ABSTRACT

EDUCATING VETERANS ON POST TRAUMATIC STRESS DISORDER

By

Delia Marie Astorga

January 2015

The purpose of this project was to create program, to identify funding sources, and to write a grant to fund a support group for veterans who suffer from Post Traumatic Stress Disorder (PTSD) at the DVA of Long Beach. The literature allowed this writer to find the main causes of PTSD in this case being exposed to combat, Traumatic Brain Injury (TBO), and the consequences to PTSD (substance abuse, commit suicide, experience family conflicts). This writer also found Cognitive Processing Therapy (CPT), Prolonged Exposure Therapy (PET), and Eye Movement Desensitization and Reprocessing (EMDR) to be effective intervention in treating veterans with PTSD. The proposed program is aimed at providing psychoeducation to veterans and to help improve the lives of our service men and women who suffer from PTSD. The program includes group counseling and as well individual counseling for veterans, family counseling. Providing the proper training will help social workers better assess and serve our veterans who return from combat with PTSD. Actual submission and/or funding of the grant were not required for the completion of this project.

EDUCATING VETERANS ON POST TRAUMATIC STRESS DISORDER

A THESIS

Presented to the School of Social Work

California State University, Long Beach

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

Committee Members:

Brain Lam, Ph. D (Chair)
Janaki Santhiveeran, Ph.D.
Lisa Jennings, Ph.D.

College Designee

Nancy Meyer-Adams Ph.D

By Delia Marie Astorga

B.A., 2011, California State University, Los Angeles

January 2015

ProQuest LLC.
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106 - 1346

TABLE OF CONTENTS

CHAPTER 1

INTRODUCTION

Veterans and Posttraumatic Stress Disorder: Overview

Posttraumatic Stress Disorder (PTSD), classified as trauma and stressor-related disorder. According to the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (*DSM-5*), is defined as "Any event (or events) that may cause or threaten death, serious injury, or sexual violence to an individual, a close family member, or a close friend, and symptoms for PTSD must be at least present for more than one month" (American Psychiatric Association, 2013, p. 265). According to the National Center for PTSD (2010b), symptoms for PTSD include: re-experiencing symptoms such as flashbacks or nightmares, reliving the trauma, including physical symptoms like a racing heart or sweating, bad dreams, and frightening thoughts. Avoidance symptoms include: staying away from places, events or objects that are reminders of the experience; feeling emotionally numb; feeling strong guilt, depression, or worry; losing interests in activities that were enjoyable in the past; having trouble remembering the dangerous event (U.S. Department of Veterans Affairs [DVA], 2014c).

The arousal symptoms for PTSD are: being easily startled, feeling irritable, difficulty concentrating, difficulty falling or staying asleep, and hypervigilance (National Center for PTSD, 2010b).

Laser and Stephens (2010) reported that 300,000 veterans who returned from Iraq and Afghanistan are diagnosed with PTSD. The authors also found that 320,000 veterans who served in the military would suffer from Traumatic Brain Injury (TBI; p. 33). Studies have found veterans with PTSD are more likely to abuse substances (Duckworth, 2011), commit suicide (DVA, 2013a), and experience family conflict (Sayers, Farrow, Ross, & Oslin, 2009).

Posttraumatic Stress Disorder and Family Relationships

Having a service person return from combat and being diagnosed with PTSD can be challenging for family members. During this time, family members and their loved ones would need to learn how to build communication and reconnect (Sayers et al., 2009). Returning home, veterans may want to regain their role in the family; however, the family members may not be ready for this type of change in the family (Laser & Stephens, 2010, p. 28). Veterans feel that if they were to share how they were doing, the process would delay their chances of being reunited with their family members, or may hurt their chance of returning to combat in the future (Darwin, 2009). Children are affected when a parent or a loved one has gone to combat. Children, when reuniting with their parent or loved one, may not remember their parent or a loved one and may need time to get to know him or her which may be painful for the veteran returning from combat (Petty, 2009).

As for couples "reunion begins with the honeymoon stage, which ends with the first argument" (Laser & Stephens, 2010, p. 33). The veterans returning home from combat may feel more comfortable being with their fellow service members than with

their partner or loved ones because they may not feel a connection with their family. This may cause resentment for many partners and loved ones as they "feel a sense of abandonment, frustration, and anger" (Laser & Stephens, 2010, p. 33).

Posttraumatic Stress Disorder and Substance Use

According to the Duckworth (2011), veterans who suffer from PTSD often turn to alcohol and drugs as a way to self-medicate and in order to cope with the trauma from reoccurring nightmares and flashbacks of being at war. Duckworth's research found that as many as 43% of veterans with PTSD develop substance abuse issues, compared to 25% among veterans without PTSD (p. 6). Veterans who are diagnosed with substance abuse and PTSD are diagnosed with major depression and/or anxiety disorder (Duckworth, 2011). As a therapist, the initial emphasis should be at the treatment of early signs of PTSD in order to prevent the reoccurring cycle and the use of substance use while also decreasing the likelihood of developing other mental disorders (Duckworth, 2011).

The Michigan Health System and Ann Arbor Healthcare System VA Medical Center found that veterans who suffer from PTSD along with drug and alcohol addiction had a higher risk of deaths (DVA, 2014b, p. 23). The research also found that veterans who suffered from PTSD and suffered from substance abuse disorder found that veterans who were under the age of 45 showed a correlation between "substance-use disorders and both injury and non-injury related deaths" (DVA, 2014e, para. 7). Injury related deaths in this case include homicides, suicides, and accident, whereas non-injury related death include heart disease, cancer, and other health problems (DVA, 2014e). Providers should

educate veterans and family members on the services available at the VA Medical Center to help treat substance use. During the treatment the provider and the patient will be able to address the issues of substance use and PTSD, which will help reduce the mortality rate (DVA, 2014e).

Posttraumatic Stress Disorder and Suicide

Veterans who suffer from PTSD and use drugs to cope are at a high risk of committing suicide (Duckworth, 2011). Veterans who have experienced trauma develop suicidal feelings (Duckworth, 2011). The DVA between the years of 2005 and 2007 found that more than 16 veterans died by suicide each year due to memories of combat guilt (Duckworth, 2011). According to the U.S. DVA (2013a), California and Texas have the highest suicide rates. The DVA found in 2013 that 22 veterans a day and one active duty soldier will take his or her own life (DVA, 2013c). Veterans often turn to suicide as their only option to relieve suffering and shame associated with PTSD rather than seeking assistance. It was also found that 30 % of veterans have considered suicide (DVA, 2013c). Veterans who are currently receiving treatment are less likely to commit suicide or exhibit suicidal behaviors (Duckworth, 2011).

Current Effective Interventions for Posttraumatic Stress Disorder

There are questions about what types of interventions are available for veterans who suffer from PTSD. A review of the literature reveals that mental health providers are currently using the following interventions: Cognitive Processing Therapy (CPT), Prolonged Exposure Therapy group therapy, and medication (Duckworth, 2011). The treatment specialist must emphasize to family members the importance of initial

treatment for early signs of PTSD, and educate them about the options of psychotherapy and medication that can effectively reduce symptoms. Mental health care providers can help treat veterans with early signs of PTSD and reduce suicide rates, as well as lower drug and alcohol abuse rates.

Cognitive Processing Therapy is defined as an "adaptation of the evidence-based therapy known as Cognitive Behavioral Therapy (CBT) used by clinicians to help clients explore the process of recovery from PTSD and related conditions" (Monson et al, 2006, p. 901). The veteran will meet with the provider for 12 individual sessions for 90 minutes. During the initial treatment, the provider educates veterans on symptoms of PTSD, which is explained in "cognitive and information-processing theory framework" (Monson et al., 2006, p. 901). At the end of the first session, the provider asks patients to write what is called an "impact statement" (Monson et al., 2006, p.901). The impact statement includes writing a meaning of the traumatic event that took place, along with the patient's beliefs why this traumatic event occurred (Monson et al., 2006). During session two, patients are asked to read what they wrote and discuss it. In this session, patients are asked to identify the relationship between events, thoughts, and feelings, and sent home to practice as homework (Monson et al., 2006). In session three, patients with their provider review the homework, and they are also asked to write about their most traumatic event in combat (Monson et al., 2006). During session four, patients are asked again to write about the trauma but in more detail including their emotions, thoughts and beliefs (Monson et al., 2006).

In session five, the provider uses the Socratic style of questioning which includes: questions for clarification, questions that probe assumptions, questions that probe reasons and evidence, questions about viewpoints and perspectives, questions that probe implications and consequence, and questions about the issues (Monson et al., 206, p. 901). Using the Socratic style method helps patients become more involved in therapy and allows them to feel comfortable asking questions regarding their assumptions and self-statements (Monson et al., 2006). During the final two sessions, six and seven, patients are taught how to utilize worksheets in order to challenge and learn how to change their thoughts and feelings relating to their traumatic experience of being in combat in their day to day lives (Monson et al., 2006). In the last five sessions of treatment, their beliefs about safety, trust, self-esteem and intimacy as they relate to others are challenged. These sessions are given twice a week and are videotaped. CPT helps treat veterans who suffer from PTSD. During the treatment, CPT focuses on a range of different emotions along with anxiety, which are caused by trauma, shame, sadness, and anger (Monson et al., 2006). CPT works because it helps patients develop coping skills in order to deal with stressful situations. It helps veterans have a better understanding of their trauma and how it has impacted their thinking.

Prolonged Exposure Therapy (PET) is a form of therapy that helps reduces the pain in one's own experience in trauma (DVA, 2014d). PET has been found to help patients by approaching trauma-related thoughts, feelings, and situations that they may be avoiding (DVA, 2014d). PET has four main parts: (a) education, (b) breathing, (c) real world practice, and (d) talking through the trauma.

PET starts with the provider educating the veteran on treatment. Next, the veteran learns about his or her reactions related to PTSD. This allows the veterans to learn more about the symptoms relating to PTSD along with understanding the purpose of treatment (DVA, 2014d). The next phase of treatment is developing breathing techniques in order to help the patient relax. When one becomes anxious one's breathing may change. In order to reduce distress, one must learn how to control one's breathing by using breathing techniques (DVA, 2014d).

Next, the provider and the patient practice a real life situation which is called in vivo exposure (DVA, 2014e). The provider works with the patient's situation which the patient may avoid due to trauma exposure. The goal in this session is to help the patient be able to approach situations with a sense of feeling safe. For example, a sexual trauma survivor may avoid going places alone or individual places in fear of being attacked or reminded of similar places. This type of exposure practice can help the veteran gain control of his or her life and reduce feelings of distress related to trauma (DVA, 2014e).

Imaginal Exposure is a component of the prolonged therapy. The therapist encourages veterans to articulate their trauma to foster a sense of control of their thoughts, feelings related to trauma. The patient can feel unafraid of recurring memories of the trauma. This may be difficult for a veteran to perform; however, many patients have felt better over time by talking to a provider, and it helps to make sense of what happened on the day the event took place and helps reduce negative thoughts (DVA, 2014e).

