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Veterans' Experiences with Combat-Related PTSD Treatment

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Veterans' Experiences with Combat-Related PTSD Treatment

by

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

The purpose of this study was to explore from Veterans' perspectives, their experiences with combat-related post traumatic stress disorder (PTSD) treatment and to report their advice to social workers involved in treating Veterans. This subject has particular importance given the increasing number of Veterans who have returned and are currently returning from deployments in Iraq and Afghanistan with this diagnosis. Interviews were conducted with four subjects, all of whom had been deployed to a combat zone, were diagnosed with combat-related PTSD, and completed outpatient treatment prior to July 1, 2012. The interviewees discussed their experiences with PTSD treatment and offered advice to social workers who treat Veterans with combat-related PTSD.

Two Veterans experienced more re-experiencing symptoms, such as dreams, after treatment. Avoidance symptoms among the Veterans in this study included avoiding treatment, avoiding people, and avoiding military duty. The findings confirmed that arousal symptoms, specifically irritability, are often triggered by common daily events, such as a camera flash, a tractor backfiring, or a neighbor's knock on the front door. All participating Veterans reported that their treatment was positively affected by family or friend-based support systems.

The implications for social workers include providing liaison-type services between doctors and Veterans and engaging and supporting family members in the treatment and recovery process. Additionally, the Veterans in this study implied an importance to the social worker having shared experiences with the Veteran.

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Combat-related post-traumatic stress disorder (PTSD) is a growing mental health concern for military members and their families, requiring the medical community, military and Veterans Administration (VA) systems to find effective treatment for related symptoms (National Alliance on Mental Illness, 2012; Reger & Gahm, 2008). Veterans from World War II through the current war on terror have been diagnosed with and are receiving treatment for post-traumatic stress disorder (PTSD) (National Center for PTSD, 2012).

Over 8.2 million Americans served during the Vietnam War between 1955 and 1975 (U.S. Census Bureau, 2004). Of the 2.5 million Americans who served in or near the Republic of Vietnam during the Vietnam War, 1.7 million of them have experienced PTSD symptoms (National Center for PTSD, 2012; Insel, 2007). Satel (2011) reported that 50% of all Vietnam Veterans, whether stationed overseas or stateside, sought readjustment treatment. Four out of five Vietnam Veterans reported more recent symptoms of PTSD when interviewed 20-25 years after returning from the war (Schnurr, Lunney, Sengupta, and Waelde, 2003). The VA experienced an eightfold increase in Vietnam Veterans seeking specialty health clinic services between 1999 and 2005 (Rosenheck & Fontana, 2007). The increase can be attributed to the 2001 disability policy change which authorized war-related diabetes claims, however, of the 140,000 patient surge, only half involved comorbid diabetes diagnoses (Rosenheck & Fontana, 2007). Likewise, almost 15 years after the war ended, new Vietnam Veterans were being diagnosed with psychological problems. The current wars continue to add new mental health patients to the VA patient rolls.

In the past decade, approximately 1,509,998 Operation ENDURING FREEDOM (OEF), Operation IRAQI FREEDOM (OIF), and Operation NEW DAWN (OND) Veterans have separated from active duty following a deployment. Approximately 55 percent (834,463) of all separated OEF/OIF/OND Veterans (whether deployed to the war or not) have used VA health care since October 1, 2001, and 53.3 percent of the health care recipients were diagnosed with mental disorders (Department of Veteran Affairs, 2012). The Department of Veteran Affairs (2012) reported that 247,243 OEF/OIF/OND Veterans were seen for potential PTSD at VA facilities following their return from the above mentioned overseas deployments between October 1, 2001 and June 30, 2012.

In 2009 the number of diagnosed combat-related PTSD cases in the U.S. military increased 50% (Richardson, Frueh, & Acierno, 2010). Insel's (2007) statement to the Committee on Oversight and Government Reform included the fact that 29% of OEF/OIF Veterans had enrolled in the VA for health care, which is a 19% increase from when the Vietnam War era Veterans returned.

PTSD is a common mental disorder that military members develop from traumatic events experienced while in or near combat (Pietrzak, Harpaz-Rotem & Southwick, 2011; Albright & Thyer, 2010; Insel, 2007). Left untreated, combat Veterans' PTSD worsens as they carry hidden, but very real, psychological wounds (Schnurr et al., 2003; Hoge, 2011; Kulkarni, Porter & Rauch, 2012). Veterans diagnosed with PTSD are likely to have physical health complaints such as higher levels of blood cholesterol, triglycerides, higher body mass indexes, osteoarthritis, diabetes, and heart disease (Romanoff, 2006). Increased cortisol levels, caused by stress, also cause excessive gastric secretions, leading to stress ulcers, thinning of the bones, and changes in

the brain chemistry possibly causing brain damage (Romanoff, 2006; Hoge, Castro, Messer, McGurk, Cotting & Koffman, 2008). Further, mood is also altered leading to depression and fatigue, trouble with concentration, hypervigilance, increased fear, increased startle response, and trouble sleeping (Kulkarni et al., 2011; Peterson, Luethcke, Borah, Borah & Young-McCaughan, 2010; Romanoff, 2006). Among other symptoms, survivor guilt, problems with intimacy, addiction and alcoholism affect many combat survivors (Richardson et al., 2010; Peterson et al., 2011).

The VA has mandated that all returning war vets diagnosed with PTSD have access to prolonged exposure therapy or cognitive processing therapy (Department of Veterans Affairs, 2012; Hoge, 2011). Yet, Veterans remain reluctant to seek help, with only 50% seeking help and predictions suggest that current strategies will reach no more than 20% of those needing PTSD treatment (Hoge, 2011). Seeking treatment for combat-related PTSD comes with the potential stigma that the Veterans will be thought of as "weak" and the Veterans themselves may fear that a PTSD diagnosis will negatively affect their military career (Corso et al., 2009; Peterson et al., 2011). A challenge for social workers is finding an effective outreach method to provide treatment for those who have served in America's military (Department of Veterans Affairs, 2012; Rosenheck & Fontana, 2007). Clinical social workers work in medical settings that treat military Veterans (Bragin, 2010; Laser & Stephens, 2011). According to Norman (2000), social workers are integral in assessing the client, and contributing to the client's ability to survive and flourish. Zimmerman and Dabelko (2007) add that a clinical social worker's goal in a hospital setting involves engaging the patient, family and medical staff to ensure complete medical services. Likewise, the social worker's role in treating combat PTSD

would alleviate dysfunction within military families and society as a whole (Peterson et al., 2011; Insel, 2007).

The purpose of this study was to explore from Veterans' perspectives, their experiences with combat-related PTSD treatment and to report their advice to social workers involved in treating Veterans.

Review of Literature

This study addresses post-traumatic stress disorder (PTSD) among combat Veterans and their experiences with treatment. Specifically, the review of literature covers a basic description of PTSD, comorbidity, modalities for treating PTSD, mental health services available to Veterans, and implications for social workers.

Post-Traumatic Stress Disorder Among Veterans

American military forces engaged in war are psychologically changed (Department of Veterans Affairs, 2012; Satel, 2011). Peterson et al. (2011) reported that combat-related trauma is the second leading cause of PTSD in men. In this section, diagnostic criteria, assessment, and interview protocols related to PTSD are discussed.

Diagnostic Criteria. The Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition – Text Revision (DSM-IV-TR, American Psychiatric Association, 2000) outlined criteria for the PTSD diagnosis and defined it according to its symptoms, duration, and the nature of the trauma. According to the DSM-IV-TR (2000) Criterion A must be met in order for a PTSD diagnosis: "the person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others" and "the person's response

involved intense fear, helplessness, or horror" (p. 427-428). Once Criterion A is met, symptoms are evaluated.

Symptoms are aligned into three clusters: Criterion B, *re-experiencing* (nightmares); Criterion C, *hyperarousal* (sleeplessness); and Criterion D, *avoidance and numbing*. Further, the DSM-IV-TR (2000) explains if the symptoms last for 30 days or longer and impair normal functioning, one may be diagnosed with PTSD. Experiencing a traumatic event will not automatically cause one to suffer from PTSD. For example, only 34% of the Oklahoma City Bombing victims were diagnosed with PTSD and less than 10% of rape victims are affected (Satel, 2011). Richardson et al. (2010) found that half of Veterans who had PTSD symptoms in the past do not currently meet diagnostic criteria.

Re-experiencing an event occurs in different ways. First, a person may have disturbing recollections of the traumatic event consciously while awake or unconsciously in a dream state. Other events may occur to trigger symptoms and the affected person may dissociate while reliving the traumatic moment or moments. The layman's term, "flashback", defines the common re-experiencing event where a person feels as though he or she is reliving the trauma (Kulkarni et al., 2011; Norman, 2000; Owens, Baker, Kasckow, Ciesla & Mohamed, 2005).

Hyperarousal is also a common PTSD symptom. A person may have difficulty falling asleep or staying asleep. Often, people experiencing hyperarousal feel edgy and have outbursts of anger-related emotions. Since they feel like they are in a continuous state of threat or danger, the sympathetic nervous system consistently readies a fight or flight response (Kulkarni et al., 2012; Myers, VanMeenen & Servatius, 2011; Norman,

2000). Kulkarni et al. (2012) found that 76% of the 214 male Veterans in their sample measured above the clinical cut score for anger. They further opined that anger is a coping mechanism the veteran may use to avoid thoughts and control the environment.

Avoidance and numbing represent a flight response to stimuli associated with the traumatic event(s). In fact, avoiding people, places and discussions relating to the trauma is common (Department of Veterans Affairs, 2012; Myers et al., 2011). Further, people may forget important parts of the traumatic event, experience lower interest in activities once enjoyed, feel estrangement from people, and reduced interest in emotionally charged relationships, such as intimacy and sexuality (DSM-IV-TR, American Psychiatric Association, 2000). Dissociation also helps the Veterans to avoid disturbing images by emotionally removing themselves from the situation. Kulkarni et al. (2012) found that of the 214 Veterans studied, 21.5% were above the clinical cut-off score for dissociation. Some evidence suggested that avoidance may predict poorer treatment response among combat Veterans with chronic PTSD (Badour, Blonigen, Boden, Feldner & Bonn-Miller, 2012). A thorough assessment is required prior to diagnosing and treating the veteran.

