bringing service providers together to receive psycho-education and training regarding complex trauma with which many veterans must deal. The feedback from the CT-PTSD workshop from the community providers may also help to address the growing issues around military post-traumatic stress disorder. CT-PTSD is an evolving issue for the military and would benefit from feedback from providers serving the veteran community.

CHAPTER 3

METHODS

Identification of Potential Funding Source

The grant writer used internet search engines Google, Bing, and Go Fetch search engines. Additionally, the California State University, Long Beach (CSULB) library resource center was used, including the social work link. The search used the key words: grants/veterans/California, grants/military/California, grants/veterans/Veterans Affairs. Also the grant writer reviewed and selected several websites on the local, state, and federal levels for grants that assist in veterans' services. The best website for grants targeting the local veterans' population were calvet.ca.gov, ca.gov/grants, and california.grantwatch.com. These three website provided the best information and were the source of the grants that were reviewed in the funding section of this chapter.

Target Population

The target population is made up service providers who work in a healthcare setting with veterans. An agency such as the VA that serve veterans is an example of one of these mental healthcare service providers. There are approximately 34 Service Providers for veterans located in the Orange County area (California Department of Veterans Affairs, 2014). These provider locations encompass the areas served by the Veterans First organization, namely the Orange County area. These service providers

have a potential client base of 131,229 veterans who reside in Orange County, and they make up about 7% of the 1,893,539 veterans in California (U.S. Census Bureau, 2014).

This grant intended to serve the service providers of this veteran population. Research shows that some 14 % of veterans from recent conflicts (OEF/OIF) and as much as 30% of Vietnam Era veterans have a lifetime prevalence of post-traumatic stress disorder (Belsher et al., 2012). The purpose of the grant is to serve and expand the service capacity of a nonprofit veterans' service organization (VSO). These agencies provide services such as advocacy, education, employment, healthcare, housing, and service connected disability claims (California Department of Veterans Affairs, 2014). This grant expands on their capabilities by providing the VSOs with training of CT-PTSD. The grant would allow for the funds for staff salaries and operational costs of the workshops. The goal of the workshop is to raise provider awareness of comorbidity between complex trauma and post-traumatic stress disorder.

Criteria for the Selection of the Grant

This grant writer researched foundation requirements, including criteria for eligibility, timelines, deadlines, and funding limits. Different foundations that offer grants were reviewed for the types of grants offered, the application process, previously awarded grants, present grants, and future grants.

Funding Sources

The Wounded Warrior Project (WWP) awards grants to other non-profit organizations that help provide assistance or services to the veteran population. There are four goals that a grant can aim for: Engagement, Body, Mind, or Economic Empowerment. There are two award cycles per year with a maximum budget of

$250,000 for a 1-year period. This grant required a Letter of Interest (LOI) which is reviewed by an agency against all other organizations. According to the WWP website (2014), when the LOI is accepted, a letter is sent out inviting the submitting organizations to complete a full grant.

This grant meets all the requirement for the thesis. The budget maximum is above the proposal budget and uses a 1-year cycle per award. The specific goals of the grant match section of providers' training in the Mind category. The requirement is that the providers' training should address a trauma or military stressor, while simultaneously bringing greater community awareness to the issue. There is additional requirement for service providers' training to be psycho-educational. Additionally, the training should include mental healthcare providers who can train or educate others after the training is complete. Finally, the training must provide ongoing education that is not provided by other programs or services. For these reasons, the Wound Warrior Project award grant was chosen for funding source for this program.

Needs Assessment and Collection of Data

This proposal used databases such as the U.S. Census, U.S. Department of Veterans Affairs, and the County of Orange, California. Currently, there are approximately 131,229 veterans in Orange County that make up about 4% of the general population of 3,114,363 in Orange County (U.S. Census, 2014). The literature review has shown that complex trauma and PTSD links in veterans have not been thoroughly researched. However, the type of traumas that could be considered as complex (such as child abuse) have been shown to significantly correlate with a veterans' exhibiting depressive syndromes and suicidal ideation (Youssef et al., 2013). The VA's National

Post-Traumatic Stress Disorder Center website also indicated that the lifetime prevalence of post-traumatic stress disorder in the general population was much lower, 3.6% of men and 9.7% of women (2014).