PET has been found to reduce PTSD symptoms in a wide range of populations such as rape survivors and men and women who have been exposed to combat (Foa, Gillihan, & Bryant, 2013). With the help of the provider, the patient changes how he or she may react to stressful memories of trauma over time. PET consists of eight to 15 sessions for 90 minutes along with practice assignments done at home (DVA, 2014b).

Duckworth, (2011) reported that veterans who joined group therapy found it to be helpful because they felt that they were able to share similar experiences with other veterans who had been exposed to combat and experienced similar symptoms of PTSD. Veterans also found it to be uplifting and felt a great amount of support especially when feeling alone or isolated. Group therapy helps in lessening feelings of shame by providing them with support and reducing feelings of helplessness (Monson et al., 2006; p.14).

Medication is shown to be effective in treating veterans with PTSD and reducing symptoms along with psychotherapy. Medications such as antidepressants, beta-blockers, mood stabilizers and antipsychotics, and sleep restoration medication have been shown to help veterans with PTSD (Duckworth, 2011). Anti-depressants such as serotonin reuptake inhibitor (SSRIs) help reduce the symptoms of PTSD (Duckworth, 2011). Beta-blockers, a type of medication used to treat high-blood pressure, have been found to help treat PTSD (Duckworth, 2011). Mood stabilizers and antipsychotic medications have been helpful in reducing aggression and reducing mood instability (Duckworth, 2011). Along with being able to restore sleeping patterns with the use of generic medication, this is an essential to recovering from PTSD for veterans

(Duckworth, 2011). It is important that mental health care providers educate veterans about medication and why they should take their medication along with coming for therapy in order to reduce the recurring cycle of symptoms of PTSD (Duckworth, 2011).

Goal of the Project

The purpose of this project is to write a grant proposal and identify funding sources to design an educational program aimed at increasing the awareness about PTSD. It is crucial to bring awareness to veterans and their families about mental health services provided at the VA Medical Centers located in Long Beach in order to help treat PTSD through early treatment of psychotherapy, medication, and support resources. Most importantly, by educating veterans early on the services available to them for PTSD located at VA Medical Centers it will reduce the damage and promote recovery and reintegration back into society.

Methods

Target Population

The population target in this grant is veterans over the age of 18-years-old and serving in the military. As of 2013, there were 21.4 million men and women serving in the military (DVA, 2014d). According to the DVA (2014d), 6 out of 10 men and women will experience at least one type of trauma in their lifetime. According to research, 7 or 8 out of every 100 will develop PTSD. Also, 5.2 million adults had PTSD (DVA, 2014d). According to a study conducted by the DVA, it was found that women were 10% more likely than their male counterparts at 5% to experience PTSD. In 2014, the DVA found

that 28% of Hispanics, 21% of African Americans, and 14% of Whites suffered from PTSD (2014c).

Strategies for Identifying and Selecting Potential Funding Resources

The strategies to finding potential funding sources will include online web searches, looking at the non-profit websites at the local, state and federal levels. Finding potential funding sources will also include visiting the nonprofit library. This strategy includes attending the Long Beach VA Medical Center located in Long Beach, California, along with going on the VA website.

In searching for an appropriate funding source with a mission that would support the application of the foundation and agencies would be considered. A search of federal, state, county, and locate private and public agencies would be conducted. There are a variety of internet databases that provide resources to locate sources including National Alliance of Mental Illness Veteran Resource Center (AMIVRC; http://www.nami.org/ template.cfm? section=PTSD), USC Social Work Center for Innovation and Research on Veterans & Military Families (http://cir.usc.edu/research/research-projects) and Grants.gov (www.grants.gov) which provides information for available grants.

After a preliminary review of possible organizations as potential funding resources, the Veterans Support Foundation stood out as a possible agency. The Veterans Support Foundation is a nonprofit 501 (c) (3) humanitarian and educational organization. This foundation's mission is to improve the quality of life for veterans and their family members. The Veterans Support Foundation office is located in Silver Spring, Maryland. The objective of the Foundation is to:

> To help fund nonprofit organizations in support of veteran related projects throughout the United States; to assist disabled veterans and their qualifying dependents family members; to assist and provide transitional and permanent housing for homeless and at risk veterans; to enrich the lives of all veterans and their families. (Veterans Support Foundation, 2009, p.4)

The Veterans Support Foundation was first established in 1991 in the state of Delaware. In 1991, the Foundation was called the Vietnam Veterans Assistance Fund, but was renamed the Veterans Support Foundation founded by and for veterans. The Foundation currently helps serving veterans and their family members by giving grants to different organizations that help with housing, education and medical needs (Veterans Support Foundation, 2009). Since 2003, the Veterans Support Foundation has expanded over $2.5 million in support of programs listed above. This will be one of the organizations that will be researched further as a potential funding source for this project.

Potential Sources for Information for the Grant

The grant problem statement is designed to show the need of targeting veterans who suffer from PTSD in Long Beach, California while at the same time increasing awareness. Resources used in this particular grant included: the U.S. Census Department, and CA.GOV. The U.S Census Bureau showed the growing population of veterans. The CA.Gov website, under the alcohol and drug program, focuses on veterans and service members. This site focuses on women veterans who serve on the front line, along with veteran's issues, which discuss the most common issues veterans face while in the military. The site also talks about how veterans are at high risk for suicide. The

CA.Gov (http://www.ca.gov) provides statistics on veterans who suffer from PTSD along with other issues while being in the military. These statistics allow the grant seeker the ability to show the need for the proposed program and make a case that the population is in greater need of services than other populations.

Cross-Cultural Relevance

NAMI reported that ethnic minority veterans have a higher rate of PTSD than Whites because minorities had a higher stress level during combat (as cited in Duckworth, 2011). It also reported that ethnic minorities veterans also had a high level of PTSD. Ethnic minorities who had high levels of PTSD had difficulties gaining access to care. The NAMI found that ethnic groups had higher rates of past traumas, major depression, and/or substance use (as cited in Duckworth, 2011).

The NAMI found that women experience PTSD at twice the rate as men (as cited in Duckworth, 2011). Women who suffered from PTSD "had a past of mental health problems, experienced a severe or life-threatening trauma, were sexually assaulted, were injured during the event, had a severe reaction at the time of the event, experienced other stressful events afterwards, and did not have a good social support" (Duckworth, 2011, p. 10). In the military, women were at twice a greater risk for developing PTSD because they experienced a high level of stress, sexual harassment, or sexual assault while in the military compared to their male counterparts (Duckworth, 2011). In addition, studies also found that women were 4 times more likely to take longer at recovering from PTSD, and are 4 times more likely than men to experience long lasting PTSD (Duckworth,

2011). These are the reasons why women are more at risk for developing PTSD compared to their male counterparts.

Woman veterans are more likely than their male counterparts to seek treatment for PTSD and seek help. A study in the National Center for PTSD (2014) found that women responded better to treatment when compared to men. Women during treatment were more willing to share how they felt and discuss their personal problems compared to their male counterparts who are less willing to talk about their feelings and personal problems (DVA, 2014c).

Social Work Relevance

According to the National Social Worker Association's (NASW:; 2008) *Code of Ethics*, the core values to social work are the following: "service, social justice, dignity and worth of a person, importance of human relationships, integrity, and competence" (p.1). In this case, veterans are among the most vulnerable in society, so it is part of a social worker's ethical duties to provide services to this population. This proposal will provide insight or additional information for prevention particularly; the focus of this proposal is to enhance awareness of the veterans about PTSD. This sense of awareness is an essential component for treatment within this population.

CHAPTER 2

LITERATURE REVIEW

This chapter is a review of the literature that describes PTSD and addresses it among veterans, PTSD: Overview, PTSD among veterans, combat exposure and PTSD, consequence of PTSD, current effective interventions for PTSD, and disability assessment for PTSD.

Posttraumatic Stress Disorder Overview

In the DSM-V (American Psychiatric Association, 2013) PTSD is classified PTSD is classified as Trauma and Stressor Related Disorder and is defined as "an event (or events) that may cause or threaten death, serious injury, or sexual violence to an individual, a close family member, or a close friend" and the symptoms for PTSD must be at least present for more than 1 month (p. 265). In the *DSM-5*, symptoms that accompany PTSD are divided into 4 clusters:

1. Re-experiencing: spontaneous memories of the traumatic event, recurrent dreams related to it, flashbacks or other intense or prolonged psychological distress.

2. Avoidance: distressing memories, thoughts, feelings or external reminders of the event.

3. Negative cognitions and mood: myriad feelings, from a persistent and distorted sense of blame of self or others, to estrangement from others or markedly diminished interest in activities, to an inability to remember key aspects of the event.

4. Arousal: aggressive, reckless or self-destructive behavior, sleep disturbances, hyper-vigilance or related problems (American Psychiatric Publishing, 2013, p. 1).

According to the DVA (2014c), approximately 60% of men and 50% of women will experience at least one type of trauma in their lifetime. The DVA (2014c) found that women were more likely to experience sexual abuse as a child and sexual assault, whereas men are more likely to experience physical assaults, combat disaster, accident, or witness a death or injury. The DVA (2014c) found that 7-8% of the U.S. population will have PTSD at one point in their lifetime. Approximately 5.2 million adults will develop PTSD in a year (DVA, 2014c). The likelihood of developing PTSD is higher for women (10%) compared to 5% of men (DVA, 2014c).

Risk factors for developing PTSD have been identified according to the U.S. DVA (2014c). One is at risk of developing PTSD if he or she: (a) was directly exposed to the trauma as a victim or witness, (b) was seriously hurt during the event, (c) went through a trauma that was long-lasting and very severe, (d) believed that he or she was in danger, (e) believed that a family member was in danger, (f) had a severe reaction during the event, and (g) felt helpless during the trauma. Other risk factors include having an earlier trauma, having another mental health issue, having family members with mental health problems, having recently lost a loved one and/or had stressful life changes, and

excessive drinking. Being a woman, younger, poorly educated, and an ethnic minority have also been identified as risk factors (DVA, 2014c).

Posttraumatic Stress Disorder among Veterans

There are over 300,000 veterans returning from combat and suffering from PTSD. The DVA (2014a) defined veteran as "an individual who served their full obligation of active duty service in the military, or received an early discharge for a medical condition, hardship, reduction in force, or at the convenience of the military"(p. 25). Many veterans have seen combat and have been exposed to life-threatening situations such as being shot at, seeing their fellow service men and women shot, or having explosives being thrown at their recreational vehicle (O'Hanlon & Campbell, 2008). In 2008, there were more that 1.6 million Operation Enduring Freedom (OIF)/ Operation Iraqi Freedom (OEF) veterans who had been deployed to Iraq and Afghanistan more than once (Veterans for Common Sense, 2008). By December 2008, more than 42,000 veterans had been killed and over 30,800 veterans had returned from combat with visible wounds and disabilities (O'Hanlon & Campbell, 2008). The prevalence of psychological and neurological wounds among veterans has been estimated to be 25-40% (Tanielian & Jaycox, 2008).

According to the DVA (2014c), as many as 20% of OIF/OEF veterans who return from Iraq and Afghanistan develop PTSD. Also, 10% of Gulf War (Desert Storm) veterans and 30% of Vietnam veterans are believed to have developed PTSD. PTSD is also caused from military sexual trauma (MST), which refers to sexual harassment or sexual assault that occurs while one is in the military (DVA, 2014c). Men and women can be exposed to MST (DVA, 2014c). The DVA (2014c) found that 23 out of 100

women reported sexual assault while in the military and 55 out of 100 women and 38 out of 100 men experienced sexual harassment while in the military.