Assessment of Combat-Related PTSD. Post-traumatic stress disorder is the most common, but not the only psychological condition following a traumatic event. Post-traumatic stress disorder may present with other behavioral or psychological problems, such as depression, substance abuse, phobias, panic disorders and other psychotic reactions (Najavits, Kivlahan & Kosten, 2011). The National Center for PTSD (NCPTSD) has outlined the components of a quality assessment and stressed the importance of neuropsychological assessments for returning OIF/OEF Veterans with

traumatic brain injury. Frequency, intensity and duration of the event determine risk for developing PTSD with intensity being the most important factor (Keane, 2009; Keane, Wolfe & Taylor, 1987). Myers et al. (2012) found Veterans with avoidant personality traits are also at an increased risk for developing PTSD.

War zone stressors add to specific symptom development (Keane, 2009; Pietrzak, Whealin, Stotzer, Goldstein & Southwick, 2011). Combat events are key components to war zone stress evaluations, and understanding what happened during the war experience is paramount in assessing PTSD symptoms (Keane, 2009; Peterson et al., 2011). Hoge et al. (2004) found that of 1,709 infantry soldiers and marines who returned from deployments, 71-86% reported having engaged in a firefight and over half handled or uncovered human remains.

Keane (2009) noted that other additional war zone stressors, such as austere environment and conditions (heat), family concerns back home and toxic exposure need consideration during assessment. Battle aftermath, such as viewing death and destruction, is a major contributor to symptom development (Keane, 2009; Keane et al., 1987; Peterson et al., 2011).

A thorough assessment interview includes discussing prewar risk factors and postwar resilience (Keane, 2009; Peterson et al., 2011). Keane (2009) also explained that adverse childhood events, lower socioeconomic status, poor relationship with parents and other family dysfunction, prior traumatic events, and age of military member experiencing the trauma also add to the risk of developing PTSD. Additionally, the absence of social support and additional life stressors in a postwar environment are

critical considerations during the assessment (Middleton & Craig, 2012; Pietrzak, Harpaz-Rotem & Southwick, 2011).

The Veteran's Administration Compensation and Pension Manual provides best practices for assessing PTSD among the veteran population (Department of Veterans Affairs, 2012). First and foremost, the clinician must determine if the combatant experienced trauma severe enough to meet DSM IV stressor criteria, which is Criterion A of the diagnosis. In any case, the clinician's judgment regarding the Veteran's interview responses and interpretation of the Veteran's affect overrides the results of the clinical interview, psychological testing and neurobiological testing (Keane, 2009).

Neuropsychological assessment is important in assessing the current era and past era Veterans. Understanding the impact of trauma on the brain and central nervous system is necessary when assessing what happened psychologically and neuropsychologically to a combat veteran (Keane, 2009). Reviewing the person's cognition, attention, and memory after a traumatic brain injury could be important in a comprehensive assessment (Peterson et al., 2011).

Interview Protocols. This section discusses several interview protocols that are available for assessing PTSD, such as Clinician Administered PTSD Scale (CAPS), PTSD Symptom Scale, Interview Version (PSS-I), and PTSD Checklist-Military Version (PCL-M).

The CAPS interview is most widely used by medical and behavioral clinicians to assess a patient presenting with PTSD symptoms (Foa & Tolin, 2000; Kulkarni et al., 2012; Peterson et al., 2011). The nature of the 45-60 minute structured interview can decrease patient distress (Peterson et al., 2011). The CAPS was developed in the VA

specifically for assessing PTSD symptoms with Veterans (Keane, 2009). The CAPS measures the frequency and intensity of each of the 17 symptoms within Criterion B, re-experiencing; Criterion C, avoidance/numbing; and Criterion D, hyperarousal as outlined in the DSM-IV-TR (Peterson et al., 2011).

The PSS-I takes approximately 20 minutes to complete and also evaluates each of the PTSD symptoms outlined in the DSM (Peterson et al., 2011). Foa and Tolin (2000) recommended using the PSS-I versus CAPS because the PSS-I had higher sensitivity to PTSD and is positively correlated with measures of trauma, depression and anxiety.

The VA and Department of Defense (DoD) predominantly use the PCL-M to measure responses to stressful military experiences in military Veterans (Department of Veterans Affairs, 2012). This measure is divided into three sections and aligned according to the three symptom clusters (Hoge, 2011; Peterson et al., 2011). Once the clinician has determined that the veteran meets Criterion A by having had a combat-related traumatic experience, the Veteran's report of symptoms will be documented using the PCL-M (Weathers, Huska & Keane, 1991). The PCL-M is organized so that the first five questions relate to re-experiencing; the next seven questions relate to avoidance; and the last five questions relate to hyperarousal. The PCL-M is scored on a numerical scale from 1 *(not at all)* to 5 *(extremely).* The PCL-M used in tangent with the DSM identifies the types of PTSD symptoms organized in three categories and levels of perceived severity.

Veterans are diagnosed with PTSD if they report one or more Criterion B symptoms; three or more Criterion C symptoms and two or more Criterion D symptoms (DSM-IV-TR, 2000; Peterson et al., 2011). Cut-point scores of the PCL are determined

by the prevalence of PTSD in a given population and the medical facility setting characteristics. The table below identifies various cut-point scores in identifying and diagnosing PTSD (The Department of Veterans Affairs, 2012).

Table 1. Suggested PCL Cut-Point Scores

Estimated Prevalence of PTSD	Typical Setting	Suggested PCL Cut-Point Scores
15% or Below	e.g. civilian practice, DoD screening, general population sample	30-35
16-39%	e.g. specialty medical clinics (such as traumatic brain injury or pain or VA primary care)	36-44
40% or Above	e.g. VA or civilian specialty mental health clinics	45-50

The VA recommends further research to establish optimal cut-point scores for a specific application. In order to measure a change in PTSD symptoms, a 5-10 point change is reliable; and a 10-20 point change is clinically meaningful (The Department of Veterans Affairs, 2012). The VA considers a five point change the minimum for determining if a veteran has responded to treatment and a minimum ten point change indicates a clinically meaningful improvement.

In addition to structured clinical interviews, which give the clinician an idea of the dimension of symptoms the person is experiencing, Keane (2009) also recommended a personality assessment as part of a thorough PTSD assessment, specifically, the Minnesota Multiphasic Personality Inventory (MMPI). One benefit of this one-hour self report MMPI is a built in PTSD component, which is not known to the person taking the test. The MMPI also contributes to the validity of a clinician's assessment and diagnosis

(Keane, 2009). Limitations of psychological testing include inaccuracies in self-report, limits of skills and background of evaluators, the lack of adopted best practices in the instruments and evaluations, and non-relevancy for all races, genders or ethnicities (Keane, 2009).

Comorbidity

Post-traumatic stress disorder is associated with high rates of comorbidity (Keane, 2009; Najavits et al, 2011). Keane (2009) further noted that epidemiological studies suggest PTSD develops first, depression second and substance abuse third. The key in the assessment process is deciding on the primary set of problems and where to focus treatment planning in order to reduce symptoms (Keane, 2009).

Elderly Veterans in particular may be misdiagnosed more often than younger Veterans, as they typically present with other significant age-related medical problems (Owens et al., 2005) such as cardiovascular, endocrine and neurological problems which can cover the somatic symptoms of anxiety that is also found in PTSD (Keane, 2009.; Keane & Wolfe, 1990; Owens et al., 2005). Characteristics of delirium and dementia, conditions often found among the elderly, include memory lapses, increased startle response and sleep difficulties which along with delirium and dementia can inhibit an accurate diagnosis of PTSD (Owens et al., 2005).

Regardless of age, depression, substance abuse and generalized anxiety disorders are common additional diagnoses among Veterans with combat-related PTSD (Owens et al., 2005). Keane and Wolf (1990) found in a sample of Vietnam Veterans that 75% were diagnosed with conditions, such as substance abuse, major depression and personality disorders in addition to PTSD.

Modalities for Treating PTSD

The VA and DoD continue to research PTSD treatment modalities in an effort to improve reducing symptoms (Insel, 2007). In fact, Insel (2007) reported that the National Institute of Mental Health invested nearly $45 million in fiscal year 2006 to support research focused on PTSD treatment among active duty and military Veterans. Although various treatments are available, the VA and DoD mandate that all returning Veterans have access to prolonged exposure therapy or cognitive processing therapy (Department of Veterans Affairs, 2012). The Department of Veterans Affairs and DoD (VA/DOD, 2010) guidelines state that the most effective treatment involves psychotherapy that includes components of exposure and/cognitive restructuring. Prolonged exposure, cognitive processing therapy and eye movement desensitization reprocessing are more effective in reducing symptoms of PTSD if combined with anxiety management, stress coping skills and psychoeducation (VA/DOD, 2010).

This section of the study examines four combat-related PTSD treatment modalities that have been used with measurable effectiveness, including cognitive processing therapy, eye movement desensitization and reprocessing therapy, prolonged exposure therapy and virtual reality exposure therapy (Albright & Thyer, 2010; Germain, Shear, Hall & Buysse, 2007; McLay, McBrien, Wiederhold & Wiederhold, 2010; Najavits et al., 2011; Owens et al., 2005; Peterson et al., 2011; Reger & Gahm, 2008; Stapleton, Taylor & Asmundson, 2006; Tuerk, Yoder, Grubaugh, Hyrick, Hamner & Acierno, 2011; Wood, Wiederhold & Spira, 2010).

Cognitive Processing Therapy (CPT). Cognitive restructuring is the basis for effective CPT. This therapy typically focuses on how thoughts impact emotional

responses and behaviors and is delivered through 12 sessions over six weeks in four phases (National Center for PTSD, 2012). The four phases include education, processing thoughts and beliefs, learning CPT skills, and understanding changing beliefs (National Center for PTSD, 2012). Cognitive Processing Therapy consists of two main components: cognitive therapy and exposure via written or verbal accounting. The focus of CPT shifts thoughts from the person's denial and self-blame to beliefs about oneself and the world pre and post trauma. Next clients are educated about how to challenge their beliefs using written experiences and worksheets (National Center for PTSD, 2012; Resick, Nishith, Weaver, Astin & Feuer, 2002).