To assess the need for the workshop, this grant writer used multiple methods of data collection. This included a thorough review of the available literature and studies past and present. Additionally, the author of this grant proposal met with veterans service officers at the VA Medical Center in Long Beach. These officers expressed views that such a workshop would be important. There was a concern that having service providers assess for CT-PTSD with veterans would "scare veterans away" from seeking the compensation benefits and healthcare to which they may be entitled. This attitude may reflect the stigma that veteran service officers have towards psychological issues of their veteran clients. This is a subject the workshop will address in an effort to create an open dialogue.

CHAPTER 4

CT-PTSD VETERANS PROJECT

Problem Statement

Since the beginning of the global war on terror and the 2003 war in Iraq, there has been an increase in suicide among veterans (McCarl, 2013). As part of a recognition within the veterans' community, the Department of Veterans Affairs has increased funding for various suicide prevention programs. One of the primary factors associated with veteran suicides have been issues surrounding military service such as post-traumatic stress disorder, depression, and substance use. Service provider education in workshops would help to improve outcomes and lower misdiagnosis rates for veterans suffering from CT-PTSD.

Specific Problem

As with any complex issue, positive treatment outcomes for post-traumatic stress disorder are reliant upon the mental composure and constitutions of individuals who must adapt to a traumatic stressor. In many cases the status of a veteran's mental well-being can be directly connected to developmental trauma during childhood or before military service (Youssef et al., 2013). Since the global war on terror and the 2003 Iraq war, there has been a high level of constant deployments. These new conflicts have be noted for their signature injuries such as Traumatic Brain Injury from homemade weapons such as Improvised Explosive Devices.

Multiple deployments, proximity to explosions, constant danger, and high stress level are factors that contribute to occurrences of CT-PTSD. One of the difficulties surrounding this issue is the fact that complex trauma is not a recognized diagnostic condition. As awareness of this condition increases, so too will accuracy of diagnosis and knowledge about the inter-connecting issues surround CT-PTSD.

Since 2001, more that 1.8 million service members have deployed to Afghanistan or Iraq (Litz & Schlenger, 2009). It is estimated that between 10% and 18% of them have some form of PTSD, and more than 48 percent were diagnosed by the VA with a mental health condition. This number also is not a true representation of the veterans who have mental health issues as only 46% of all veterans come to the VA for any request for service (Litz & Schlenger, 2009). More recently, the recently discharged veterans in southern California have double the occurrence of PTSD when compared to their active duty counterparts (Bormann, Hurst, & Kelly, 2013). One of the most important factors in seeking and/or continuing mental wellness is the professionalism and competency of service providers (Karlin et al., 2010). There is also an issue of cultural competence or lack thereof among service providers. Evidence-based practices have been shown to be effective in the treatment of traumatic related conditions due to the ability to integrate a provider's expertise with the unique client characteristics and situations (Edwards, 2013). However, the number of veterans who could be treated for these conditions usually far exceeds the number of providers with the requisite skills. This can lead to undiagnosed veterans who are unable to receive the necessary care they deserve.

Description of Project

This project is a series of workshops about CT-PTSD for mental health service providers who work with veterans. These workshops aim to increase knowledge about these conditions among the veteran service providers. This training is necessary because the cost of not addressing CT-PTSD is high. The cost of these workshops will remain low, with the aim of duplicating and widely disseminating. The overarching goal of this project is to provide more holistic, patient centered care for the veterans in the Orange County area.

Program Goals and Objectives

The CT-PTSD workshop will be addressing the unique linkage of pre-service trauma and post-traumatic stress disorder and how the two issues often manifest in veterans. The training aims to raise awareness among providers and allow them to identify CT-PTSD in veterans. Currently, there is not recognition of CT-PTSD in the newest DSM-5, suggesting that this aspect of post-traumatic stress disorder is not thoroughly understood in the provider community. While increasing the awareness and knowledge about CT-PTSD, the workshop will also engage the providers working with veterans and solicit their perspectives and experiences from working with clients with trauma.