Combat Exposure and Posttraumatic Stress Disorder

Combat exposure is defined as "exposure to typical warfare experiences such as firing a weapon, being fired on, and witnessing injury and death" (Vogt et al., 2011, p. 799). The study also found that veterans were exposed to: "artillery, rocket or mortar fire (87%), gunshot (80%), seeing dead bodies or human remains (65%), being attacked or ambushed (74%), and knowing someone seriously injured or killed (63%)" (Peterson, Luethcke, Borah, & Young-McCaughan, 2011, p. 165). In the past 9 years, there have been over 2 million veterans who have been sent in support of OIF in Iraq and OEF in Afghanistan. It has been found that between 5-17% of veterans who have returned from combat were found to be at risk for combat-related PTSD (Peterson et al., 2011). Upon returning from combat, many veterans will seek mental and medical health care. Veterans who return from combat who are either OIF or OEF will develop acute stress disorder (ASD) and/or PTSD, which places them at risk for developing psychological problems (Engelhard et al., 2007). The National Comorbidity Survey (NCS) assessed 5, 877 veterans between the ages of 15-54 for PTSD symptoms in the United States (Peterson et al., 2011). The prevalence of PTSD was found to be higher in women (10%) than in men (5%; Peterson et al., 2011). Peterson et al. (2011) found that 61% of men compared to 51% of women reported exposure to trauma. In addition, the survey found that 46% of women and 65% of men developed PTS as a result of rape (Peterson et al., 2011). However, the survey also found that 9% of women and 1% of men reported being

raped (Peterson et al., 2011). NCS found that 39% of men had combat-related trauma which was the most common cause of developing PTSD, while none of the female veterans in this study has experienced combat-related trauma (Peterson et al., 2011)

Veterans who return from combat in OIF/OEF have been evaluated for the risk of developing combat-related PTSD (Hoge et al., 2004). In addition, PTSD is connected with combat experiences such as "being attacked or shot at, firing on or killing the enemy, and seeing or handling human remains" (Peterson et al., 2011, p. 165). These factors increased diagnosis for PTSD in veterans who have been injured or wounded while in combat. However, reports have pointed out that combat-related PTSD can be found in those not identified as combatants. The study found that 5% of OIF/OEF veterans reported PTSD symptoms and combat-related PTSD compared to 30-45% of veterans who reported a high rate of PTSD symptoms and combat-related PTSD (Peterson et al., 2011, p. 165).

In the literature, women veterans have been found to be more vulnerable to trauma exposure. Female veterans compared to their male counterparts have reported less exposure to combat-related stressors, but instead have a higher rate of exposure to life stress and sexual harassment during deployment (Vogt et al., 2011). Female veterans have experienced a high level of combat exposure in Afghanistan (OEF) and Iraq (OIF). However, women have been banned from engaging in tasks that involve combat because women are at risk for combat exposure (Vogt et al., 2011). It has been found that 750 women veterans have been wounded or killed during combat (Vogt et al., 2011, p. 798). Women have been banned from combat while men reported having a higher level of

combat exposure. In a national sample of U.S. OIF/OEF veterans, 45% of women and 50% of men reported experiencing combat exposure (Vogt et al., 2011, p. 798). In addition, another study reported that men were more likely than female counterparts to report being in firefights: 47% versus 36% (Vogt et al., 2011, p.798). In addition, men reported shooting at the enemy on the opposite side (15% versus 7%); however, women were more likely to report handling remains (38% and 19%) when compared to their male counterparts (Vogt et al., 2011, p. 798).

Women are at risk for being exposed to combat in OIF/OEF. This research gave a better understanding of the differences in gender. In addition, another sample found that women veterans compared to male veterans screened higher for mental health problems when exposed to combat (17% compared to 9%; Vogt et al., 2011).

Consequences of Posttraumatic Stress Disorder

The negative consequences of PTSD have been well documented. The negative repercussions that result from veterans having PTSD include PTSD affecting family relationships (Lasers & Stephens, 2010), PTSD and substance use (Duckwork, 2011), and PTSD-related suicide (DVA, 2013d).

Posttraumatic Stress Disorder and Family Relationships

Service members returning from combat can be a challenge for family members. Veterans feel that if they were to share their trauma, it would delay the process and their chances of being reunited with their family members, or may hurt their chance of returning to combat in the future (Darwin, 2009). Returning home from combat can be a time of joy but at the same time, it can be stressful when trying to reintegrate into civilian

life. Upon returning home, OIF/OEF veterans will experience a high level of conflict with family and social relationships such as recurrent arguments and poor communication (National Center for PTSD, 2010a). Also, it is not uncommon for veterans and their spouses to have "expectations of a rapid return to normal" (American Psychological Association, Presidential Task Force on Military Deployment Services for Youth, Families and Service Members., 2007, p. 56). Veterans who have gone to combat for a long period find it difficult to return to their role as a spouse, mother, daughter, and sister and can be difficult especially when dealing with a traumatic event and injury when returning home from combat (Foster & Vince, 2009). Upon returning home, veteran women are expected to take care of the children and work around the house in addition to maintaining employment. Some may also take on the caregiving role of their military partner or spouse (Foster & Vince, 2009). Family members must understand that veterans who return from combat may not be the same as when they were recruited and deployed. Veterans who return from combat may exhibit violent tempers, numbness, show a lack of interest in their daily life, and may be unable to solve problems (DVA, 2008). During this time, family members and their loved ones would need to learn how to build communication in order to reconnect (Sayers et al., 2009).

Having PTSD affects the veteran's ability to work, maintain relationships with family and friends, and interact within an environment. Vietnam veterans who suffer from PTSD were more likely to divorce and experience multiple divorces compared to veterans without PTSD (American Psychological Association, Presidential Task Force on Military Deployment Services for Youth, Families and Service Members., 2007). Having

PTSD affects the veteran's job performance such as difficulties concentrating on the job, handling high levels of stress, working with others, taking orders from a supervisor, and maintaining attendance (American Psychological Association, Presidential Task Force on Military Deployment Services for Youth, Families and Service Members., 2007). Suffering from PTSD can cause veterans to isolate from the outside world as they are triggered by certain sights, smells, sounds, and feelings which might remind them of a traumatic event or a time when they were in combat (American Psychological Association, Presidential Task Force on Military Deployment Services for Youth, Families and Service Members., 2007).

Children and spouses of veterans may also display symptoms of PTSD; a phenomenon known as secondary traumatization (Ochber & Peabody, 2008). Ochberg and Peabody (2008) found that children are at high risk for intergenerational transmission of trauma. For example, a parent will teach a child to avoid certain discussions, situations, thoughts, or emotions, and as a result, the child's anxiety level will rise (Ochber & Peabody, 2008). Children are also afraid of provoking the veteran's symptoms leading children to developing their own ideas as to what the veterans may have experienced in combat which can be more terrifying to a child (Ochber & Peabody, 2008). Disclosing to a child about what happened in combat can also be an issue. By doing so, a child can develop PTSD symptoms in response to the graphic details and images (Ochber & Peabody, 2008). Children who live with a traumatized parent will relate with the parent, and as a result, they can develop the same types of symptoms (Ochber & Peabody, 2008).

Posttraumatic Stress Disorder and Substance Use

According to Duckworth (2011), veterans who suffer from PTSD often turn to alcohol and drugs as a way to self-medicate and in order to cope with the trauma from reoccurring nightmares and flashbacks from combat. Duckworth's research found that as many as 43% of veterans with PTSD develop substance abuse issues, compared to 25% among veterans without PTSD. Veterans who are diagnosed with substance abuse and PTSD can later be diagnosed with major depression and/or an anxiety disorder. As a therapist, the early emphasis should be the treatment of the early signs of PTSD in order to prevent the reoccurring cycle of substance use while also decreasing the likelihood of developing other mental disorders (Duckworth, 2011). Veterans who suffer from recurring flashbacks also use drugs to cope and are at higher risk of suicide (Duckworth, 2011).

Male veterans were at a higher risk for drinking and abusing alcohol compared to female veterans (Substance Abuse and Mental Health Services Administration [SAMHSA], 2012). In comparison, female veterans were more likely to develop PTSD and depression than male veterans (Tolin & Foa, 2006). The VA's healthcare reported that more than 11% of OIF/OEF veterans were diagnosed with a substance use disorder (SUD; Seal, 2011). The VA data also showed that 22% of OIF/OEF veterans who are diagnosed with PTSD also were diagnosed with SUD (Brancu, Straits-Tröster, & Kudler, 2011). Studies have also shown that OIF/OEF veterans had a high rate of abusing and misusing alcohol (Calhoun, Elter, Jones, Kudler, & Straits-Troster, 2008). Veterans have been found to abuse alcohol as a way to numb their feelings and any thoughts that remind

them of combat (National Center for PTSD, 2010a). For example, OIF veterans who have been exposed to combat which involved violence or trauma are at a greater risk of using higher doses of alcohol (Kilgore et al., 2008).

According to the research from the Michigan Health System and Ann Arbor Healthcare System from the VA Medical Center (DVA, 2014b), veterans who suffer from PTSD along with drug and alcohol addiction had a higher risk of deaths (DVA, 2014b). Injury related deaths in this case included homicides, suicides, and accidents, while non-injury related deaths included heart disease, cancer, and other health problems (DVA, 2014f). As providers, it is important to educate veterans and family members about the services available at the VA Medical Center to help treat substance use. In the treatment, the provider and the patient will be able to address the issues of substance use and PTSD which will help reduce the death rate (DVA, 2014f).

Posttraumatic Stress Disorder and Suicide

Veterans who suffer from PTSD are at a higher risk of committing suicide. Veterans who have experienced trauma develop suicidal feelings. According to the DVA (2013a), California and Texas have the highest suicide rates. The DVA found 22 veterans and one active duty soldier took their own lives in 2013. Veterans often turn to suicide as their only option to relieve suffering and shame associated with PTSD rather than seeking assistance. It was also found that 30 % of veterans have considered suicide (DVA, 2013a). In 2009, among OIF/OEF veterans, 94 men and 4 women completed acts of suicide (Miles, 2010). Miles (2010) found that between 2002 and 2005, male veterans had a higher rate of committing suicide compared to female veterans. Male and female

veterans had a higher rate of committing suicide compared to the general population (Miles, 2010). In addition, in 2010 the Department of Defense found that more than 6,000 veterans each year took their own lives, which resulted in the VA increasing its efforts to help prevent suicide among veterans (Miles, 2010). Veterans who have mental disorders such as depression, PTSD, TBI, and SUDs had a high rate of suicide (Brancu et al., 2011). Jakupcak et al. (2009) found that veterans who suffered from PTSD were 4 times more likely to have suicidal thoughts compared to non-veterans. Jakupcak et al. also found that veterans who were not married had a high rate of suicide risk. It is important as health care providers to screen veterans for the risk of PTSD, depression, and substance along with alcohol abuse in order to treat them early. When working with veterans, it is important to look for warning signs such as "threatening to, or talking about wanting to hurt, or kill one-self, feelings of hopelessness, feeling uncontrolled anger or rage, and feeling trapped" (National Center for PTSD, 2010b, p. 8). Veterans who are currently receiving treatment are less likely to commit suicide or exhibit suicidal behaviors (Duckworth, 2011).