Although several studies support the effectiveness of CPT in reducing anxiety and depression (Forbes et al., 2012; Alvarez et al., 2011), cognitive based therapy may not be an appropriate intervention for Veterans with limited cognitive functioning or severe physical restrictions (Owens et al., 2005). The VA and DoD guidelines (VA/DOD, 2010) are in agreement that CPT is effective in reducing PTSD symptoms; however in order to support effectiveness in a group format, additional research is needed. Further, the guidelines state there is limited data to support that CPT is currently more effective than exposure therapy (ET).

Exposure Therapy (ET). This section addresses three specific types of exposure therapy: eye movement desensitization and reprocessing (EMDR), prolonged exposure (PE), and virtual reality exposure therapy (VRET). Exposure therapies have been used to treat anxiety disorders since the 1920s (McLay et al., 2011). Most recently, eye movement desensitization and reprocessing and virtual reality exposure therapy joined the list of other exposure therapies used today, such as flooding, implosion therapy,

systematic desensitization, and prolonged exposure (McLay et al., 2011; Reger & Gahm, 2008; Wood et al., 2010). Learning coping techniques prior to exposure is imperative so re-traumatization does not occur. Clients are taught cognitive skills to control negative thoughts and somatic skills to control physiological sensations, such as a racing heart, while being exposed to traumatic past events (McLay et al., 2011, Tuerk et al., 2011).

Eye Movement Desensitization and Reprocessing Therapy (EMDR). Eye Movement Desensitization and Reprocessing Therapy was developed over 20 years ago as a cognitive-behavioral therapy for treating anxiety-related PTSD. During treatment, the client is asked to recall a traumatic memory and emotions attached to the memory while also focusing on a visual, auditory or tactile external stimulus (Albright & Thyer, 2010). Van Etten and Taylor (1998) critically compared EMDR and Cognitive Behavioral Therapy (CBT) in treating PTSD. They found both interventions had similar effects directly after treatment and upon follow-up. Van Etten and Taylor (1998) opined EMDR as more efficient, though, because treatment duration was less than CBT. However, Albright and Thyer (2010) studied nine articles that reviewed EMDR treatment of VA-related clients, and found limited evidence to support EMDR as an effective treatment in reducing PTSD among combat Veterans.

Stapleton et al. (2006) studied 60 participants who were diagnosed with PTSD and supported the effectiveness of three therapies in treating anger and guilt symptoms. In fact, the three therapies studied (prolonged exposure, eye movement desensitization and reprocessing and relaxation training) were known to reduce four categories of anger and guilt. The EMDR treatment involved the participant recalling the trauma and the therapist simultaneously either moving a finger horizontally in the participant's line of

vision or hand tapping (Stapleton et al., 2006). Although their study supported EMDR as an effective treatment to reduce anger and guilt in PTSD, they also noted it may be necessary to include cognitive restructuring as another component of the treatment to focus specifically on reducing anger and guilt. The VA and DoD Guidelines (2010) note that the effectiveness in EMDR has not yet been determined, but effectiveness is expected to be similar to other trauma-focused exposure and cognitive-based therapies.

Prolonged Exposure Therapy (PE). This therapy model involves continuous exposure to the trauma through talking to a therapist and viewing real-life reminders of the trauma repeatedly until the person habituates the psychological and emotional arousal (McLay et al., 2011, Corso et al., 2009). A standard PE treatment program includes 45-minute sessions for eight to 12 continuous weeks. During the session, clients talk about their traumatic events as if they are occurring in the present time while remembering as many sensory details as possible. The sessions are audiotaped and clients listen to their narratives five times a week (Hagenaars & van Minnen, 2010).

The VA outlined their PE treatment program and highlighted four areas that comprise this treatment. The clients are educated about trauma reactions, PTSD, and goals for treatment. Next, they are trained to relax their breathing. Third, the clients are introduced to real-world exposure (in vivo). Lastly, clients are guided to talk repeatedly about their traumatic memories to restructure their negative thoughts (National Center for PTSD, 2010). The effectiveness of PE is affected by persistent alcohol use, which reduces anxiety and interferes with treatment because the client cannot fully engage psychologically or physiologically (VA/DOD, 2010).

Hagenaars and van Minnen (2010) opined that exposure treatment may improve relating to others and personal strength by allowing the mind to create new attachments and increase a sense of mastery. Conversely, van Minnen, Harned, Zoellner and Mills (2012) stated that prolonged exposure worsened anger and guilt, especially with clients who have PTSD and comorbid problems.

Virtual Reality Exposure Therapy (VRET). Virtual reality exposure therapy is much like a video gaming system in that the client uses a joystick to navigate through the treatment. Unlike a regular video game, VRET recreates a realistic environment, complete with smells, 3D sights, sounds and body motion tracking (Reger & Gahm, 2008). The patient may wear a head-mounted display system or enter a computer-automated room where trauma images are present in a 360 degree view. Virtual reality exposure therapy allows the patient to relive the trauma (versus avoid it) in a controlled, safe environment, which allows them to face their fears with a clinician present. The ultimate goal of VRET is to reduce fear and anxiety (Reger & Gahm, 2008). Wood reported that exposure therapy should work because fear is associated with safety and the brain learns new associations during VRET (2010).

Reger and Gahm (2008) found that VRET was an effective treatment for combat-related PTSD, and vehemently opposed using prolonged exposure (PE) therapy. They suspected that PE treatment may negatively affect a warrior who has been continuously exposed to trauma throughout a lengthy deployment (Reger & Gahm, 2008). Four studies supported VRET as an effective treatment for combat-related PTSD (McLay et al., 2010; McLay et al., 2011; Reger & Gahm, 2008; Wood, 2010). The VA and DoD Guidelines (2010) reported that more virtual reality exposure techniques are being used in

exposure therapy. However, there are no randomized studies of VRET compared with standard exposure therapy that support its effectiveness (VA/DOD, 2010).

In an effort to support their claim that ET, specifically VRET, is an effective treatment for PTSD, McLay and McBrien deployed with the First Marine Expeditionary Force to Camp Fallujah, Iraq, and documented the first use of virtual-reality based therapy to treat combat-related PTSD (McLay et al., 2010). Active duty soldiers (n=10) received ET with and without virtual reality exposure treatment. The veterans were seen as often as twice a week, but sometimes sessions were more "spread out" (p.39). McLay et al. (2010) warned that due to the nature of treating in a war zone, procedures were not standardized and record keeping didn't allow for a comprehensive sample. Deployed patients in VRET experienced a 67% decrease in PTSD symptoms and overall the six patients who received VRET experienced statistically significantly drops in their PCL-M score. McLay et al. (2010) further reported that all four patients treated with traditional ET reported reduction in symptoms and did not qualify for a PTSD diagnosis based on the DSM criteria. The authors noted that the traditional ET patients did not start off with PTSD Checklist scores that were quite as bad as the VRET patients, which may account for the more successful ET outcome (McLay et al., 2010).

The following two case studies involved one participant each with comparable results (Reger & Gahm, 2008; Wood et al., 2009). Reger and Gahm (2008) studied one Army infantry man who was deployed over one year in Operation Iraqi Freedom as a HUMVV gunner. After six VRET sessions, the patient's initial PTSD Checklist (PCL) score of 58 declined to 29, which is below the cut-off for a PTSD diagnosis (2008). Additionally, the patient reported a decrease in problematic symptoms, increased

socialization and improved functioning. A 26 year-old female Navy Seabee also received VRET after returning from a third deployment to Iraq in 2006 (Wood, et al., 2009). Wood et al. (2009) reported that she had a significant decrease (65 to 24) in self-report symptoms of PTSD between pretreatment and post-10-week assessments. Additionally, they supported VRET's efficacy with decreased CAPS scores (83 to 12). While each study involved only one case, the findings illustrate potential usefulness that requires further documented study.

Another virtual reality machine includes an arousal control feature (VRET-AC). It runs on three computers: one displays the visual aspect of treatment; one displays the control panel and menu, and the third runs physiological monitoring (heart rate, skin temperature, etc.) (Wood, et al., 2010). The goal of VRET-AC is to help the warrior control reliving traumatic thoughts. Wood et al. (2010) studied VRET-AC as an effective treatment for combat-related PTSD and found the method effective for learning and creating new memories. The study involved over 350 VRET sessions over the course of three months with 30 service members. Wood et al. (2010) concluded that the VRET-AC group was able to desensitize because they became fully aroused during exposure and remained "on task", which cannot occur during imaginal exposure.

VRET is a relatively new treatment technique, especially in the military arena. Reger and Gahm (2008) first published results of treating an active duty soldier, who was diagnosed with PTSD in 2008. Further testing and validation on VRET in treating combat-related PTSD is needed (Wood et al., 2010; McLay et al., 2011). Wood et al. (2010) especially urged continued validation for VRET-AC for combat-related PTSD treatment.

Mental Health Services Available to Veterans

Veterans have several options available to them for help with mental health issues. While deployed, the military member can seek counseling from military chaplains and behavioral health technicians, who deploy to austere locations with them (McLay et al., 2010). Stateside, military members and Veterans are eligible for mental health care at military treatment facilities (Department of Veterans Affairs, 2012). The VA offers inpatient and outpatient care and Vet Centers offer individual and group counseling (Department of Veterans Affairs, 2012; National Center for PTSD, 2012). Additionally the military health insurance, TRICARE, is accepted at a select number of community-based hospitals and outpatient mental health clinics (Department of Veterans Affairs, 2012; National Center for PTSD, 2012). Veterans who do not want to use the military health care system can use public community hospitals and outpatient clinics with TRICARE, private or civilian employee insurance (Department of Veterans Affairs, 2012; National Center for PTSD, 2012). Lastly, for those who do not want face-to-face contact with providers, help is available on-line (National Alliance on Mental Illness, 2012).

As of July 2010, the VA operates 153 hospitals, 773 outpatient centers and 260 Vet Centers located in cities across the country for counseling in the United States (National Alliance on Mental Illness, 2012). The VA offers 200 specialized PTSD programs, which includes a specialized outpatient program that simultaneously treats substance abuse and PTSD and another program that offers one-on-one treatment for women only (Department of Veterans Affairs, 2012). Additionally, several 14 to 90-day inpatient and day treatment programs are available (Department of Veterans Affairs,

2012; National Center for PTSD, 2012). The VA typically offers cognitive processing therapy, prolonged exposure and several group therapies (Department of Veterans Affairs, 2012).