The veteran population already has difficulty seeking mental health assistance due to stigma, a lack of understanding, and biases against veterans' healthcare (U.S. Government Accountability Office, 2011). The workshop will be using evidence-based practices identified in the literature to train the mental health service providers (Cucciare

et al., 2012; Frueh, Grubaugh, Cusack, & Elhai, 2009; Jensen-Doss, Cusack, & De Arellano, 2008; Karlin et al., 2010).

Just as the attitudes around PTSD have changed, this workshop aims to promote the modern view that complex trauma is not a lifelong disorder without a possibility of recovery.

Program Activities and Timeline

Timeline

The following is the timeline for the 1-year grant for the CT-PTSD workshop. The overseeing agency is Veterans First. Veterans First is one of the non-profit agencies in Orange County that works exclusively with at risk populations of veterans. One of their core beliefs is the idea of "veterans helping veterans" (Veterans First, 2014). This model focuses on creating a safe temporary environment for veterans to reorganize their lives. Additionally, in 2011, Veterans First was the one of the founding organizations in the first Orange County Stand Down. Stand downs are homeless veterans outreach events to connect at risk veterans and their families with essential services (Veterans First, 2014). Once the workshop has been created it will continue at a rate of once a month for 12 months with approximately 12 to 15 providers in attendance each time.

Months 1-3:

Veterans First agency will hire the Licensed Clinical Social Worker (LCSW) with experience working with veterans (a veteran is preferred) and knowledge and experience with CT-PTSD.

The LCSW will design the curriculum for the workshop and apply to the Board of Behavioral Sciences to become a Continuing Education Unite (CEU) provider.

The LCSW will arrange a schedule with Veterans First for available times and workshop space. The LCSW will network with mental health providers in Orange County by attending providers' forums, and *veterans' stand-downs* (homeless outreach) to increase the footprint of possible service providers to apprise them of the benefits of attending the workshop and the opportunity to earn CEUs.

The LCSW will deliver one (1) 6-hour workshop within the second month and distribute/recover the intake surveys and post-training surveys and certificates. LCSW will conduct follow-up interviews with service providers.

Months 4-6:

The CT-PTSD workshops will continue with new classes at a rate of once per month with 12-15 participants per session.

LCSW will continue to meet with new service providers and to reach out to other agencies that work with veteran mental health.

LCSW will continue to conduct follow-up interviews with service providers.

LCSW will design and distribute monthly newsletter updates to service providers who have already attended a CT-PTSD workshop.

During the 6th month, the first cohort from the first workshop will meet again for a half-day session to discuss the outcomes from service providers. The outcomes will be used to address shortcoming in the workshop and will be included in the interim report.

LCSW will prepare and submit the interim report prior to the 6th month mark for the Wounded Warrior Project.

Using the evaluation feedback, the LCSW will work on making changes to the CT-PTSD to increase effectiveness.

Months 7-9:

The CT-PTSD workshops will continue with new classes at a rate of once per month with 12-15 attendees per session.

LCSW will continue to meet with new service providers and to reach out to other agencies that work with veteran mental health.

LCSW will continue to conduct follow-up interviews with service providers.

Months 10-12:

The CT-PTSD workshops will continue with new classes at a rate of once per month with 12-15 attendees per session.

LCSW will continue to meet with new service providers and to reach out to other agencies that work with veteran mental health.

LCSW will continue to conduct follow-up interviews with service providers.

During the 12th month, the first cohort from the first workshop will meet once again for a final half-day session to discuss the outcomes from service providers. The outcomes will be used to gauge the overall effectiveness of the workshops with the providers. In addition, the CT-PTSD team will share any final information that was learned from conducting the workshop. All of this will be included in the final report.