Current Effective Interventions for Posttraumatic Stress Disorder

Veterans who suffer from PTSD lack adequate treatment, which leads to family relationship problems, substance use, and suicide. The VA currently uses Cognitive Process Therapy (CPT), Eye Movement Desensitization and Reprocessing (EMDR), and Prolonged Exposure Therapy (PET) as interventions in order to help treat PTSD along with group and individual counseling, and medication for veterans. It is important that

therapists, medical doctors, psychologists and other mental health providers have an understanding of the severity of trauma in order to better service veterans.

Cognitive Processing Therapy

Cognitive Processing Therapy (CPT) is an "adaptation of the evidence-based therapy known as Cognitive Behavioral Therapy (CBT) used by clinicians to help clients explore the process of recovery from PTSD and related conditions" (Monson et al., 2006, p. 901). The veteran will meet with the provider for 12 individual sessions for 90 minutes each. During the initial treatment, the provider educates veterans on symptoms of PTSD which is explained as "cognitive and information-processing theory framework" (Monson et al., 2006, p. 901). At the end of the first session, the provider asks patients to write what is called "impact statement" (Monson et al., 2006, p.901). The impact statement includes writing a meaning of the traumatic event that took place, along with the patient's beliefs of why this traumatic event occurred (Monson et al., 2006). During session two, patients are asked to read what they wrote and discuss it. In this session, they are asked to identify the connection between events, thoughts, and feelings (Monson et al., 2006). In session three, patients with their provider review the homework and they are also asked to write about their most traumatic event in combat (Monson et al., 2006). During session four, patients are asked again to write about the trauma but in more detail including their emotions, thoughts and beliefs (Monson et al., 2006).

In session five, the provider uses the Socratic style of questioning which includes: questions for clarification, questions that probe assumptions, questions that probe reasons and evidence, questions about viewpoints and perspectives, questions that probe

implications and consequence, and questions about the questions (Yang, Newby & Bill, 2005, p167). Using the Socratic methods helps patients become more involved in therapy and allows them to feel comfortable asking questions regarding their assumptions and self-statements (Monson et al., 2006). During the final two sessions, six and seven, patients are taught how to utilize worksheets in order to challenge and learn how to change their thoughts and beliefs relating to their traumatic experience of being in combat in their daily lives (Monson et al., 2006). In the last five sessions of treatment, their beliefs in safety, trust, self-esteem and intimacy as they relate to others are challenged. During the treatment, CPT focuses on a range of different emotions including shame, sadness, and anger, along with anxiety, which may have been caused by trauma (Monson et al., 2006). CPT works because it helps patients develop coping skills in order to deal with stressful situations. It helps veterans have a better understanding of their trauma and how it has impacted their thinking.

Prolonged Exposure Therapy

Prolonged Exposure Therapy (PET) is a form of therapy that helps reduce the pain in one's own experience in trauma (DVA, 2014b). PET has been found to help patients by approaching trauma-related thoughts, feelings, and situations that they may be avoiding (DVA, 2014b). PET has four main parts: (a) education, (b) breathing, (c) real world practice, and (d) talking through the trauma.

PET starts with the provider educating the veteran on treatment. Next, the veteran learns about his or her reactions related to PTSD. This allows the veterans to learn more about the symptoms relating to PTSD along with understanding the purpose of treatment

(DVA, 2014b). The next phase of treatment is developing breathing techniques in order to help the patient relax. When one becomes anxious and/or scared, one's breathing may become shallow. In order to reduce distress, one must learn how to control his or her breathing by using breathing techniques (DVA, 2014b).

Next, the provider and the patient practice a real life situation which is called in-vivo exposure (DVA, 2014b). The provider works with a situation where the patients may avoid discussion due to trauma exposure. The goal in this session is to enable the patient to approach situations with a sense of safety. For example, a sexual trauma survivor may avoid going places alone or certain places in fear of being attacked or reminded of similar places. This type of exposure practice can help the veteran gain control of his or her life and reduce feelings of distress related to trauma (DVA, 2014b).

PET is a component of prolonged therapy. The provider encourages veterans to articulate their trauma to foster a sense of control of the veteran's thoughts and feelings related to trauma. The patient can feel unafraid of recurring memories of the trauma. This may be difficult for a veteran to perform; however, many patients have felt better over time by talking to a provider; it also helps to make sense of what happened on the day the event took place and helps reduce negative thoughts (DVA, 2014b).

PET has been found effective in reducing PTSD symptoms in a wide range of populations such as rape survivors and men and women who have been exposed to combat (Foa, Gillihan, & Bryant, 2013). With the help of the provider, the patient changes how he or she may react to stressful memories of trauma over time. PET

consists of eight to fifteen sessions for 90 minutes along with practice assignments done at home (DVA, 2014b).

According to the Naval Center for Combat and Operational Stress Control (NCCOSC; 2009), PET and CPT are effective in treating veterans with PTSD and operation's stress injuries (Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010). It has also been found to help reduce symptoms of PTSD and have a positive effect on one's life. PET has been found also to help increase one's confidence and daily functioning, along with reducing feelings of fear when dealing with real life situations. Healthcare providers have noticed PET was effective in reducing anger and guilt among patients with PTSD. PET has been found to be the most effective in treating veterans who suffer from PTSD.

Eye Movement Desensitization and Reprocessing

Eye Movement Desensitization and Reprocessing (EMDR) was established by Shapiro (1987). EMDR has been used across the United States in clinics and institutions. Shapiro noticed that moving her finger back and forth had a reducing effect on her disturbing thoughts (Lee, Beaton, & Ensign, 2003). EMDR helps patients recall disturbing thoughts by watching a finger move side to side (Lee et al., 2003). Shapiro, in 2001 found that EMDR also helped decrease symptoms of anxiety. EMDR has been found to effectively help treat veterans with anxiety related symptoms (Lee et al., 2003). Research indicates that EMDR is effective in treating various mental health problems including anxiety, depression, panic disorders, grief, addictions, and PTSD (Lee et al., 2003). EMDR has been considered to be more effective in treating PTSD than any other

form of treatment. This type of therapy has been effective in treating women who have been sexually abused (Lee et al., 2003).

EMDR has eight phases for treatment: "(a) client history and treatment planning; (b) trust building and preparation; (c) assessment; (d) desensitization and reprocessing; (e) installation; (f) body scan; (g) closure; and (h) reevaluation" (Lee et al., 2003, p.26-27). During the first phase of treatment, the provider assesses the client's mental stability, physical health, and history. The provider and the patient also develop a treatment plan which includes identifying positive attitudes (Lee et al., 2003). During the second phase, a trusting therapeutic relationship is built between the provider and the patient and the therapist starts educating the patient on EMDR procedure. During this phase, patients are taught relaxation techniques to help them cope with emotional release. In this case, it is the emotional reactions to trauma which are recalled during EMDR. The provider also helps teach the client how to regain emotional stability by going into what is called a "safe place" (p.27). A safe place is a place where the patient finds security and calm (Lee et al., 2003). During the third phase, the provider identifies the negative thoughts which are associated with the traumatic events and disturbing images. The patient's belief of new thoughts is measured on a 7-point Validity of Cognition (VoC) scale. The patient's emotions that are connected with memory are also rated on the scale (Lee et al., 2003). During the fourth phase, the patient and the provider work together on recalling the traumatic picture. The provider then moves his or her finger side to side within the patient's visual field while the patient follows the provider's finger with his or her eyes. The provider does this 25 times. At the same time, the provider asks the

patient to let go of those traumatic images, while the patient takes deep breaths and explains the changes the patient might experience in his or her thoughts about one's self, changes in their body feelings, and disturbing images of the traumas they might have experienced (Lee et al., 2003).

During the fifth phase, the provider and the patient develop a positive outlook connected to the memories related to a trauma. The provider helps the patient develop coping skills to help with the memories, current feelings, and emotions associated with the trauma (Lee et al., 2003). During the sixth phase, the provider asks the patient to hold onto the memories of the traumatic event along with the new thoughts associated with those memories. The patient is then asked to examine any remaining feelings of tension which may be a sign of unprocessed trauma. Eye movement is repeated during this phase while the client focuses on their physical discomfort (Lee et al., 2003). During the seventh phase, the provider asks the patient to keep a journal of his or her dreams and thoughts relating to the traumatic event. The provider uses relaxation techniques at the end of the session if there are emotions left relating to the trauma (Lee et al., 2003). During the eighth phase, the provider determines if the EMDR has been effective and this is done by asking the patient how he or she feels about the traumatic event. The provider, during this phase, reviews the patient's journal to examine problems within his or her social system and to address them during the session (Lee et al., 2003). EMDR has been effective in providing a safe environment for patients in reflecting on disturbing memories. EMDR allows patients to have control of their own treatment goals and how

much they will tolerate the trauma. This makes EMDR "user friendly" compared to other therapeutic approaches (Lee et al., 2003, p. 29).

Group Therapy

Duckworth, (2011) reported that veterans who joined group therapy found it to be helpful because they felt that they were able to share similar experiences with other veterans who had been exposed to combat and experienced similar symptoms of PTSD. Veterans also found it to be uplifting and felt a great amount of support especially when feeling alone or isolated. Group therapy helps in lessening feelings of shame by providing them with support and reducing feelings of helplessness (p.14).

Medication

Medication has been effective in treating veterans with PTSD and reducing symptoms along with psychotherapy. Medications such as antidepressants, beta-blockers, mood stabilizers and antipsychotics, and sleep restoration medication have been shown to help veterans with PTSD (Duckworth, 2011). Anti-depressants such as serotonin reuptake inhibitors (SSRIs) have been found to reduce the symptoms of PTSD (Duckworth, 2011). Beta-blockers, a type of medication, used to treat high-blood pressure, have also been found to help treat PTSD (Duckworth, 2011). Mood stabilizers and antipsychotic medications have been helpful in reducing aggression and reducing mood instability (Duckworth, 2011). Along with being able to restore sleeping patterns with the use of generic medication, this is a key to recovering from PTSD for veterans (Duckworth, 2011). Benzodiazepine is prescribed by a doctor and is given to those who suffer from PTSD and have problems with anxiety. Although Benzodiazepines may be

of help to those who suffer from PTSD and anxiety, it does not treat the core symptoms of PTSD. The downside to the medication is that it cannot be used for long term treatment since it can lead to addiction. It is important that mental health care providers educate veterans about medication and why they should take their medication along with attending therapy in order to reduce the recurring cycle of symptoms from PTSD (Duckworth, 2011).