Congress created the Vet Center Program in 1979 after the VA found that a large number of Vietnam vets continued to struggle with readjusting to civilian life after the war. Congress has since extended eligibility for services to Veterans who served in all hostile zones before and after the Vietnam Conflict. The Vet Center is an outreach program that has counseled and referred Veterans to either the VA or civilian mental health agencies to help them readjust (National Center for PTSD, 2012; Department of Veterans Affairs, 2012).

TRICARE coverage extends to some civilian medical facilities. One such facility is Laurel Ridge Treatment Center, located in San Antonio, Texas. Laurel Ridge dedicated 25% of its facility to treat Veterans suffering from PTSD. The staff is trained to assess and treat military specific issues and their programs are based on best practices as outlined by National Center for PTSD (NCPTSD). Laurel Ridge also offers day treatment and prolonged exposure and cognitive behavioral therapy interventions (National Center for PTSD, 2012; Laurel Ridge Treatment Center, 2012).

Lastly, due to technological advances, several on-line resources have been made available in addition to attending treatment at VA and civilian medical facilities. The NCPTSD produced “About Face”, an interactive site that includes several real-world Veterans who tell their story from trauma experience to treatment results (National Center for PTSD, 2012). The Marine Corps implemented dstressline.com that offers 24/7 telephone assistance, a chat line, and resource locator (U.S. Marine Corp., 2012). A third

on-line resource is “Make the Connection,” a website which offers information on treatment options and recovery. Additionally, this website, sponsored by the VA, offers self-help and self-assessment links as a way to reach out to Veterans who may be skeptical of seeking help (Department of Veterans Affairs, 2012). A Veterans Crisis Line was established by the VA to give Veterans a hotline available 24 hours a day. Additionally, an online chat is available as a link on the Department of Veterans Affairs web site as an opportunity for support and to prevent suicide (Department of Veterans Affairs, 2012).

Implications for Social Workers

Since 1926, the VA Social Work staff has addressed the needs of all veteran populations, including but not limited to ex-Prisoners of War and all combat and non-combat Veterans (Department of Veterans Affairs, 2012). Between 1997 and 2005, the VA experienced a 56% increase in specialty mental health treatment with PTSD cases doubling to 279,256 cases (Rosenheck & Fontana, 2007). Social workers who hold an MSW degree are commissioned as officers and employed at military installations around the world and often deploy with combat units. Civilian behavioral health treatment facilities also employ social workers and treat military Veterans suffering with PTSD. Around the world, clinical social workers possess an opportunity to improve treatment experiences and help the Veterans reduce their symptoms. The purpose of this study was to explore from Veterans’ perspectives, their experiences with combat-related PTSD treatment and to report their advice to social workers involved in treating Veterans.

Conceptual Framework

The focus of this study was to explore from Veterans' perspectives, their experiences with combat-related PTSD treatment and to report their advice to social workers involved in treating Veterans. The diagnostic criteria outlined in the DSM-IV-TR and the PTSD Checklist – Military Version (PCL-M) will provide a framework to determine the severity of the combat-related PTSD symptoms before and after treatment. The integrated framework of the PCL-M will be used to organize the data collection for this study. Further, Criterion B, C, and D of the DSM will be operationalized by the PCL-M.

The interview questions are crafted to enable the participant to discuss military duty background, type of treatment modality used, personal experience with PCL-M checklist items (PTSD symptoms) before and after treatment, any prescribed psychotropic medications, comorbid diagnoses and support systems in place before, during and after treatment. The last question asks the participant for their advice for social workers who treat Veterans with combat-related PTSD.

The researcher will use the PTSD Checklist, which mirrors the PCL-M (Appendix E) to document the Veteran's report of symptoms in response to stressful military experiences before and after treatment (Weathers, Huska & Keane, 1991). The PTSD Checklist is organized so that the first five questions relate to re-experiencing; the next seven questions relate to avoidance; and the last five questions relate to hyperarousal (Weathers, Huska & Keane, 1991). The PTSD Checklist is scored on a numerical scale with (1) meaning *not at all* and (5) meaning *extremely* and is used in tangent with the DSM to identify the types of PTSD symptoms and levels of perceived severity.

In order to measure if symptoms are severe enough to support a PTSD diagnosis, the veteran would need to report at least one re-experiencing event; at least three avoidance or numbing responses to events associated with the trauma; and at least two symptoms of increased arousal (DSM-IV-TR, 2000).

This study will utilize as its framework Criterion A of the DSM and the three symptom clusters identified in the DSM-IV-TR (Criterion B, C and D) as outlined in the PCL-M. The PTSD Checklist, which mirrors the PCL-M, will be used as a guide for the participant to describe their experience. Conceptually, this tool addresses Criterion B, C and D of the DSM. The Veterans in this study will be invited to recall their experience with these symptoms before and after treatment. In addition, Veterans will be asked to offer advice to social workers for their work with Veterans and their families. The goal of this study was to explore from the Veterans' perspective their experiences with treatment for combat-related PTSD and to report their advice to social workers involved in treating Veterans.

Methods

Research design

This was an exploratory qualitative study. Data was gathered from interviews with combat Veterans who were diagnosed with and treated for combat-related PTSD. The research focus was to document from Veterans' perspectives, their experiences of combat-related PTSD treatment and their advice to social workers who treat Veterans and their families.

The researcher is a 22-year Air Force veteran, who retired as a Major in 2011. Committee member A has more than five years experience as a licensed mental health

counselor in both office and in-home settings and she specializes in treating veterans' issues and PTSD. Committee member B is a 22-year Army Reserve member and works with deploying units and the command staff. Committee member B was deployed to Iraq from 2008-2009.

Participants

Five military-related and community based agencies facilitated participant recruitment (Appendix A). A recruitment flyer (Appendix B), including researcher's contact information, was placed at the agencies. Both the invitation flyer (Appendix B) and the consent form (Appendix D) referenced the researcher's shared experience with military duty and an understanding of the participants' roles as military members. Interested participants contacted the researcher to verify participation criteria. Participants were telephonically screened to verify that they met the following criteria for the study: deployed to a combat zone; received a PTSD diagnosis based on combat-related service in the military; and completed PTSD treatment prior to July 1, 2012 (Appendix C). After the researcher discussed the research project overview and determined the caller's eligibility, the researcher asked if the caller was still interested in participating. Participants who met the criteria scheduled an in-person, audio-taped interview at a private location with others present for the safety of the participant. A telephone was available at the interview site as a precaution in case the participant needed immediate professional mental health assistance. The researcher also gave the caller the Veterans Administration Crisis Line contact information. The Crisis Line operates 24/7 and the phone number is 1-888-273-8255. The researcher expected to interview 7-10

military Veterans in-person; however, four interviews were completed. The interviews were recorded on a secure laptop computer using recording software.

Protection of Human Subjects

Review process. After the chair and clinical research committee approved the proposal, an application was submitted to the St. Catherine University Institutional Review Board (IRB) with all required supporting documentation, e.g., agency approvals, flyers, screening questions, consent forms, and interview questions, including the PCL-M based Checklist. After the application was approved, the researcher began interviewing participants.

Protocols to insure protections. Invitations to participate were sent to organizations and therapy agencies to recruit participants (Appendix A). Participants were recruited using a flyer (Appendix B). When participants contacted the researcher, they were asked three screening questions (Appendix C) to ensure they met the criteria for this study. The screening questions asked if they were deployed to a combat zone; if they were diagnosed with combat-related PTSD; and if they completed treatment prior to July 1, 2012. The researcher also provided the VA Crisis Line phone number, 1-800-273-8255, at this time. Participants who met the criteria and agreed to participate received a consent form (Appendix D) the day of and prior to the interview. The consent form addressed risks, offered options during the interview, discussed background information, procedures of the interview (including written questions along with the interview component) and steps to ensure confidentiality were addressed. Further, the participants were informed of the voluntary nature of the study and that they may withdraw from the study at any time without repercussions. In accordance with the

consent form, audio and interview transcriptions were destroyed by June 1, 2013. Participants who were subsequently interviewed were asked several questions, including three "Assurance of Participant Understanding" questions (Appendix E) which ensured they understood what the study was about and what was covered in the consent form. The questions were as follows: In your own words how would you explain the purpose of this study? What can you do if you feel uncomfortable answering questions at any time during the interview process? What happens if you decide to withdraw from the study? To further reduce risk, the researcher asked the Veteran the following question after the interview was over: Now that we are finished, how are you doing? A telephone was available at the interview site as a precaution in case the participant needed immediate professional mental health assistance. Two interviews were transcribed by the researcher and two by a professional transcriber. The transcript did not include participants' names for data analysis purposes. The transcriber signed a confidentiality agreement prior to having access to the taped interviews (see Appendix D).

Results were kept confidential. In any written reports or publications, no one was identified or identifiable. The researcher kept the research data in a locked file cabinet in the researcher's home office in Woodbury, Minnesota. Electronic data was stored on a flash drive and kept in the same locked file cabinet. Only the researcher or the researcher's faculty advisor had access to the records during this study. The researcher analyzed the data by June 1, 2013 and then destroyed all original reports and identifying information that could be linked back to participants. Tape recordings were not presented to others for educational purposes. The recordings were erased by June 1, 2013.

Data Collection

Instrument development. All questions were open-ended. After the researcher was assured each Veteran understood the goal of the study and interview process (Questions 1-3, Appendix E), basic information was gathered about the Veteran's military background (Question 4, Appendix E). Next the participants were asked about their treatment (Questions 5-12, Appendix E). The researcher modified the PCL-M Checklist by adding the columns "Before Treatment" and "After Treatment" to gather data from the participants regarding any changes in symptoms. Using this modified PCL-M Checklist as an interview guide, participants were asked to discuss their experience with PTSD symptoms before and after treatment by indicating how much they were bothered by that symptom using numbers ranging from (1) *not at all* to (5) *extremely* (Appendix E). Next, the participants were asked about support systems before, during and after treatment, any prescribed psychotropic medications, and comorbid diagnoses (Questions 13-15, Appendix E). The last question asked the participant for their advice for social workers who treat Veterans with combat-related PTSD (Question 16, Appendix E). After the interview was completed, the researcher asked the participant the following question: Now that we are finished, how are you doing? Three participants indicated no physical or psychological disturbances due to the interview questions. One participant indicated anxious feelings; however he decided to continue answering questions for the interview.