An additional half-day session will be conducted with the group of service providers who attended their first workshop after the changes from the interim report were implemented. This will allow the LCSW to compare the changes in outcomes from the first (original series) cohort and the modified cohort. In addition, the LCSW will share any final information that was learned from conducting the workshop. All of this will be included in the final report.

LCSW will finalize and submit the report prior to the 12th month mark for the Wounded Warrior Project.

Program Evaluation

The workshop will be using several instruments to measure outcomes and outputs. Within the workshop there will be a pre-workshop and post-workshop survey. This will be used to evaluate the level of knowledge, interest, and exposure that service providers have with CT-PTSD. There will also be post-workshop online surveys that will be used to determine the workshop's effectiveness.

At the 6th month, mark there are two important evaluation events. The first is a half-day follow-up with the first cohort of service providers from the first class. This will be an opportunity for the LCSW to interact with service providers who have been trained and implemented CT-PTSD interventions. From this session the workshop can be re-tooled to increase effectiveness. The second is the interim report that is required on the 6th month by the Wounded Warrior Project. This report will be used to describe a number of characteristics including: progress in goals and objectives in service provider effectiveness and awareness, changes in the workshop, accomplishments of the workshops, challenges that have impacted effectiveness, ways that challenges to the workshop were mitigated, techniques that are being used to measure program effectiveness, and human interest stories that show the impact of the CT-PTSD workshops.

Two more additional half-day follow-ups will be conducted, and a final report written regarding the findings and success of the program. First, a final half-day follow-up with the first cohort of service providers from the first class. This will be an

opportunity for the LCSW to interact with service providers who have been trained and implemented CT-PTSD interventions. During this session the LCSW will share what was learned from the CT-PTSD workshops between the LCSW and the service providers. Second, a half-day follow-up with the cohort after modifications were implemented will be conducted. During this session the LCSW will share what was learned from the CT-PTSD workshops between the CT-PTSD staff and the service providers. Lastly, a final report due to the Wounded Warrior Project will be completed by the LCSW. The final report will include findings such as: the workshops' impact, outcomes, new support as result of the program, resources for continuation, and any human interest stories that speak to the success of the project will be presented by the LCSW.

Linkages

The recruitment of service providers will start by linking in to the network of agents that Veterans First is already in contact with. The primary focus will be on service agencies, and groups that work with veteran mental health and counseling. The VA community clinics who work with veterans' mental health will be a primary agency in this network. The workshops will be made available to all service providers working in a general therapy setting that specialize in veterans care. If the provider is interested in attending they can e-mail or call the assistant who will RSVP for the workshops.

Staffing

The staff includes an LCSW as program director. The program director will already be familiar with various forms of client focused therapy. The program director will be responsible for the creation, maintenance, and modification of the workshops. The program director will also be meeting with service providers to encourage

enrollment, provide support, and increase the effectiveness of the workshop. Also, the program director will be conducting follow-up interviews in order to track implementation and progress between multiple workshop cohorts. The LCSW also is supervisor for an assistant.

As a MSW student intern, the assistant will should be to work with clients who are part of vulnerable populations. The assistant will be responsible for administering and recovering all workshop related surveys. Additionally, the assistant will also be responsible in follow-up surveys to providers that have taken the workshop (Awkward. The assistant will also be responsible for the monthly updates found in the newsletter. Most importantly, the assistant will be preparing the first drafts of the interim report and the final report. Finally, the assistant will provide feedback and support to the program director.

There is also a receptionist who is working at Veterans First. The receptionist will be directing service providers to contact the program director about the workshop. Some of the other tasks that the receptionist will be responsible for will include…

Budget Narrative

Personnel

The CT-PTSD workshop program series requires $132,347.00. The staff include: one half-time LCSW, one MSW student intern, and the receptionist at Veterans First. The social worker will be paid an hourly rate of $40 for 20 hours a week for 12 months ($40,000). Additionally, the LCSW will receive a travel pay stipend to offset mileage ($3,600). The MSW student intern will be an unpaid social work intern who will use this opportunity for his or her field placement during the school year. There will be a one-

time stipend ($2,500) and the intern will be present 16 hours per week. The receptionist is already hired at Veterans First. There is a personnel training cost of $1,200 for the LCSW to attend workshops, seminars, trainings related to complex trauma, PTSD, and veterans.