Posttraumatic Stress Disorder Disability Assessment

Veterans with a psychiatric condition may apply for the service-connection disability when they return from combat. PTSD claim is an evaluation done by the DVA by a medical provider, social worker, doctors, and a therapist. A compensation examiner has an obligation to the VA to gather information to make a claim (Rosen, 2010, p.xv). The compensation examiner's role is to evaluate the veteran; in this case, the examiner's role is to collect information about the traumatic issues that the veterans are not ready to address in therapy. The examiner, during the evaluation, focuses on the traumatic event rather than focusing on the collecting data (Rosen, 2010, p.xv). Veterans, during the interview, often feel rushed because the examiners are limited on the time spent helping the veteran on processing his or her experience in combat. The examiner must think about the veteran's perspective and different forms of questions that challenge the veteran's versions of events that took place during combat (Rosen, 2010, p.xv). During the evaluation expression, empathy can be complicated because providers are trained to listen which may instead trigger veterans who are asked to describe a traumatic event or asked to share their private (Rosen, 2010, p.xv). At the end of the evaluation, the

examiner gathers all the information from the interview and makes a decision and writes a report that may lead to the denial of benefits (Rosen, 2010, p.xv). Veterans who are from OIF/OEF, who are diagnosed with PTSD and have applied for service-connected compensation should be immediately provided with treatment after being evaluated by the examiner (Rosen, 2010, p.xv). Veterans who are discharged from combat are eligible for up 5 years of treatment from the VA Medical Center (Rosen, 2010, p.xvi).

In 2009, out of 1.7 million veterans 1.1 million OIF/OEF veterans have left combat (Rosen, 2010, pxvi). Rosen, (2010) found that 12 to 20% of OIF/OEF who return from combat met the criteria for PTSD, while 9.8% of OIF/OEF veterans met the screening for PTSD (Rosen, 2010, pxvi). Seal, Metzler, Gima, Bertenthal, Magun, and Marmar, (2009) found an increase of veterans who have been treated for mental illness between 2004 and 2008 (p.2). Based on the compensation claims that have been filed, 50% of OIF/OEF veterans have filed service-connected compensation, which increased by 44% since the Gulf war. Those who are partially disabled applied for service-connected compensation (Rosen, 2010, pxvi). Veterans who have applied for service-connected compensation for PTSD showed that the reason for seeking service-connected compensation was for financial gain. There are a number of applications that are filed each year after veterans return from combat. Veterans apply for service-connected compensation after the first onset of symptoms (Sayer, Spoony, & Nelson, 2005, p. 2135). Sayer, Spoony, and Nelson, (2005) found that 439 veterans with PTSD were asked to rate their reason for seeking service-connected compensation (Sayer et al., 2005, p.2135). However, after being examined, veterans showed a valid reason for seeking

service-connected compensation such as having unmet mental health needs (Sayer, et al., 2005, p.2135). On the other hand, stigma played a big role for veterans who did not seek service-connected compensation (Sayer et al., 2005). The compensation examiner may over exaggerate the veteran's motivation for seeking service-connected benefits and under estimate the reason one may seek benefits. However, it would be beneficial for veterans to seek treatment during this phase to help treat PTSD.

Veterans who apply for benefits are asked by the Veterans Health Administration (VHA) treatment facility to arrange a compensation examination once they submit their claim to the Veterans Benefits Administration (VBA). The examiner will then review the application and conduct a psychiatric face-to-face interview with a veteran. Next, the examiner will write a report regarding the veteran's diagnosis, functional impairment, and relationship impairment to military services (Rosen, 2010, p. xvii). The report is then reviewed by the VHA claims which will then decide whether the veteran will be awarded benefits and the amount of compensation for disability. The application process for the veteran can be difficult when having to describe the symptoms of trauma and the trauma they endured during combat which can be painful (Rosen, 2010, p. xvii). Spoon, Sayer, Nelson, Clothier, Murdoch, & Nugent (2008), evaluated 109 veterans during the application process and again during the examination (p.52). From the time of the veteran's initial application and their assessment, there was a significant change in symptoms and functional impairment (Spoon et al., 2008). And, veterans who were unemployed had an increase in PTSD and functional impairment compared to veterans who were employed (Rosen, 2010, p. xvii). Veterans who were used during this study

were assured that their ratings would not affect their application process for service-connected compensation (Rosen, 2010, p. xvii). In other studies as part of the examinations for compensation veterans would exaggerate their distress (Rosen, 2010, p. xvii). According to veterans they reported that the application was stressful. Veterans Service Officers shared the same opinion. For example, in this case, 70% agreed with this statement that veterans have difficulty talking about their experience in combat and as a result will become upset and angry it was found that 57% also agreed that veterans who get denied for service-connection have difficulty accepting denial (Rosen, 2010, p. xvii). Rosen, (2010) also found that 42% disagreed with the statement that veterans are better understood by those who are involved in the compensation and pension process and 36% disagreed that PTSD evaluators can be trusted (Rosen, 2010, p. xvii).

There is a considerable amount of veterans who have not received VA services before being examined for compensation. Administration records indicated that there were 452 veterans who received service-connected compensation for PTSD and 112 veterans who used mental health services before opening a claim. A study found that veterans, who filed a claim for PTSD were disproportionately married, younger, and dependent on the insurance (Rosen, 2010, p. xviii). In the study, the majority of the veterans were Vietnam-era veterans who suffered from recurring PTSD. It has declared that veterans are not motivated to seek treatment once they receive service-connected compensation; however veterans diagnosed with PTSD benefited from treatment (Frueh, Grubaugh, Elhai, & Buckley, 2007 p.2143). In addition, veterans who were awarded compensation for disability left treatment prior to when they first filed a claim for

disability with the hope that if they engage in the treatment, that treatment will help with a claim for service-connected compensation (Rosen, 2010, p. xvii).

Rosen, (2010) found that 62 OIF/OEF veterans were tested for service-connected compensation at the VA Connecticut Healthcare Systems for PTSD during a 6-month period. During the 6 –month period, veterans were examined to find an estimate of how many veterans are substance abusers, and who also receive mental health services. Out of the 61% of veterans who were diagnosed with PTSD during the examination, 50% had psychiatric treatment at the VA Medical Center within the last 3 months after being examined for compensation, and almost 53% of veterans has a psychiatric visit within the last 3 months (Rosen, 2010, p. xvii). The 5 veterans that were examined did not have a substance abuse diagnosis. In addition, to alcohol use, 1 veteran had received treatment at the VA Medical Center for substance abuse during the 3-month period before being evaluated (Rosen, 2010, p. xvii). These finding was correlated with veterans not receiving treatment from the VA for their disability (Rosen, 2010, p. xvii). Veterans who are OIF/OEF and diagnosed with PTSD have difficulty interacting in treatment. A survey found that from the veterans who return from combat, 23 to 40% seek services for mental health (Rosen, 2010, p. xvii). In addition, there has been a considerable decrease in attendance for treatment and an increase in treatment dropout in OIF/OEF veterans when compared to Vietnam-era veterans (Rosen, 2010, p. xvii).

The examiner will tell to the veteran the reason for the examination is to record his or her experience during combat. After the assessment, veterans should seek treatment for PTSD. The treatment would include: (a) correspondence from the VBA

that will explain to the veteran how to access treatment for PTSD at his or her local VA Medical Center, (b) the compensation examiner would inform the veteran that his or her application has been filed with the VBA branch and that he or she will be conducting an assessment and explain the services available to help treat PTSD and help reduce his or her distress, (c) the compensation examiner would make a referral for treatment at the end of the assessment, (d) a therapist at the end of the assessment will be available to see veterans to help with treating PTSD (Rosen, 2010, p. xix). It is important to provide veterans with the options of seeking treatment for PTSD to avoid making veterans feel that they are forced to go to treatment. It is also helpful in educating veterans on the benefit if seeking treatment after the assessment in order to help treat and reduce symptoms of PTSD.

Conclusion

This review of the literature revealed that veterans are at risk for developing PTSD. It also showed that PTSD not only affects veterans, but also affects relationships with family, can lead to substance use, and suicide. There are many veterans who have served in Iraq, Afghanistan, and foreign wars that meet the criteria of PTSD, depression, or Traumatic Brain Injury (TBI). If left untreated, veterans are at risk for family problems, drug abuse, and suicide. It is important that as a social worker to teach and educate veterans and the community about the symptoms and diagnostic criteria for PTSD. Educating and encouraging our veterans and their family members will lead them to seek services available through a variety of treatment facilities.

CHAPTER 3

METHODOLOGY

Identification of Potential Funding Sources

The grant writer used various sources for identifying and selecting potential funding sources such as the following websites: The NAMI Veteran Resource Center (http://www.nami.org/template.cfm?section=PTSD), USC Social Work Center for Innovation and Research on Veterans & Military Families (http://cir.usc.edu/research/research-projects), and Grants.gov (www.grants.gov). The grant writer also visited the Long Beach VA Medical Center located in Long Beach, California, and explored the VA website.

After a preliminary review of possible organizations as potential funding resources, the Veterans Support Foundation was identified as a potential foundation. The Veterans Support Foundation is a 501(c) (3) nonprofit humanitarian and educational organization whose mission is to improve the quality of life for veterans and their family members. The Veteran Support Foundation serves veterans of all services and all eras (Veterans Support Foundation, 2009).

The Foundation's office is located in Silver Spring, Maryland. The Veterans Support Foundation was first established in 1991 in the state of Delaware. In 1991, the Foundation was called the Vietnam Veterans Assistance Fund, but was renamed the Veterans Support Foundation. The Foundation offers grants to different organizations that help veterans and their families with housing, education and medical needs (Veterans Support Foundation, 2009). The objectives of the Foundation are the following: (a) to help fund nonprofit organizations in support of veteran related projects throughout the United States; (b) to assist disabled veterans and their qualifying dependents family members; (c) to assist and provide transitional and permanent housing for homeless and at risk veterans; and (d) to enrich the lives of all veterans and their families (Veterans Support Foundation, 2013). Since 2003, the Foundation has spent over $2.5 million to achieve these objectives.

In 2013, the Veteran Support Foundations Supportive Housing Program provided support for 54 homeless veterans (47 transitional and 7 permanent; Veterans Support Foundation, 2013). In connection with the Vietnam Veterans of America, the Veteran Support Foundation supports Service Officer Programs that assist veterans with service-incurred obtain disabilities that obtain health and financial compensation. In 2013, the Veteran Support Foundation gave $184,000 to 15 different states in grants for Service Officer Programs (Veterans Support Foundation, 2013). In addition the Veteran support Foundation took World War II veterans to veterans to Washington, DC to see memorials, and helped wounded World War II veterans and family members attend camps (Veterans

Support Foundation, 2013). In 2013, Veterans Support Foundation also gave $70,000 to different programs that provided health services and transportation to veterans who were homeless (Veterans Support Foundation, 2013).

The Veterans Support Foundation states on its website that the grants are scheduled once a year and are considered for "one time or start up projects" and are due March 31st every year (Veterans Support Foundation, 2009). In order to be considered for funding the following year one must show that the proposed program can be beneficial to veterans and can provide needed services (Veterans Support Foundation, 2009). Other important information applicants must consider are the following:

1. Applicants must file a complete proposal, meeting the requirements stated on the grant application.

2. The postmark on the submission is used to determine the date of submission. It is not necessary to use priority mailing methods provided the submission is postmarked on or before.