Data collection process. Recruiting flyers (Appendix B) were mailed to organizations and therapy agencies that agreed to participate (Appendix A) as soon as the IRB approved the proposal. Participants contacted the researcher and were asked

screening questions to ensure they met the criteria for the study (Appendix C). The researcher provided the VA Crisis Line contact information, 1-800-273-8255 as a precaution and effort to protect the participants. Eligible participants signed the consent form (Appendix D) prior to the interview and were given a 2" x 4" magnet from the Department of Veterans Affairs that lists the crisis line phone number, 1-800-273-8255. As relevant based on the source of referral, phrases describing specific contact people and for crisis references were included in the consent form.

The interview began with three questions that clarified the participants understanding of the study (Appendix E). All participants were asked pointed questions during the interviews and asked to complete a written portion (Appendix E). The interviews lasted approximately 1 to 1 ½ hours and took place between January 10, 2013 and February 28, 2013.

Participation in the study had potential risks for the participants. Talking about combat-related PTSD treatment experiences may be uncomfortable and may trigger memories of the traumatic events. If that happened, the participants were instructed to request to skip a question, pause the interview, or terminate the interview. None of the participants, including the participant who experienced anxious feelings, made any of these requests. The researcher disseminated crisis resource information during the telephonic screening and at the beginning of the interview as part of the consent process. Every participant received a 2" x 4" magnet from the VA Crisis Line, which listed their phone number (1-800-273-8255). As relevant based on source of referral, phrases describing specific contact people and for crisis references were included in the consent form. The researcher assured each participant that the interview would stop if they

encountered re-experiencing, avoidance/numbing or hyperarousal symptoms. To further reduce risk, the researcher asked the veteran the following question after the interview was over: Now that we are finished, how are you doing? The interview was conducted in a private location with others present for the safety of the participant. A telephone was available at the interview site as a precaution in case the participant needed immediate professional mental health assistance.

Data Analysis

The professional transcriber signed a confidentiality agreement and data was transcribed void of names or identifying information. Data was analyzed using content analysis. Berg and Lune (2012) described content analysis as a strategy for examining and interpreting data by discovering patterns, themes, biases, and meanings. The researcher analyzed the interview transcript and identified codes and themes. Initially, the coding process began with a process called open coding. Each line of the transcript was analyzed and broadly coded according to its meaning. A theme was identified when three or more instances of a code were annotated. The researcher documented theoretical notes during the coding process, which proved valuable when forming themes. For example, the importance of support systems in recovery was found several times, which led to identifying family, friend, and military comrade support systems. Direct quotes are presented in *italics*.

Strengths and Limitations

Veterans' recollections of the effects of perceived symptoms then and now and their experiences with treatment were limited depending on the lapsed time between treatment and interview. According to King and Horrocker (2009), an oral history

interview requires the participant to recall specific events or feelings in the past. The possibility of bias is great as memory lapses may distort the data. The study also had a limited number of participants who were not randomly selected, which limited generalizability (Berg & Lune, 2012).

Capturing the Veterans' experiences with treatment through personal interviews and conducting the study via qualitative research were strengths. The researcher gathered comprehensive information about combat-related PTSD treatment directly from the client. The researcher was able to glean non-verbal cues and ensure the Veterans' safety throughout the interviews. Although the participant pool was small, it was somewhat diverse in that one woman's experiences were included in the study. Analyzing the data and making cross-case comparisons were easier because of the small number of participants. The researcher was also able to gather vivid demonstrations of personal PTSD symptom experiences, including the effect of pharmacological and previous mental health interventions on treatment experiences.

The sample size and limited diversity in race and ethnicity affected the scope of the study findings. Future research using a larger and more diverse sample would expand our knowledge of Veterans' treatment experiences and their advice to social workers. The results are not generalizable to the population as a whole because it was conducted with only four Veterans spanning from the Vietnam War era to the more current Global War on Terror. Lastly, the general themes expected (three symptom clusters of PTSD) and the ability to use coding frames to organize the data and later identify findings (Berg & Lune, 2012).

Findings

This study sought to investigate Veterans' experiences with combat-related PTSD treatment. The findings were developed from interviews with four Veterans who received outpatient treatment for combat-related PTSD. All four interviews were conducted face-to-face. Three occurred at the participants' residences with family members nearby but not in the same room. One interview was conducted in a meeting room with the door closed. The intent was to conduct interviews in a safe and quiet environment where the respondent would be most comfortable.

Four combat Veterans were interviewed for the purpose of this study. One female had deployed to Iraq. Two were men who completed combat tours in Vietnam. Another male had deployed twice, once to Afghanistan and once to Iraq. All four participants voluntarily joined the Army. Two were active duty and two belonged to the Army Guard. One Vietnam Veteran was in Artillery, the other an Infantryman. One Global War on Terror (GWOT) Veteran was in Infantry; the other was a Light Wheeled Vehicle and Generator Mechanic. The length of time the participants spent in combat ranged from one year to two years. Their time in service ranged from one to six years. All participants were enlisted members ranging in rank from E-1 (Private) to E-6 (Staff Sergeant). One Vietnam Veteran received inpatient, individual and group therapy in the 1970s. The other Vietnam Veteran received EMDR and individual and group psychotherapy, all in an outpatient setting. One GWOT Veteran received inpatient treatment and cognitive processing therapy (CPT) in outpatient treatment. The other GWOT Veteran received both prolonged exposure (PE) and CPT in outpatient settings.

The themes that emerged from the interviews regarding Veterans' experiences with combat-related PTSD treatment fall into six categories, 1) Re-experiencing Symptoms, 2) Avoidance Symptoms, 3) Arousal Symptoms, 4) Experiences of Treatment, 5) Support Systems and 6) Advice to Social Workers. The themes are delineated below and are illustrated with excerpted comments from the qualitative data.

Re-experiencing Symptoms

The researcher modified the PTSD Checklist – Military Version (PCL-M) to help determine the severity of the combat-related PTSD symptoms before and after treatment (Appendix E). The researcher also used the symptoms listed on the PCL-M to facilitate a discussion about the Veterans' experiences. The Veterans described in more detail the frequency, intensity, and duration of their symptoms before and after treatment. As noted in Table 2, Respondent 1 received psychotherapy; Respondent 2 received EMDR and psychotherapy; Respondent 3 received CPT; and Respondent 4 received PE and CPT at different times.

Table 2. Re-experiencing Symptoms

	Respondent 1		Respondent 2		Respondent 3		Respondent 4			
	Psychotherapy		EMDR/Psychotherapy		CPT		PE		CPT	
	Pre Tx	Post Tx	Pre Tx	Post Tx	Pre Tx	Post Tx	Pre Tx	Post Tx	Pre Tx	Post Tx
Repeated, disturbing *memories, thoughts* or *images* of a stressful military experience	5	4	5	4	3	4	4	5	4	3
Repeated, disturbing *dreams* of a stressful military experience	5	5	5	3	4	4	5	5	4	4
Suddenly *acting* or *feeling* as if the military experience *were happening again* (as if you were reliving it)	4	3	5	4	4	3	4	4	4	4
Feeling *very upset* when *something reminded* you of a stressful military experience	5	4	5	4	4	3	5	5	4	4
Have *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful military experience	5	5	5	3	4	3	4	5	4	4

Note: Rating indicates how much the Veteran was bothered by that problem before treatment and after treatment. The numbers indicate the following: (1) *Not at all*; (2) *A little bit*; (3) *Moderately*; (4) *Quite a bit*; (5) *Extremely*

The researcher identified re-experiencing symptoms as a strong theme. As noted on Table 2, this study supports that 3 of the 5 re-experiencing symptoms for one Veteran (repeated, disturbing memories, thoughts or images; reliving experiences; feeling upset when something reminded) reduced, but other symptoms (repeated, disturbing dreams of a stressful military experience) did not change after treatment. The Veteran who received EMDR coupled with psychotherapy was bothered by repeated, disturbing dreams *extremely* prior to treatment, but reported these symptoms reduced to *moderately* after treatment. In fact, this Veteran experienced less re-experiencing symptoms in all five categories of this symptom cluster. Both Veterans who received CPT treatment, did not experience a change in repeated, disturbing dreams of a stressful military experience after treatment. In fact, the second Veteran reported being *quite a bit* bothered by the last 4 of the 5 symptoms before and after treatment. Further, disturbing memories, thoughts or images bothered her *moderately* after treatment; a reduction from *quite a* bit before treatment. This same Veteran did not experience any change in symptoms involving disturbing dreams or feeling upset when something reminded her of a stressful military experience after receiving PE. She reported both symptoms as *extremely* bothersome before and after treatment. The same Veteran reported an increase in disturbing memories, thoughts or images and experiencing physical reactions from *quite a bit* to *extremely*.

All respondents reported at least one incident from the four main areas of re-experiencing a stressful military experience: repeated, disturbing memories, thoughts, or images; repeated, disturbing dreams; reliving the experience; or feeling upset from a memory.

Memories, thoughts, and images. The two Vietnam Veterans indicated that they will always think of their stressful military experiences. One reported, *There isn't a day that goes by that I don't relate something back to Vietnam.* The other Veteran reflected, *Once you kill another human being your living a normal life is pretty much over. You can never get that out of your head. Never. You still think about it. It will never leave you.* Two respondents reported an increase in the frequency of their thoughts and dreams after treatment. One respondent reported that treatment unblocked his thoughts: *A lot of my memories were blocked out before treatment, but after treatment more of the memories were recalled. Treatment made these symptoms worse.*

The second respondent described how treatment affected the frequency and intensity of thoughts:

> *After treatment, my thoughts were reawakened. I couldn't avoid it anymore.* [Thoughts] *happened more frequently and I started talking about it more again. Prolonged Exposure made my triggers worse. Fireworks or the smell of garbage brought me back.*

Another respondent has vivid memories of his involvement in the Tet Offensive and the destruction of war:

> *That was a bad one because we lost…we had 127 guys killed. We had one gun out of six that was operational. We shot artillery fire…direct beehive fire for 10 straight hours. When daylight came, it looked like a field of toothpicks. We fired all our ammo and were attacked by 2,500 strong North Vietnamese. We only had two batteries of artillery! I shouldn't be alive today. The only thing that saved us were the B-52 bombers.*

Dreams. For one respondent re-experiencing symptoms blurred with arousal symptoms:

> *After two weeks in country I shot a North Vietnamese Officer.* [Now] *I see him, his wife and son. Sometimes I would see their eyes over my bed. I would wake up and destroy the bedroom.*

The same respondent reported acting out his dreams during sleep.