Additionally, there are two consultants that will be utilized during the workshop. A web designer who is paid to set up and maintain a website for the workshops. This web designer is also on call at any time during the day to ensure the website operates and is accessible ($3,000). The last consultant is external evaluator who would be hired through the CSULB Social Work Alumni Association. This evaluator will be a means to establish credibility of the CT-PTSD workshops. By having an independent evaluator from outside the program, objectivity and effectiveness can be maintained. The evaluator is paid 10% of the total cost of the grant (i.e. $13,000). The personnel costs subtotal was $66,500, before adding a 19% benefits cost of $12,635. The consultants subtotal was $16,000 and there is one travel expense provided to the program director (LCSW) of $3,600. This brought the personnel cost subtotal to $98,735.

Direct Operating Costs

The budget included a set of $10 gift cards, to be given to clinicians who attend the workshops and completed the surveys on survey monkey. It is assumed that 50 clinicians attended all 12 monthly workshops, and this totaled to $6000. Catering was also provided for the workshops, including a light breakfast snack/drink, and a catered lunch. This was calculated at a rate of $15 per person attending a 20 person (maximum) workshop each month ($3,600). CEU certification were offered for the workshops. The cost ($200 per workshop) would meet the requirements of the board of behavioral

sciences requirements for CEU hours. This applied to licensed Marriage and Family Therapists (MFTs), LCSWs, Licensed Educational Psychologists (LEPs), and Licensed Professional Clinical Counselors (LPCCs) who attended the workshop.

Office stationary included all the supplies that are used in commercial offices and workshops including a copier, paper, toner, pens, pencils brochures, business cards, fliers, markers, highlighters, staplers, tape, envelopes, and folders. This was calculated at $300 per month ($3,600). Computer equipment included two new computers and a projector ($4,000). One computer is a primary and a second is the backup, and the projector is used for the workshop presentations.

The room used for the workshop presentation is a 25 by 30 foot room and it is calculated at the average cost of $2 a square foot in the city of Santa Ana. This was an in-kind donation of about $18,000 from Veterans First. Additionally, there was an office space which is shared with a veteran's service representative. This was also an in kind donation of $3,600 from Veterans First. Internet is provided through the Veterans First internet service provider and was considered in kind ($720). The fee for training staff was approximately $1200 which included course fees and materials, and the training which was eligible for CEU credit. The training consisted of online courses in PTSD and trauma related therapy, for a total of 21 credit hours. All the workshop surveys were conducted with Survey Monkey's one year premium level of service ($780). The cost of the gifts cards was $6,000 dollars in cost with $1,000 in kind from sponsored donations. The catering cost $3,600. The CE certification cost $2,400. The office stationary cost $3,600 and an additional $2,000 is in kind donations from using Veterans First own office supplies. The computer equipment cost $4,000 and has an additional $1,000 in in

kind donation from using Veterans First computer systems. This brings the direct operating subtotal to $21,580 in costs, and $26,320 in in-kind donations. There is indirect cost of 10% added to the direct operating subtotal of $12,032 and $2,632 of in kind donations. The personnel, direct, and indirect operating totals added up to a total cost of $132,347 and $28,952 of in kind donations for a grand total of $161,299.

CHAPTER 5

REFLECTIONS

Lessons Learned

When the grant writer set out to undertake this project, he already knew that veterans would be his target group. This was an essential stepping stone to having a successful and fulfilling grant writing experience. The grant writer is a veteran himself, so he felt that it was a subject with which he could personally connect. Additionally, the grant writer has friends and colleagues who are veterans who suffer from trauma, physical, emotional, and mental. So creating something that could possibly help people in a similar situation as his friends was personally important to him. There was some concern at the beginning of this process about whether he should have chosen a veterans' theme. However, after just talking with some other social work students who had already completed a grant, they had one piece of advice: choose something you like. This simple thought helped make the thesis process, which was at times tedious, an overall enjoyable endeavor. If the grant writer could say something to future groups of social work students who are about to start a grant, it would be this: choose something you like, look at a part that you do not know much about, and go out and talk to someone in your target population before writing anything.