3. Applicants will be notified in writing of a decision within 12-16 weeks following the deadline for submission.

4. All materials submitted become the property of Veteran Support Foundation.

5. Recipients of Veteran Support Foundation grants may be required to submit periodic reports detailing all activities related to the grant. The number of reports and their due dates will be outlined in the grant award letter. Failure to file reports in a timely manner may result in forfeiture of the remaining grant

6. Any and all issues relating to the VVA Service Officer program are administered through and by the VVA National office.

7. Veteran Support Foundation considers all complete proposals. However, the Veteran Support Foundation does not fund the following: memorial projects, administrative expenses, attending meetings, and building projects (Veterans Support Foundation, 2009).

Target Population

The target population for this grant is veterans who are over the age of 18, have served in combat, have been diagnosed with PTSD, and are receiving services at the VA Medical Center. The VA Medical Center is located in 5 different regions: Greater Los Angeles, San Diego, Loma Linda, Las Vegas, and Long Beach, and the target population is those who are receiving services at the Long Beach location. There are 469,428 veterans residing in Long Beach (U.S. Census Bureau, 2013). Of the 469,428 veterans, 46.1% are white, 40.8% Hispanic, 13.5% African American, 1.1 % Native Hawaiian and other Pacific Islander, 0.7% American Indian and Alaska Native, and Asian 12.9% (U.S. Census Bureau, 2013)

Potential Sources for Information for the Grant

The problem statement was designed to show the need for a program targeting veterans who suffer from PTSD in Long Beach, California, while increasing awareness. Resources used in this particular grant included the U.S. Census Department, CA.gov, and Long Beach VA Medical Library. The U.S Census showed the growing population

of veterans. The CA.gov under alcohol and drug program provides information on veterans and service members including high rates of PTSD and suicide risk. This site also provides information on women veterans who served on the front line and issues these veterans face while in the military. These data allowed the grant writer to show the need for the proposed program and make a case that the population is in greater need of services than other populations. The grant writer also used CSULB library, and most academic journals used for the literature review were accessed through the library online databases.

CHAPTER 4

GRANT PROPOSAL

Proposal Narrative

Host Agency Profile

The Continental Congress in 1776 provided pension for veterans who were disabled and served in combat. The nation's veteran's assistance program was expanded in the 19th century which included benefits and pension for veterans who served in combat (DVA, 2013i). The VA Health Care System has grown since 1776 in 1930 there were 54 hospitals, which then turned in 152 hospitals, which then included 800 community based outpatient clinics (DVA, 2013i). Within the next six decades the Veterans Administration grew enormously especially the responsibilities and benefits program for veterans. In WWII there was a huge increase in the veteran population, also in benefits which was enacted by Congress for veterans who served in combat.

Then in 2009, Eric K. Shinseki secretary of President Obama lead a change that allowed us to help better serve veterans who have fought in combat. Under Secretary Eric K. Shinseki, the VA adopted three principles which plan to serve as a platform the 16 major initiatives:

1. Eliminating Veteran homelessness.

2. Enabling 21st century benefits delivery and services.

3. Automating GI Bill benefits.

4. Creating Virtual Lifetime Electronic Record.

5. Improving Veterans' mental health.

6. Building Veterans Relationship Management capability to enable convenient, seamless interactions.

7. Designing a Veteran-centric health care model to help Veterans navigate the health care delivery system and receive coordinated care.

8. Enhancing the Veteran experience and access to health care.

9. Ensuring preparedness to meet emergent national needs.

10. Developing capabilities and enabling systems to drive performance and outcomes.

11. Establishing strong VA management infrastructure and integrated operating model.

12. Transforming human capital management.

13. Performing research and development to enhance the long-term health and well-being of Veterans.

14. Optimizing the utilization of VA's Capital portfolio by implementing and executing the Strategic Capital Investment Planning (SCIP) process.

15. Improving the quality of health care while reducing cost (DVA, 2013b).

The target population for this grant is veterans who are over the age of 18, have served in combat, have been diagnosed with Post Traumatic Stress Disorder (PTSD), and are receiving services at the VA Medical Center. The VA Medical Center is located in 5 different regions: Greater Los Angeles, San Diego, Loma Linda, Las Vegas, and Long Beach, and the target population are those who are receiving services at the Long Beach location. There are 469,428 veterans residing in Long Beach (U.S. Census Bureau, 2013). Of the 469,428 veterans, 46.1% are white, 40.8% Hispanic, 13.5% African American, 1.1 % Native Hawaiian and other Pacific Islander, 0.7% American Indian and Alaska Native, and Asian 12.9% (U.S. Census Bureau, 2013)

The DVA and the Department of Defense (DOD) have spent $100 million dollars to help improve treatment for TBI and PTSD (DVA, 2013j). According to Secretary Eric K. Shinseki the DVA goal is to ensure that our veterans receive the best quality of care. This means by investing in research to help treat veterans who suffer from PTSD and TBI. On August 31, 2013 Barack Obama signed an order to help improve mental health access for veterans, and military family. As part of the order Obama developed a National Research Action Plan that will help improve early onset diagnosis and treatment for PTSD and TBI (DVA, 2013j). Mr. Obama also conducted a study on mental health with an emphasis on veterans who suffered from PTSD and TBI, and related injuries in order to develop diagnosis, treatment, and prevention, options (DVA, 2013j). The DVA is known for its integrated health care system and for its medical research programs. In 2012, 1.9 billion was funded for 2,300 projects for PTSD and TBI (DVA, 2013j).

Problem Statement/Justification for Need

There have been over 300,000 veterans since 2001 returning from combat and suffering from PTSD. Many veterans have seen combat and have been exposed to life-threatening situations such as being shot at, seeing their fellow service men and women shot, or having explosives thrown at their High Mobility Multipurpose Wheeled Vehicle (HMMWV) (RV; O'Hanlon & Campbell, 2008). In 2008, there were more that 1.6 million service members who had been deployed to Iraq and Afghanistan for multiple tours of duty. By December 2008, more than 42,000 veterans had been killed and over 30,800 veterans had returned from combat with visible wounds and disabilities (O'Hanlon & Campbell, 2008). The prevalence of psychological and neurological wounds among veterans who have been put in combat situations has been estimated to be 25-40% (Tanielian & Jaycox, 2008).

According to the DVA (2014c), as many as 20% of OIF/OEF veterans who return from Iraq and Afghanistan develop PTSD. Also, 10% of Gulf War (Desert Storm) veterans and 30% of Vietnam veterans are believed to have developed PTSD. PTSD can be caused from military sexual trauma (MST), which refers to sexual harassment or sexual assault that occurs while one is in the military (DVA, 2014c). The DVA (2014c) found that 23 out of 100 women reported sexual assault while in the military and 55 out

of 100 women and 38 out of 100 men experienced sexual harassment while in the military.

Veterans with PTSD are more likely to experience difficulty once returning from deployment including family conflict, develop substance abuse problems, and high rate of suicide. Having a veteran return from combat and having being diagnosed with PTSD can be very challenging for family members. During this time, family members and their loved ones would need to relearn how to build communication and reconnect with one another (Sayers, Farrow, Ross, & Oslin, 2009). Returning home, veterans may be eager to regain their role in the family; however, the family members may not be ready this type of dramatic change in the family dynamics (Pincus, House, Christenson, & Adler, 2008; Rotter & Boveja, 1999; Sayers et al., 2009). Veterans are reluctant to seek help and feel that if they were to share what they are going through, the process would delay their chances of being reunited with their family members, or may hurt their chance of returning to combat in the future (Darwin, 2009). Children can be affected when their parent or loved one has experience combat. Children, when reuniting with their parent or loved one, may not remember and may need time to get to know him or her which maybe painful for the veteran returning from combat (Petty, 2009). When their parent or loved one returns, children may not remember them, which maybe a painful process for the veteran returning from combat (Petty, 2009).

According to Duckworth (2011), veterans who suffer from PTSD often turn to alcohol and drugs as a way to self-medicate and in order to cope with the trauma from

reoccurring nightmares and flashbacks of war. Duckworth (2011) found that as many as 43% of veterans with PTSD develop substance abuse issues, compared to 25% among veterans without PTSD. Veterans who are diagnosed with substance abuse and PTSD are often also suffering with major depression and/or an anxiety disorder (Duckworth, 2011).

The Michigan Health System and Ann Arbor Healthcare System VA Medical Center found in 2012 that veterans who suffer from PTSD along with drug and alcohol addiction had a higher risk of also found that veterans who were under the age of 45 showed a correlation between substance-use disorders and both injury and non-injury related deaths due to overdose ore reckless accidents (DVA, 2014e). Injury related deaths in this case include homicides, suicides, and vehicle accidents, whereas non-injury related deaths include heart disease, cancer, stroke, and other health problems (DVA, 2014e).

Veterans who suffer from PTSD and use illegal street drugs in order to cope are at a high risk of committing suicide. Veterans who have experienced trauma are more likely to develop suicidal feelings. According to the DVA (2013a), California and Texas have the highest suicide rates. The DVA found in 2013 that one active soldier and 22 veterans will take their own lives each day. Veterans often turn to suicide as their only option to relieve suffering and shame associated with PTSD rather than seek professional assistance. It was also found that 30 % of veterans have experience exposure to combat situation considered suicide (DVA, 2013a). Veterans who are currently receiving treatment are less likely to commit suicide or exhibit suicidal behaviors (Duckworth,

2011). Therefore this grant is important because there are veterans who are not aware of the services in which the VA provides and this grant will help provide psycho-education to veterans and their family members.

Program Description

The program is designed for veterans who suffer from PTSD. The group will consist of 6-8 group members. The duration of this program is 6 months and will be held one time a month for 90 minutes long. The purpose of this group is designed to help veterans manage their symptoms of PTSD. The support group will help with veterans with PTSD symptoms, anger, substance abuse, and relationships with family. At the end of the 9 month program veterans will be able to have control o their own life and the ability to live a normal life.

Objectives and activities of the proposed program are the following:

Objective 1: Increase Knowledge about PTSD.

Activity:

To achieve this objective of the proposed program, the following activities will be administered by the program director, and two interns. During the first session the program director will introduce herself and the two interns from California State University of Long Beach and their role in the support group. The program director and two interns will next do an ice breaker to help participants get to know each other. Next, the program director and the interns will administer a survey on PTSD. Following the

survey the program director will explain what this program is about, explain the rule, and guidelines.

The curriculum in the first month will include the following definition of PTSD, consequences of PTSD, and symptoms of PTSD. Next, the participants will watch a movie on PTSD. At the end of the session the participants will be ask to participate in a discussion on the movie. The veterans will be provided with material on the topic, and handouts in order to help educate veterans on PTSD. The participants well then go home with homework and write about what they have learned from the discussion and asked to write a time where they experienced trauma and how it made them feel and are asked to bring it to the next session.

Duckworth, (2011) reported that veterans who joined group therapy found it to be helpful because they felt that they were able to share similar experiences with other veterans who had been exposed to combat and experienced similar symptoms of PTSD. Veterans also found it to be uplifting and felt a great amount of support especially when feeling alone or isolated. Group therapy helps in lessening feelings of shame by providing them with support and reducing feelings of helplessness (p.14).

Objective 2: Increase Coping Skills To Help Manage PTSD.