> *When my wife was pregnant, her doctor told her not to sleep with me because I could kill the kid. I would kick, throw, and swing. I had my wife in a choke hold and didn't even know it.*

Another respondent noted her dreams sometimes caused her to relive a military experience:

> *I dreamed one of my guys that died told me to get ready and that there were people coming. I covered myself from face to chest in camo paint, got my uniform on, and got in my bathtub. My friend found me like this. She took a picture of me and I didn't recognize myself.*

A third respondent noted a lack of control when he identified his dreams. *I dreamed of helplessness where you can't save yourself or others. It would feel very real.*

Acting/feeling – reliving. Reliving combat-related events may trigger the Veterans to return to combat mode. One respondent recalled her behavior during a celebration one October. She reported, *I was inconsolable. I was in soldier mode and that's where I stayed until I calmed down. The trigger was fireworks.*

Another respondent recalled an unconscious thought that prompted his unconscious, but very real actions:

> *I was sleeping and swear I saw a Vietnamese in the back yard with a rifle, so I fired a 12 gauge right through the window about midnight-one a.m. I woke everyone up. They said I fired and put my shot gun back under my bed and went back to sleep.*

A third respondent noted how CPT treatment reduced her unconscious reliving episodes:

> *The Prolonged Exposure made my sleep very violent. The second time I destroyed my apartment, I woke up, saw the apartment was destroyed and my dog look terrified. I still had nightmares after starting CPT, but I stopped destroying my apartment.*

Reminded of trauma. One respondent discussed the similarities between his feelings of being part of stateside crowds and being in a deployed location:

> *I would be at sporting events or around large amounts of people where I didn't have any control or an escape route.* [I would feel upset at] *places that I feel like I'm not in control or loud places where I feel distracted and unsafe. This got better after treatment.*

Physical reactions. The memories, thoughts and images, also known as flashbacks, can cause physical reactions, including racing heart, trouble breathing, or sweating. All four respondents experienced these types of reactions. Treatment did not extinguish the symptoms, but did reduce the intensity for two Veterans (Table 1.).

One respondent recalled physical reactions to tornado sirens and fireworks: *My heart starts racing. I get tunnel vision.* Another respondent noted these symptoms did not change after treatment: *I'll tell you right now that* [physical reactions] *don't change. Whenever I'm in a group and someone takes a picture with a flash, my heart just races. It just sends me.* A third respondent explained his emotional reactions to combat trauma: *I would have a hyper fixation and I couldn't let go of a thought. I would get a claustrophobic feeling that everything is too close and I don't have room to move or escape.* A fourth respondent exhibited a visual physical reaction to group therapy:

> *My face broke out and swelled up from the constant counseling of bringing up this shit. I think about it every day, OKAY. I talked about it. I understand it. But why do you keep bringing it up? Why don't you just help me?*

That same respondent identified the benefits of psychoeducation in treatment:

> [Because of treatment] *now I look at my physical symptoms and say, "Okay, I am having a panic attack." The main thing I got out of treatment was how to recognize what's happening with me.*

Another respondent noted that treatment reduced the duration of her physical symptoms: *The longevity of the startles doesn't last as long now. I'm able to calm down faster.*

Avoidance Symptoms

Avoidance symptoms are described in seven distinct categories (see Table 3). Veterans may avoid thinking or talking about their military experiences for fear it will trigger traumatic memories. They may avoid activities or situations because they are reminded of a stressful military experience. Some Veterans may have trouble remembering important parts of their experience. A loss of interest in things they used to enjoy also measures avoidance. The Veterans may fee distant or cut-off from other people and/or feel emotionally numb or unable to have loving feelings. Lastly, the Veterans may feel as if the future will end prematurely. As noted in Table 3, Respondent 1 received psychotherapy; Respondent 2 received EMDR and psychotherapy; Respondent 3 received CPT; and Respondent 4 received PE and CPT at different times.

Table 3. Avoidance Symptoms

	Respondent 1		Respondent 2		Respondent 3		Respondent 4			
	Psychotherapy		EMDR/Psychotherapy		CPT		PE		CPT	
	Pre Tx	Post Tx	Pre Tx	Post Tx	Pre Tx	Post Tx	Pre Tx	Post Tx	Pre Tx	Post Tx
Avoid *thinking about or talking about* a stressful military experience or avoid *having feelings* related to it	5	3	3-4	3-4	5	4	4	4	4	5
Avoid *activities or situations* because *they remind you* of a stressful military experience	5	4	5	4	5	4	3	3	4	5
Trouble *remembering important parts* of a stressful military experience	5	5	1	1	5	5	1	1	1	1
Loss of *interest in things that you use to enjoy*	5	5	5	3	5	5	3	3	3	2
Feeling *distant* or *cut off* from other people	5	3	5	3	5	4	3	5	4	4
Feeling *emotionally numb* or being unable to have loving feelings for those close to you	5	4	5	3	5	4	3	3	3	3
Feeling as if your *future* will somehow be *cut short*	5	4	5	3	3	2	4	5	4	4

Note: Rating indicates how much the Veteran was bothered by that problem before treatment and after treatment. The numbers indicate the following: (1) *Not at all*; (2) *A little bit*; (3) *Moderately*; (4) *Quite a bit*; (5) *Extremely*

The researcher identified avoidance symptoms as a strong theme. Both Vietnam Veterans' ability to remember important parts of their combat experiences did not change

after treatment. The remaining avoidance symptoms decreased from *extremely* to *quite a bit* for the Veteran after he received treatment. The Veteran who received EMDR and psychotherapy experienced a reduction in the last four avoidance symptoms after treatment. He reported these symptoms bothering him *extremely* before treatment and *moderately* after treatment.

The two Veterans who received CPT experienced very different treatment outcomes. One Veteran reported being bothered *extremely* before treatment and *quite a* bit after treatment by four of the seven categories of avoidance symptoms (thinking or talking about; activities or situations; feeling distant or cut off and feeling emotionally numb). The other Veteran reported an increase in two of these symptoms (thinking or talking about) from *quite a bit* to *moderately* being bothered. One Veteran reported *extremely* being bothered with trouble remembering events before and after treatment. The other Veterans reported *not at all* being bothered with trouble remembering events before and after treatment.

The latter respondent received PE and CPT treatments at different times. This Veteran's experience with PE included no affect on four of the avoidance symptoms (thinking/talking; activities/situations; loss of interest; feeling emotionally numb). This Veteran experienced being *extremely* bothered by feeling distant or cut off from other people after treatment, whereas before treatment she was *moderately* bothered. Her feelings of the future being cut short also increased from *quite a bit* to *extremely* after PE treatment.

Avoid thinking or talking. Veterans may avoid thinking or talking about their military experiences for fear it will trigger traumatic memories. One respondent avoided

treatment as an effort to not think about the trauma: *I stopped outpatient treatment from 2005 through 2010. I didn't want to speak to anybody, so I didn't go. I wanted to just get away from it. I just didn't think…I felt hopeless.* When his symptoms started increasing, he decided to return to treatment. Another respondent who did not have the arousal symptom of 'trouble sleeping' (see Table 1) used sleep as an avoidance measure. He reported, *When I was depressed back then, and now if I have a bad day or something, I can just lie down and go to sleep. I just check out. I'm lucky that way.*

Avoid activities/situations. Veterans who have re-experiencing symptoms use avoidance techniques to cope with being reminded of traumatic events. One respondent described his avoidance of crowds: *I avoid large gatherings, parades, sporting events, 4th of July celebrations. It's not so much the fireworks, but the screaming people and children.* Another respondent avoided activities that reminded him of the sound of war. He reported, *I attended the Memorial Day celebration a few years back, but normally don't go because of the rifle noise.*

A third respondent avoided an activity that triggered memories of combat in multiple ways. Wearing the uniform, seeing deployed comrades, and completing tasks related to her deployed job were overwhelming triggers that this respondent ultimately avoided by being physically removed from the activity. *Drill was too stressful. It caused panic attacks and reopened up everything. I finally got a doctor to excuse me from drill.*

Trouble remembering events. The next two quotes detail another symptom of avoidance: being unable to remember important aspects of the trauma. One respondent noted that the only reason he knows what happened during some of his deployment is from reading it in military reports.

> *I have a sketchy memory. I'm able to remember important parts because of the documentation that followed from other people. When I read the reports, I wondered how I didn't remember them, but others noted that it happened.*

The same respondent reported what his mother told him about his own behavior during a phone call while he was deployed.

> *I called home to my mother and was somewhat hysterical and explained to her about someone who died. I look back now and don't know who that could have been. I don't have any recollection of that ever happening. Somehow I called and told her about things going on that I have no memory of.*

Loss of interest. A loss of interest in things they used to enjoy also measures avoidance. For one respondent, memories of the war caused him to lose interest in an activity he once enjoyed. He reported, *I used to hunt squirrel and deer. I haven't gone hunting in the last 40 years. I own a gun, but that's about it.* The psychotherapy this Veteran received had no affect on decreasing his loss of interest in things he once enjoyed. Another respondent is aware he has lost interest, and he's been unsuccessful discovering a new hobby: *I don't find really much interest in anything. I'm trying to find something to occupy my mind that I enjoy and I'm having a hard time finding that.* A third respondent experienced a decrease in this avoidance symptom after treatment: *I used to work out a lot and lost interest in that. I started working out more after CPT treatment started.*

Feeling distant/cut-off. The Veterans may feel distant or cut-off from other people and/or feel emotionally numb or unable to have loving feelings. One Vietnam Veteran blames himself for things that happened during the war and continues to have negative views of himself:

> *I consider myself a failure because I didn't do anything to change the war. I was a part of it. I was a failure. I still do. I see so many wrongs and here's another one* [war] *I am going to live with and have to put into perspective.*

Another respondent experienced rejection from her own family after returning from a deployment where she also experienced sexual assault from a comrade:

> *My family and I don't talk anymore. When I told my mom about my experiences, she called me a liar and said that women in a combat zone can't get PTSD because we're not on the front line. I haven't talked to her in 2 years. I refuse to have a relationship with someone who called me a liar during the worst experience of my life.*

This Veteran received PE and CPT at different times. Prolonged exposure, the first treatment series, increased her symptoms of feeling distant or cut-off for the above respondent by two scale scores. Cognitive processing therapy, the second treatment series, did not affect her feeling distant or cut-off, as the above Veteran indicated she was bothered *quite a bit* before and after CPT treatment. Cognitive processing therapy helped another respondent overcome feelings of distance with others: *My symptoms reduced because I was more comfortable with other vets and realized it wasn't just me.* This Veteran's symptoms involving feeling distant or cut-off and feeling emotionally numb reduced by one scale score.