Why Veterans? Well, Why Not?

The grant writer chose to do a workshop for service providers who treat or serve veterans with CT-PTSD. The choice of a veterans' focus was not entirely obvious at the start of this process. For a while the grant writer thought that doing something with active duty military personnel would be a more enjoyable but difficult target population to work with. The decision of veterans over active or reserve military was chosen for a couple of reasons. First was the obvious fact that the U.S. military has a near limitless budget. The military funds the projects that it deems worthy, and there are project groups that focus on different military field applications. The grant writer thought that this would not be as educational for future grant writing to focus on a workshop or project that is funded by a direct military budget. It would lose the purpose of experience in writing grants. Second was that the population of veterans is so much larger than the population of service members. The grant writer wanted to create a grant that would be able to help as many veterans as possible. So a workshop for the large veteran population had a number advantage over the active military as well.

The grant writer decided that he should go and talk to his target population before he would start to write anything down. At first he talked to his friends and associates in the veterans' centers in Orange County and at the VA hospital in Long Beach. Previously, the grant writer had done his community project at VALB with military sexual trauma victims. So the idea of trauma as a workable aspect was already present. The biggest experience was when the grant writer went to talk to a veteran service officer at VALB whom he knew. The reaction he got from the VSO was a bit of a surprise. The VSO was very upset about the grant writer wanting to do something related to trauma

with veterans. The VSO essentially told the grant writer that this was not appropriate because the veterans would get scared and leave his office if he mentioned anything like complex trauma. This left the grant writer thinking, *how could a VSO talk about these issues with a veteran?* Which led to the shift in the focus of the project. Instead of the veterans as the direct focus, it would be the service providers who work with veterans who would now be the reason for the workshop.

Get to Work

At this point the grant writer was able to create a proposal for a project he would like to see become a reality. Next was the actual project of researching CT-PTSD and previous attempts to work with veterans' service providers. The research of PTSD and complex trauma was an amazing and enlightening experience for the grant writer. It took up perhaps a hundred hours of searching and following leads. The experience was wonderful, despite the time consumption. Quickly, the grant writer realized how much information had been written about trauma as a human phenomenon. The history of trauma was the highlight of the project. The grant writer went as far back as the earliest writing and fables of antiquity. Starting with Homer, to Shakespeare up until the current lack of CT-PTSD in the DSM-5, it was an enriching experience. The thesis advisor described it as "falling into a rabbit hole", an analogy to Alice in Wonderland. Every time the grant writer thought he had reached as far as he could go, another whole angle, story, or aspect of military trauma would open up.

Brother, Can You Spare a Dime?

Once the project was underway, it became important to find an agency that would oversee this project. The grant writer first went around to the different service groups or

centers that helped veterans in Orange County. The grant writer's previous field experience had been with a non-profit agency in Santa Ana. When the grant writer went to Veterans First in Santa Ana and met with a case manager there, he knew that he had his partner agency. The group worked with veterans of all types, it worked with their families, and it was centrally located next to the county governance. The agency also had previously overseen grants so they had some experience with these types of projects.

Finding a funding source for the project was not too much of a difficulty. Because of the wars in Iraq and Afghanistan winding down, there has been what could best be described as a glut of money, resources, and interests around veteran centered care. Initially, the easy answer was to look for some rich companies who like flashy projects to fund. The workshop is not so flashy and deals with a rather delicate topic. For a while the Walmart Foundation was chosen as the funding source after a few internet searches. But after another visit to VALB, the grant writer encountered the Army Wounded Warrior Coordinator, and he advised the grant writer to look at groups such as the Wounded Warrior Project as a possible funding source. When the grant writer saw the application, he knew that he had his source. It was limited in its focus, it provided a budget that was not too large or too small, and the requirements of the grants were within the purview of the workshop. In fact, when the grant writer saw the requirements for a providers' workshop, they were already almost matching the goals and objectives of the proposed workshops. The grant writer would like to emphasis again that when a grant writer is stuck, it is always a good idea to stop and go spend time with a target population.