Activity:

Veterans will develop coping skills by using deep breathing techniques, and through self talk. The participants whom are the veterans are to practice twice a day for 10 minutes. Veterans will also be given a handout on breathing and self talk exercises.

They will be asked to identify stressors which can be physical, emotional, behavioral, and problems with thinking and are asked to keep a log of exercises they used to reduce their stress levels and are asked to bring it with them in their next session. This will help veterans be able to identify their stressors and identify what is causing them by seeing a pattern or change in their behavior. This will help veterans come up with solutions to their problems and what is causing them to feel and act a certain way.

Cognitive Processing Therapy (CPT) is an "adaptation of the evidence-based therapy known as Cognitive Behavioral Therapy (CBT) used by clinicians to help clients explore the process of recovery from PTSD and related conditions" (Monson et al., 2006, p. 901). The veteran will meet with the provider for 12 individual sessions for 90 minutes each. During the initial treatment, the provider educates veterans on symptoms of PTSD which is explained as "cognitive and information-processing theory framework" (Monson et al., 2006, p. 901). At the end of the first session, the provider asks patients to write what is called "impact statement" (Monson et al., 2006, p.901). The impact statement includes writing a meaning of the traumatic event that took place, along with the patient's beliefs of why this traumatic event occurred (Monson et al., 2006). During session two, patients are asked to read what they wrote and discuss it. In this session, they are asked to identify the connection between events, thoughts, and feelings (Monson et al., 2006). In session three, patients with their provider review the homework and they are also asked to write about their most traumatic event in combat (Monson 22 et al., 2006). During session four, patients are asked again to write about the trauma but in

more detail including their emotions, thoughts and beliefs (Monson et al., 2006). In session five, the provider uses the Socratic style of questioning which includes: questions for clarification, questions that probe assumptions, questions that probe reasons and evidence, questions about viewpoints and perspectives, questions that probe implications and consequence, and questions about the questions (Yang, Newby & Bill, 2005, p167). Using the Socratic methods helps patients become more involved in therapy and allows them to feel comfortable asking questions regarding their assumptions and self-statements (Monson et al., 2006). During the final two sessions, six and seven, patients are taught how to utilize worksheets in order to challenge and learn how to change their thoughts and beliefs relating to their traumatic experience of being in combat in their daily lives (Monson et al., 2006). In the last five sessions of treatment, their beliefs in safety, trust, self-esteem and intimacy as they relate to others are challenged. During the treatment, CPT focuses on a range of different emotions including shame, sadness, and anger, along with anxiety, which may have been caused by trauma (Monson et al., 2006). CPT works because it helps patients develop coping skills in order to deal with stressful situations. It helps veterans have a better understanding of their trauma and how it has impacted their thinking.

Objective 3: Increase Relationship with Veterans and Family Members.

Activity:

Family therapy will help veterans and their family members increase their relationship. During family therapy they will be able to learn how to help veterans return

back to civilian life after combat, and learn how to reconnect through communication skills. The veteran and the family will be asked to attending activities outside the home together as a family. Next, they will discussion on how it affected them while he/she was away on duty as a parent, child, and how they feel now that he/she is home from combat. Attending family activities will help veterans feel connected with their family, and friends.

Staffing

Program Director: The program director will be a Licensed Clinical Social Worker (LCSW) that will speak both Spanish and English. The program director must have experience in Cognitive Processing Therapy (CPT), Prolonged Exposure Therapy (PET), and Eye Movement Desensitization and Reprocessing (EMDR). The program director will be responsible for overlooking the support group and interns. The program director's responsibilities include interviewing and selecting interns, providing the interns orientation and training, recruiting veterans to the support group, overlooking the budget and the spending, overlooking the evaluation provided by the veterans, and providing the interns with an evaluation of their over performance at the end of the program.

Case manager: will be to conduct intakes and assessments, provide individual counseling, facilitate support groups, and develop plans to help assist the participants, refer patients to resources, and provide transportation to and from the facility to get to and from support group, respond to crises, and follow up with participants at the end of

the program. His/or her job will be to link veterans to resources outside the VA Medical Center.

Therapist: A substance abuse counselor will be working part-time for 1 hour per month. His/her role will be to provide support and treatment to veterans who suffer from drug or alcohol addiction.

Interns: The interns will be students from California State University, Long Beach. Selected interns must be fluent in Spanish and in English. The intern's job will be to conduct intakes and assessments, provide individual therapy, facilitate the support group, link veterans to outside resources, and work as need interns.

Timeline

Month 1:

1. Interview and hire staff.
2. Select program director, therapist, and case manager.
3. Interns are interviewed and selected from California State University of Long Beach.
4. Student orientation.
5. Staff and intern training.
6. Use office space located at the VA Medical Center in Long Beach.

Month 2:

1. Promote the program and recruit veterans.
2. Welcome veterans and introduction to support group.

3. Develop curriculum, and create handouts.

4. Watch video on PTSD and have a discussion.

Month 3:

1. Veterans will start to meet with interns for individual therapy on a weekly basis outside support group.

2. What is PTSD? Provide handouts and statistics and facts on PTSD.

3. Discussion on four main symptoms of PTSD.

4. Discussion on the causes of PTSD.

Month 4:

1. Discussion on Triggers, avoidance, and safety behaviors.

2. Discussion on common reactions to trauma after combat.

Month 5:

1. Discussion on PTSD, alcohol and drug use.

2. Veterans are provide with and handouts and facts on the use of alcohol and drug use.

Month 6:

1. Develop coping strategies to manage symptoms of PTSD, anger, and provide handouts.

2. Develop breathing techniques through self talk, and breathing exercises.

Month 7:

1. Work on building relationships with family, children, and friends.

2. How to develop communication when returning from combat.

Month 8:

1. Discussion on treatment and handouts.

2. Discussion on medications and handout.

3. Discussion on resources available to veteran and family.

Month 9:

1. Satisfaction survey will be distributed by interns at the end of the program.

2. Discuss treatment needs after the program.

3. Completion of program.

4. Graduation.

Budget

See the Appendix

Personnel:

Program Director: The program director (100% FTE) working 40 hours a week for 48 weeks (1 @ $60,000 + benefits @ 15% = $69,000).

Case manager: The hourly rate is $18.00 per hour at 40 hours per week equaling $34,560 per year (1 @ $34,560 + benefits @ 15% = $5,184).

Therapist: Program Director: The program director (100% FTE) working 40 hours a week for 48 weeks (1 @ $60,000 + benefits @ 15% = $69,000).

Operations and Expenses:

The support group staff will need copy paper, filing cabinets, pens, pencil, staples, paper clips, highlighters, post-its, and note pad paper which will cost the program $250/per month=$3,000 per year. In addition the support group will need desk top computer(s), lab top(s), and copier machine which will cost the program $1,000 per year for maintenance. The staff will need work phones for staff members with low cost phone plan which will cost the program $40.00 month=$480 per year. In addition support group will need educational material videos and work booklets which will cost the program $100.00 per month= $1,200 per year. The program will also need refreshments for staff meetings and support group which will cost the program $300.00 per month= $3,600 per year. The support group staff will also need $200.00 per month for miscellaneous expenses including conferences, guest speakers, and employee of the month the total for is $2,400 per year.

In-Kind Resources:

The DVA will provide a conference room where the support group will be held for 90 minutes for 9 months free of charge to veterans. To use the conference room the VA will be free of charge which will include utilities, electricity, and phone access. The VA will provide extra office space if needed to do intakes and extra space for interns to do documentation.

CHAPTER 5

LESSONS LEARNED

Grant Writing Process

Writing a grant for this proposal is no small undertaking. First, it required the writer to gather and analyze a significant amount of research and information on veterans being impacted by PTSD. This research and information includes: the history of PTSD, statistics on the targeted population, psychological assessments that help identify veterans with this disorder, potential funding sources and lastly, effective treatments. The second part this process will require the writer to work or volunteer with an agency for which he/she is writing the grant for. Next, the writer must develop a curriculum as well as a budget for the agency for which the writer is seeking funding for. Upon completion of the grant, the writer will come to the conclusion that the majority of publicly funded agencies receive a significant portion of their budget from this process.

Challenges

Some of the major challenges in writing this grant was developing topic, potential funding sources, and getting it approved by the community. Also, I found it difficult to gather information on topic of PTSD, because it was only been considered a real mental health disorder by DSM in 1978. Also, gathering information on this disorder was very challenging because, it could not be done in the library or at home;

I was required to go the Long Beach VA hospital and do much of my within their medical research library. I also had to interview staff members on services which they offer to veterans. Next, I had to go to the Cal-State Long Beach's library and gather research outside the VA via their data base which I found to be difficult navigate in; however, with help of the librarian I was able to find information on my topic by using certain key terms.

During this process I have found chapter 3 and chapter 4 to be my most challenging. Chapter 3 consisted of me identifying potential funding sources which took me a more time than I anticipated. I must admit, initially, I did not know what I had to look for, where I should even begin. Thus, I spend a lot of time looking through different internet search engines; this involved using many different key words to identify potential funding sources and after three days, I had no significant leads. However meeting with my advisor on different occasions and looking online together help me have a better understanding of what I was looking for online. Chapter 4, was my biggest challenge because, it required the development of an activity for each objective within the curriculum. Another portion of chapter 4, which was just as complex was the formation of a budget**.** For example, I had to think about how much I was going to spend on the program, and consider of what I needed to develop a support group for veteran who suffered from PTSD. Also, I had had to determine what supplies, materials, and other expenses are needed to make this support group effective. Case in point, who should be hired to provide staff training, the number of additional staff and volunteers needed and

what kind of technology will be need to help facility the group**.** In addition, having to develop a curriculum and knowing what will be presented and discussed during each session. For example, I found it difficult because I had to make sure that it covered all aspects of PTSD by providing an overview on PTSD, and show how it affects veteran's family relationships, and how veterans abuse substances, and commit suicide, and current interventions being used to treat PTSD. Next, I had to identify and select positional funding resources. I also had to develop a budget which I also found changeling.

Implications for Social Work

Social workers strive to improve the veteran's quality of life's that are unable to help themselves. In this case, it is important as social workers that we help focus on veterans who return from combat with Prost Traumatic Stress Disorder (PTSD). Furthermore, PTSD does not only affect the veteran in particular but, his family members as well as our society. Thus, it is important that social workers are properly trained while working with this type of population so we can properly assess, diagnose and treat veterans with this disorder before it is too late. As a social worker, I find it necessary to learn how to write grants because it helps fund new and innovative programs for veterans who suffer from PTSD.