Emotionally numb. One respondent is acutely aware of his emotional numbness that developed after he returned from deployment:

> *The biggest thing I find myself doing is trying to feel the emotions for a situation that I know should be there, but still not naturally feeling them on my own. I put on a smile and show outwardly that I'm happy, but inwardly having no emotion at all.*

The same respondent explained to the doctor what he expected from psychotropic medications and his thoughts when he does have a brief moment of emotion: *I told the*

doctor to bring me to pudding face [with meds] – you know that commercial with the kid smiling from ear to ear – then back me down a hair. This respondent reflected on feeling his emotions: *When I do feel a high of happiness it is so addicting that I'd do almost anything to keep that feeling because it felt so unnatural and felt so good.* He further discussed how treatment helped him understand his emotions:

> *I blocked out a lot of the emotion attached to* [my military experiences]. *When I went through treatment, I was forced to open up and I better understood why the situations bothered me.*

Future cut short. Lastly, the Veteran may feel as if the future will end prematurely. Shortly after returning from Vietnam, this respondent nearly bled to death and believes his life will be cut-short because of what he was exposed to while deployed in the 70's: *I had Agent Orange. I know something happened to me physically from it."* One respondent had a sense of a foreshortened future so precise she has a specific life span prediction:

> *I don't see myself living past the age of 25. I don't see having kids or being married or having a house. I don't feel like I should be here. I'm not suicidal; I just don't feel like there is a grander idea for me. I don't know what kind of ending. I just don't see it.*

This Veteran's feeling as if the future will be cut short increased from *quite a bit* to *extremely* after PE treatment and remained *quite a bit* bothered before and after CPT treatment.

Arousal Symptoms

Veterans diagnosed with combat-related PTSD often feel overly alert due to an increased emotional arousal. As noted on Table 4, arousal symptoms can cause sleep disturbances, irritability, angry outbursts, and difficulty concentrating. Additionally, a

Veteran may be hypervigilant and/or easily startled. Additionally, noted in Table 4, Respondent 1 received psychotherapy; Respondent 2 received EMDR and psychotherapy; Respondent 3 received CPT; and Respondent 4 received PE and CPT at different times.

Table 4 Arousal Symptoms

	Respondent 1		Respondent 2		Respondent 3		Respondent 4			
	Psychotherapy		EMDR/Psychotherapy		CPT		PE		CPT	
	Pre Tx	Post Tx	Pre Tx	Post Tx	Pre Tx	Post Tx	Pre Tx	Post Tx	Pre Tx	Post Tx
Trouble *falling* or *staying asleep*	4	3	4	3	5	5	4	5	4	3
Feeling *irritable* or having *angry outbursts*	5	3	5	3	4	3	3	5	4	3
Having *difficulty concentrating*	3	3	5	4	5	4	3	4	4	3
Being *"super alert"* or watchful on guard	5	5	5	5	5	4	4	3	4	3
Feeling *jumpy* or easily startled	5	4	5	5	3	2	4	3	4	4

Note: Rating indicates how much the Veteran was bothered by that problem before treatment and after treatment. The numbers indicate the following: (1) *Not at all*; (2) *A little bit*; (3) *Moderately*; (4) *Quite a bit*; (5) *Extremely*

The researcher identified arousal symptoms as a very strong theme. The Veteran who received psychotherapy experienced three reduced arousal symptoms (trouble falling/ staying asleep; feeling irritable/angry outbursts; feeling jumpy). The same treatment contains data showing no affect towards improving concentration or reducing watchful/ on guard behavior for him. Both Vietnam Veterans experienced arousal symptoms (trouble falling asleep; feeling irritable) after receiving treatment. In fact, in both cases symptoms of feeling irritable decreased from *extremely* to *moderately*. The two Veterans who were recently deployed, reported decreased arousal symptoms in three of the five categories (feeling irritable; difficulty concentrating; watchful/on guard). The widest

scale score difference reported involves the experiences of the Veteran who received PE and CPT at different times. The arousal symptoms described as feeling irritable or having angry outbursts increased from *moderately* to *extremely* after PE treatment. The same symptoms decreased from *quite a bit* to *moderately* after CPT.

Falling/staying asleep. One respondent described how he coped with sleep disturbances: *My mind would wander and I would think, so I'd get up and find something to do to get my mind off of racing thoughts. Medication let me shut off my thoughts and go to sleep.* Another respondent discussed experiences with sleep deprivation while being treated with Prolonged Exposure: *I was getting maybe 2 hours of sleep a night – solid sleep – even on the sleep meds.* The same respondent reported decreased arousal symptoms with CPT treatment: *I still had nightmares, but was back to 4 or 5 hours of sleep a night.* A third respondent identified not having sleep disturbance arousal symptoms as a blessing: *I've always been able to sleep. Mother said that was my salvation that I could let my brain rest.*

Irritable/angry outbursts. Irritable thoughts and anger may follow physical reactions, which are re-experiencing symptoms. The respondent highlighted earlier, whose heart races when he sees a camera flash, explained his anger: *I really get pissed, just like that. I want to take that camera and stick it down their throat.* Another respondent described an angry outburst with his boss, who served three months of combat service in the Navy: *I took my arm and cleared his whole desk off and then walked out. I said, "F*** you and your combat.* The same respondent discussed his violent actions in a restaurant when someone called him a 'baby killer': *I rocked her. Dropped her right*

down like a bad habit. It's a sad thing, kids, but war doesn't have a conscious, you know?

Angry outbursts often occur when the Veteran does not have control of his or her situation or surroundings. One respondent stated several times that he needed to feel in control of his surroundings: *I was in violent fights. The violence would come out misdirected. After treatment I learned to control my emotions better.* Another respondent reported his anger increased due to recent health diagnoses based on past combat involvement and exposure to Agent Orange: *I am probably angrier now then 30 years ago because of the shit that's happened to me and my Army buddy. Especially my* [current] *health issues. They are frustrating and draining and it pisses me off.* Another respondent reported decreased anger arousal symptoms but is unsure why the symptoms decreased:

> "*I was going to school for massage therapy and part of my job is to be calm, so I don't know if it was the CPT or being in massage school that helped* [decrease my anger]. *Overall, I noticed a difference."*

Concentration. All three respondents measured their lack of concentration by their inability to remember what they have read:

> *I don't think I have ever read a book* [since returning from deployment] *because I can't remember what I read.*
>
> *I still have a lot of troubles concentrating. I don't retain what I read because my mind wanders.*
>
> *I noticed it got worse in college. I couldn't read my textbook for more than five minutes at a time. My mind went back to the deployed location.*

One respondent explained how he copes with his lack of concentration: *I have to write things down, anything. You know, I have since Vietnam.* Another respondent reported

that treatment helped reduce concentration symptoms: *I was actually able to finish a couple of books after starting CPT treatment.*

Alert/watchful/on guard. A Veteran suffering from combat-related PTSD may be hyperalert or hypervigilant. This respondent is constantly on guard, especially around Vietnamese immigrants who live in his neighborhood: *There's a lot of Vietnamese that live in the neighborhood. When I see them, I go into combat mode. I start thinking about my next move. I try to maintain and I keep walking which helps me considerably.*

Another example of hypervigilance for this respondent is depicted by his on-guard demeanor: *It's worse in civilian life because you don't know what you're going to run into whereas in war, you do….someone with a gun. If I go out, I have a belt on to use as a weapon.* The same respondent credited treatment for his reduced symptoms: "*I'm constantly evaluating surrounding situations. This has decreased some since treatment. I'm less disturbed by it and more conscious of it."* Another respondent noted decreased arousal symptoms after treatment: *I seemed calmer after treatment, but my friends know not to scare me. I'm not sure how PE helped with that.* However, the same respondent remains vigilant and on guard: *I still watch people. I still have a knife on me at all times. I sleep with a knife under my pillow. My roommate is not allowed to enter my room unless he knows I'm awake.*

Jumpy. A common symptom of PTSD is being startled by an unexpected noise or movement. All four respondents commented on their startle response. One Veteran recalled, *I'm jumpy around loud noises I'm not expecting.* This Veteran also reported CPT reduced these symptoms by two scale scores. A second Veteran reported, *A guy started a John Deer tractor and I hit the ground, just like that.* Psychotherapy reduced

his symptoms by one scale score. One of the Vietnam Veterans reported, *Man, if I am sitting here and my neighbor just pounds the door, I am up and about real quick. I don't think that will ever change.* He rated this symptom as a (5) *extremely* before and after treatment. The fourth Veteran recalled two instances of her startle symptoms after CPT. First she reported, *My client sneezed. It was sudden and everything was quiet. My heart jumped.* Next she stated, *A guy jumped out of the room at me. I had a panic attack for a full 20 minutes.* CPT had no affect on her symptoms, as she rated feeling jumpy or easily startled as a (4) *quite a bit* before and after treatment. Prolonged exposure reduced this symptom by one scale score for her.