Grant Writing 2.0

For the grant writer, the high water mark was the literature review. Once that process was done, the rest of the grant pretty much fell into place. Having devoted so much time and effort to the subject gave the grant writer the constitution to finish. When the literature review was completed, there was a sense of fulfillment but also sadness. The effort was so great in that part of the grant that the grant writer hoped that each section after that would be an equal challenge with equal growth to match. Sadly, this was not the case, and the grant writer considered if he should have chosen a literature-based thesis instead of grant. The grant writer tried to spend as much time as he could seeing his thesis advisor. It appeared that the grant writer had his best creative moments in the presence of others. The ideas for improving the workshops came from talking to others rather than looking at what others had done before.

Thank a Vet

Veterans as a percentage of population are shrinking as is expected to drop by a third within the next 25 years (Weeks, & Auerbach, 2014). However, the monetary amounts going to the groups and organizations serving veterans probably will not. This means there will more funds for each veteran every year as this trend continues. One day this trend will stop, but for the near future this will be a group that social workers can work with, focus on, and expand services for. Social work in the active military is not very well understood or even advertised in the general military culture. The veterans that the grant writer talked to had this common experience about social work: none of them knew that social workers even existed when they were in the military. Before last year, the grant writer did not know social workers existed in the military at all, and did not

know a fellow service member who had ever met one while serving. One final piece of advice for future social work grant writers: promote active military social work. It has a lot of potential for growth, mainly because most service members know nothing about it.

APPENDIX

ONE YEAR BUDGER OF CT-PTSD WORKSHOP

Veterans First
Complex Trauma - PTSD Workshop
Duration of Program: One Year

	Project Effort	Total Cost	In Kind Support	Requested Amount
PERSONNEL COSTS				
Program Director (LCSW) @$40	20hr/wk.	$ 40,000	$ -	$ -
MSW Student (One Time Stipend)	16hr/wk.	$ 2,500	$ -	$ -
Receptionist @$12	20hr/wk.	$ 24,000	$ -	$ -
		$ -	$ -	$ -
		$ -	$ -	$ -
		$ -	$ -	$ -
Benefits @ 19%		$ 12,635	$ -	$ -
CONSULTANTS				
Website Developer @$250/mo.		$ 3,000	$ -	$ -
External Evaluator @10% Total		$ 13,000	$ -	$ -
Travel Expenses				
LCSW (One-Time)		$ 3,600	$ -	$ -
		$ -	$ -	$ -
PERSONNEL SUBTOTAL		$ 98,735	$ -	$ -
DIRECT OPERATING COSTS				
$10 Dollar Gift Cards x600		$ 6,000	$ 1,000	$ -
Caterings @$15*20*12		$ 3,600	$ -	$ -
CE Certification @$200/per		$ 2,400	$ -	$ -
Office Stationary		$ 3,600	$ 2,000	$ -
Computer Equipment		$ 4,000	$ 1,000	$ -
Workshop Space @ $1500/mo.		$ -	$ 18,000	$ -
Office Space @300/mo.		$ -	$ 3,600	$ -
Internet @$60/mo.		$ -	$ 720	$ -
Personnel Training		$ 1,200	$ -	$ -
Survey Monkey Platinum		$ 780	$ -	$ -
		$ -	$ -	$ -
		$ -	$ -	$ -
DIRECT OPERATING SUBTOTAL		$ 21,580	$ 26,320	$ -
INDIRECT COSTS @ 10%		$ 12,032	$ 2,632	$ -
The Foundation allows up to maximum of 10% for indirect costs. Please change formula if less is being requested.				
TOTAL COSTS		**$ 161,299**	**$ 28,952**	**$132,347**

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