APPENDIX

APPENDIX

LINE-ITEM BUDGET (EXPENSES ONLY)

APPENDIX

LINE-ITEM BUDGET (EXPENSES ONLY)

Salaries and Wages	
Program Director	$60,000
Employee-Related Benefits @ 15%	$69,000
Case Manager	$34,560
Employee-Related Benefits @ 15%	$5, 184
Therapist	$60,000
Employee-Related Benefits @ 15%	$69,000
Total Salaries and Wages	$297, 744
Other Operating	
Office supplies	$3,000
Equipment supplies	$1,000
Cell phones	$480.00
Program Supplies	$1,200
Food/refreshment	$3,600
Miscellaneous	$2,400
Total Budget	$11,680

In-kind Resources

Rent	$0.00

Utilities	$0.00
Total In-Kind Resources	$0.00

REFERENCES

REFERENCES

Allred, K., Jones, M., Hargrove, S., & Hargrove, S. (2014) *Veterans and military resource center*. Retrieved from http://www.nami.org/Template.cfm?Section=Veterans_Resources&Template=/ContentManagement/ContentDisplay.cfm&ContentID=53242&lstid=877

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

American Psychiatric Publishing, (2013). *Posttraumatic stress disorder*. Retrieved from: http://www.dsm5.org/Documents/PTSD Fact Sheet.pdf

American Psychological Association, Presidential Task Force on Military Deployment Services for Youth, Families and Service Members. (2007). *The psychological needs of U.S military service members and their families: A preliminary report*. Retrieved from: https://www.apa.org/pubs/info/reports/military-deployment-summary.pdf

Brancu, M., Straits-Tröster, K., & Kudler, H. (2011). Behavioral health conditions among military personnel and veterans: Prevalence and best practices for treatment. *North Carolina Medical Journal*, *72*(1), 54.

Calhoun, P. S., Elter, J. R., Jones, E. R., Kudler, H., & Straits-Troster, K. (2008). Hazardous alcohol use and receipt of risk-reduction counseling among U.S. veterans of the wars in Iraq and Afghanistan. *Journal of Clinical Psychiatry, 69*(11), 1868-1693.

Darwin, J. (2009). Families: ‘‘They also serve who only stand and wait.’’ *Smith College Studies in Social Work, 79*, 433–442.

Duckworth, K. (2011). *Posttraumatic stress disorder*. National Alliance on Mental Illness. Retrieved from http://www.nami.org/Template.cfm?Section=Post Traumatic_Stress_Disorder&Template=/ContentManagement/ContentDisplay.cfm&ContentID=68535

Engelhard, I., Van Den Hout, M., Weerts, J., Arntz, A., Hox, J., & McNally, R. (2007). Deployment-related stress and trauma in Dutch soldiers returning from Iraq: Prospective study. *The British Journal of Psychiatry: The Journal of Mental Science*, *191*(2), 140-145.

Foa, E. B., Gillihan, S. J., & Bryant, R. A. (2013). Challenges and successes in dissemination of evidence-based treatments for posttraumatic stress: Lessons learned from prolonged exposure therapy for PTSD. Challenges and Successes in Dissemination of Evidence-Based Treatments for Posttraumatic Stress: Lessons Learned From Prolonged Exposure Therapy for PTSD *14*(2), 66-111. Retrieved from http://psi.sagepub.com/content/14/2/65.full.pdff

Foster, L. K., & Vince, S (2009), *California's women veterans: The challenges and needs of those who served.* Sacramento, CA: California Research Bureau, California State Library.

Frueh, B. , Grubaugh, A. , Elhai, J. , & Buckley, T. (2007). U.S. Department of Veterans Affairs disability policies for posttraumatic stress disorder: Administrative trends and implications for treatment, rehabilitation, and research. *American Journal of Public Health, 97(12)*, 2143-2145.

Hoge, C., Castro, C., Messer, S., McGurk, D., Cotting, D., & Koffman, R., (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *The New England Journal of Medicine*, *351*(1), 13-22.

Jakupcak, M., Cook, J., Imel, Z., Fontana, A., & Rosenheck, R., Fontana, A., & McFall, M., (2009). Posttraumatic stress disorder as a risk factor for suicidal ideation in Iraq and Afghanistan war veterans. *Journal of Traumatic Stress*, *22*(4), 303-306.

Jakupcak, M., Vannoy, S., Imel, Z., Cook, J., Fontana, A., Rosenheck, R., & McFall, M., (2010). Does PTSD moderate the relationship between social support and suicide risk in Iraq and Afghanistan war veterans seeking mental health treatment? *Depression and Anxiety*, *27*(11), 1001.

Kilgore, W. D. Coting, D. I., Thomas, J. L., Cox, A. L., McGurk, D., Vo, A.H., …,Hoge, C.W., (2008). Post-combat invincibility: Violent combat experiences are associated with increased risk-taking propensity following deployment. *Journal of Psychiatric Research, 42*(13), 1112-1121.

King, K. (2013). Annual report. Retrieved from Veterans Support Foundation website: http://vsf-usa.org/documents/VSF_Annual_Report2013.pdf

Laser, J., & Stephens, P. (2010). Working with military families through deployment and beyond. *Clinical Social Work Journal*, *39*(1), 28-38.

Miles, D. (2010). *VA Strives to prevent veteran suicides.* Washington, DC: U.S. Department of Defense. Retrieved from http://www.defense.gov/news/newsarticle .aspx?id=58879

Monson, C. M., Schnurr, P. P., Resick, P. A., Friedman, M. J., Young-Xu, Y., & Stevens, S. P. (2006). Cognitive processing therapy for veterans with military-related posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology,* 74(5), 898-907. doi:10.1037/0022-006X.74.5.898

National Association of Social Workers. (2008). *Code of ethics of the National Association of Social Workers*. Washington, DC: NASW Press.

National Center for PTSD. (2010a). *Returning from the war zone: A guide for families of military members.* Washington, DC: U.S. Department of Veterans Affairs. Retrieved from http://www.ptsd.va.gov/public/reintegration/guide-pdf/Family Guide.pdf

National Center for PTSD, (2010b). *Returning from the war zone: A guide for military personnel.* Washington, DC: U.S. Department of Veterans Affairs. Retrieved from http://www.ptsd.va.gov/PTSD/public/reintegration/guide-pdf/SMGuide.pdf

National Center for PTSD. (2014). *How common is PTSD*. Retrieved from http://www.ptsd .va.gov/public/PTSD-overview/basics/how-common-is-ptsd.asp

O'Hanlon, M. E., & Campbell, J. H. (2008). *Iraq index tracking variables of reconstruction & security in post-Saddam Iraq*. Retrieved from http://www. brookings.edu/saban/iraq-index.aspx

Ochberg, F., & Peabody, C. (2008). *Post traumatic stress in the military. In Military Family Network (Ed.), Your military family network: Your connection to military friendly resources, benefits, information, businesses and advice* (pp. 187-192). Herndon, VA: Capital Books.

Peterson, A. L., Luethcke, C. A., Borah, A. M., & Young-McCaughan, S. (2011). Assessment and treatment of combat-related PTSD in returning war veterans. *Journal of Clinical Psychology in Medical Settings, 18*(2), 164-175.

Petty, K. (2009). *Deployment strategies for working with kids of military families*. St. Paul, MN: Redleaf.

Pincus, S., House, R., Christenson, J., & Adler, L. (2008). *The emotional cycle of deployment: A military perspective*. Retrieved from http://hooah4health.com/deployment/familymatters/emotionalcycle2.htm.

Powers, M., Halpern, J., Ferenschak, M., Gillihan, S., & Foa, E. (2010). A meta-analytic review of prolonged exposure for posttraumatic stress disorder. *Clinical Psychology Review*, *30*(6), 635-641.

Rosen, M. (2010). Compensation examinations for PTSD--an opportunity for treatment? *Journal of Rehabilitation Research and Development, 47(5), xv.*

Sayers, S., Farrow, V., Ross, J., & Oslin, D. (2009). Family problems among recently returned military veterans referred for a mental health evaluation. *Journal of Clinical Psychiatry, 70*(2), 163–170.

Seal, K. (2011). Substance use disorders in Iraq and Afghanistan veterans in VA healthcare 2001-2010: Implications for screening, diagnosis and treatment. *Drug and Alcohol Dependence*, *116*, 93-101.

Spoont, M et al., (2008*).* Does clinical status change in anticipation of a PTSD disability examination? Psychological Services, 5(1), 49-59

Substance Abuse and Mental Health Services Administration. (2012). *Behavioral health issues among Afghanistan and Iraq U.S. war veterans.* (HHS Publication No. (SMA) 12-4670). Washington, DC: U.S. Government Printing Office.

Tanielian, T., & Jaycox, L. H. (2008). *Invisible wounds of war psychological and cognitive injuries, their consequences, and services to assist recovery*. Santa Monica, CA: Rand Corporation. Retrieved from: http://www.rand.org/pubs/monographs/MG720/

Tolin, D., & Foa, E. (2006). Sex differences in trauma and posttraumatic stress disorder: A quantitative review of 25 years of research. *Psychological Bulletin*, *132*(6), 959-992

U.S. Census Bureau. (2013). *Long Beach, California quick facts*. Retrieved from http://quickfacts.census.gov/qfd/states/06/0643000.html

U.S. Department of Veterans Affairs. (2008). *Hearing on services to the families of wounded warriors*. Retrieved from U.S. Department of Veterans Affairs website: http://www.va.gov/OCA/testimony/svac/080311SS.asp

U.S. Department of Veterans Affairs. (2012). *VA and DOD to fund $100 million PTSD and TBI study*. Retrieved from http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2386

U.S. Department of Veterans Affairs. (2013a). *History of the National Center for PTSD*. Retrieved from http://www.ptsd.va.gov/about/mission/history_of_the_national_center_for_ptsd.asp

U.S. Department of Veterans Affairs. (2013b). *History - VA history.* Retrieved from http://www.va.gov/about_va/vahistory.asp

U.S. Department of Veterans Affairs. (2013c). *VA issues new report on suicide data*. Retrieved from http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2427

U.S. Department of Veterans Affairs. (2014a). *For veterans with PTSD, substance abuse increases mortality rate*. Retrieved from http://www.research.va.gov/news features/ptsd-sud.cfm

U.S. Department of Veterans Affairs. (2014b). *Prolonged exposure therapy*. Retrieved from http://www.ptsd.va.gov/public/treatment/therapy-med/prolonged-exposure-therapy.asp

U.S. Department of Veterans Affairs. (2014c). *Posttraumatic stress disorder (PTSD)*. Retrieved from http://www.research.va.gov/research_topics/ptsd.cfm

U.S. Department of Veterans Affairs. (2014d). *Glossary of terms*. Retrieved from http://www.va.gov/VETDATA/docs/SurveysAndStudies/GLOSSARY.pdf

U.S. Department of Veterans Affairs. (2014e). *Substance-use disorders*. Retrieved from http://www.annarbor.va.gov/ANNARBOR/features/Substance_use_disorders_linked_to_increased_risk_of_death_fo.asp

U.S. Department of Veterans Affairs. (2014f). *Treatment of PTSD*. Retrieved from http://www.ptsd.va.gov/public/treatment/therapy-med/treatment-ptsd.asp

Veterans for Common Sense. (2008). *VA fact sheet: Impact of Iraq and Afghanistan Wars*. Retrieved from http://veterans.house.gov/Media/File/110/2-7-08/VA-DoDfactsheet.htm

Veterans Support Foundation. (2009). *Welcome to VSF.* Retrieved from http://www.vsfusa.org/index.html

Vogt, D.,Vaughn, R., Glickman, M., Schultz, M., Drainoni, M., Lywy. R., & Eisen. S (2011). Gender differences in combat-related stressors and their association with post-deployment mental health in a nationally representative sample of U.S. OEF/OIF veterans. *Journal of Abnormal Psychology, 120*(4), 797-806.