Experiences of Treatment

One participant in this study vehemently opposed PE treatment due to the increased frequency and intensity of arousal and re-experiencing symptoms she experienced. Her therapist did not audiotape her narratives. She reported, *I wonder if they would have had me audiotape myself and repeat it, it might have helped. Maybe if I heard myself say it, it might have clicked more.* Another Veteran expressed his frustration with inpatient and outpatient treatment in that after several years of treatment, he still didn't feel relief from PTSD symptoms. Specifically, he did not understand EMDR and how tapping on his body while talking about his trauma could help reduce symptoms. He ultimately asked to try a different treatment. This Veteran personally researched Virtual Reality Exposure Therapy in hopes of finding a treatment that could reduce his symptoms. Additionally, he searched on-line for a nearby treatment facility that uses VRET for combat-related PTSD. Lastly, three of the four participants offered negative comments regarding medication as a treatment option. One hoped for

alternative medicine; one felt unimportant in the VA system and that receiving medication was an easy way to get him out the door; the third believed he was over-medicated.

Treatment was interrupted by continuous events for one Veteran: *Shortly after I started treatment in country, three of my men were killed. Six months after that I was sexually assaulted by one of my comrades. So it was hard to get anywhere with my treatment because things kept happening.*

Support Systems

Friends and family can provide a much needed level of emotional support for combat Veterans. The following quotes depict the importance of support systems to Veterans' recovery. One respondent recalled, *My friends and family took part in treatment with me, about the emotions I was feeling or not feeling.* The same respondent reported the presence of a family's love: *My mother and some of my family have been there with unconditional love.* The same respondent explained the importance of acceptance from his Veteran friend: *One of my best friends is a vet and he accepts me the way I am now.* Another respondent credited his family for his ability to manage life: *I was able to cope because I had my wife and my son. My wife, you won't find one better.* A third respondent recognized the importance of treatment coupled with his family: *Treatment was part of my salvation. It was that and the support of my wife and family.* The same respondent recalled indirect family support while he was deployed: *I never really talked about it* [with my family]. *My mom wrote me, but we never...I guess I thought she always knew*. When asked how he made it through the perils of war, this

respondent reported an important relationship with a comrade: *My Army buddy. We survived it together."*

In one case, family support is not existent. This respondent's friends responded to her need for emotional support:

> *I didn't have a family support system. My two best friends were my support. They put up with everything…the outbursts, the nightmares, the calls at 3 o'clock in the morning. They are still a big part of my recovery.*

Lastly, Veterans offered words of advice to social workers who treat Veterans diagnosed with combat-related PTSD.

Advice to Social Workers

The advice Veterans in this study offered to social workers included: providing liaison-type services between doctors and the Veteran; engaging and supporting family members in the treatment and recovery process; and having shared experiences with the Veteran.

One respondent addressed how the social worker can be a liaison between the doctor and Veteran to encourage treatment options other than medication: *Maybe be educated in alternative medicine. I don't like being on meds. I'd like to know more about therapy dogs, equestrian therapy.* Another respondent indicated similar distaste for medication: *Don't push the med portion. We feel like a number at the VA. Here, we'll just push meds at you and you can just go away.* A third respondent justified social worker's role as liaison in the hospital setting when he admitted to being over-medicated at the VA: *I was on so many drugs, that there were times I didn't even know who I was.*

One respondent urged social workers to involve spouses more in the Veterans' treatment and recovery: [Social workers] *have never talked to my wife.*

They should talk to wives. Another respondent wants to be treated like a normal person:

> *Treat us like normal people. I've worked with social workers in the OEF/OIF program. I've had positive experiences with them. They were hands on, proactive and grounded to help you get help.*

Another respondent offered sound advice about the most basic characteristic in communication: *From my experience, they need to be good listeners.* The same respondent discussed other importance features social workers should display: *Try to be at my level. A lot of professional people are up here* [pointing to head]. *You need to really listen and be at the person's level. Also be compassionate and caring.* Finally, another respondent considered shared experiences important for the counselor/client relationship to be successful: *I had a hard time connecting with my counselor because she was never in the military. She often used the line, "I know how it is." I finally told her, "No, you don't know how it is."* The review of the literature both supports and contradicts the findings in this study.

Discussion

The purpose of this study was to understand, from the Veterans' perspective, experiences with combat-related PTSD treatment. The literature reviewed was provided by practitioners who are interested in combat-related or treated Veterans with this disorder. This study includes documented experiences of treatment from the Veterans who were deployed to a combat zone. The study offers a range of experiences from the voice of Veterans deployed in the 70s to Vietnam, as well as combat Veterans from the Global War on Terror. The findings are consistent with information found in the literature that warrants the use of different treatment modalities with the common goal to

reduce symptom frequency, duration, and intensity (Albright & Thyer, 2010; Germain, Shear, Hall & Buysse, 2007; McLay, McBrien, Wiederhold & Wiederhold, 2010; Najavits et al., 2011; Owens et al., 2005; Peterson et al., 2011; Reger & Gahm, 2008; Stapleton, Taylor & Asmundson, 2006; Tuerk, Yoder, Grubaugh, Hyrick, Hamner & Acierno, 2011; Wood, Wiederhold & Spira, 2010). This section will review how this study's findings compared to literature regarding the Veterans' experiences with combat-related PTSD treatment. Veterans' support systems, advice to social workers, implications for social work practice, policy, and future research will also be discussed.

Re-experiencing Symptoms

Both Vietnam Veterans discussed being exposed to Agent Orange, viewing dead bodies and the destruction resulting from bombs and bullets. Toxic exposure and the aftermath of battle are war zone stressors that contribute to PTSD symptom development (Keane, 2009; Keane et al., 1987; Peterson et al., 2011).

Avoidance Symptoms

According to the Department of Veterans Affairs (2012) and Myers et al. (2011), the Veterans in this study who experienced pounding hearts during 4th of July fireworks displays, lost interest in hunting, which was a once favorite pastime; and can no longer feel emotions are experiencing common flight responses. The DSM-IV-TR (2000) dedicated one of the three symptom clusters to *avoidance*, and this term describes many of the symptoms Veterans in this study experienced. The Veterans in this study experienced a range of avoidance symptoms with some stating the symptoms have decreased since treatment and some stating they have increased or not changed during treatment. For those Veterans who have chronic PTSD and are extremely bothered by

avoidance symptoms, Badour, et al. (2012) suggested they may have a poorer response to treatment.

Arousal Symptoms

The process of exposure therapy outlined in the literature supports that skills are taught to control negative thoughts and physiological sensations prior to receiving the therapy (McLay et al., 2011; Tuerk et al., 2011). The experiences of one Veteran who received prolonged exposure (PE) and reported increased insomnia, anger and difficulty concentrating contradicts these findings. Van Minnen, Harned, Zoellner and Mills (2012) support this Veteran's report of worsened anger after receiving PE. Additionally, the Veteran has comorbid diagnoses, which Van Minnen et al (2012) further attribute to increased anger.

Experiences of Treatment

The literature supports that PE worsened anger and guilt, especially with clients who have PTSD and comorbid problems (van Minnen, Harned, Zoellner and Mills, 2012). Reger and Gahm (2008) study also supported not using PE, as this treatment may increase symptoms for Veterans who have been repeatedly exposed to trauma. The findings of this study is congruent with the literature in that one Veteran experienced increased re-experiencing and arousal symptoms after receiving PE. The Veteran in this study did not receive audiotaped sessions although the literature regarding PE included audiotapes so clients could listen to their narratives (Hagenaars & van Minnen, 2010).

Social workers should be trained on all combat-related PTSD treatment modalities offered at treatment facilities in order to attain knowledge on evidence-based practices and better serve the clients being treated with new modalities. A social worker well

versed in virtual-reality exposure therapy (VRET) treatment outcomes could have shared Reger and Gahm's (2008) and Wood's et al. (2009) case study results of successful VRET sessions with the Veteran in this study who educated himself on VRET and the availability of treatment facilities that offered this intervention.

Albright and Thyer (2010) found little evidence to support the effectiveness of eye movement desensitization reprocessing (EMDR) in reducing PTSD symptoms for combat Veterans. The findings in this study are congruent in that the Veteran who received EMDR was disappointed with little symptom reduction and requested a different treatment modality.

Additionally, social workers should be involved coordinating Veterans' care throughout the VA system. Rosenheck and Fontana (2007) reported an increased number of PTSD cases in the VA healthcare system. Assigning a social worker to each Veteran would provide another level of care and give the Veteran another professional whom to voice concerns, such as medication concerns.

Keane and Wolf's study (1990) supports comorbid diagnoses among Veterans with PTSD. Such is the case with one Veteran in this study who reported no problems with anxiety or depression prior to deploying. However, after being diagnosed with PTSD, she also developed depression and anxiety.

Support Systems

Although all Veterans in this study described solid family and/or friend support systems, the literature suggests other types of support systems. The National Center for PTSD (2012) produced "About Face" interactive site could help those Veterans who are not fortunate to have supportive family and friends. A Veteran could use the Veterans

Crisis Line anytime of the day or night if they do not have a supportive wife, mother or friend to contact, like the support systems available to Veterans in this study.

Advice for Social Workers

Social workers work with combat Veterans to help them overcome physical and emotional challenges and to provide an easier transition back to civilian life. A treatment team could develop a social worker liaison position that could help convey the Veterans' treatment concerns to the physician and include family members in treatment planning and goals. As noted by participants, caring and compassionate listening skills are important characteristics for a social worker treating Veterans. A shared military experience between the therapist and Veteran would be helpful to many who are leery of talking about combat experiences to a professional who may not understand deployed situations. The shared experience one Veteran expressed as important to the therapeutic relationship is exemplified when military members currently deployed receive mental health services from professionals at the deployed location (McLay et al., 2010).

Implications for Social Work Practice

This section will discuss implications for social work practice. Specifically, this section will review the need for social workers to focus on screening returning Veterans to identify PTSD symptoms early and coordinate intervention. Additionally, this section discusses the importance of performing thorough interviews and assessments.

Post-traumatic stress disorder symptoms can occur immediately after a Veteran experiences a traumatic event or surface several months or years after the event(s). Symptoms may also come and go over many years. Social workers need to be aware that screening to identify PTSD is an ongoing process and when identified, it is important to

refer Veterans for appropriate mental health care. Support systems are also paramount to realizing the courage to seek treatment and to support the Veteran through recovery. Further outreach and research involving family systems and available psychoeducational resources for Veterans' families would expand the source of recovery to the home environment.

Keane (2009) recommended that the MMPI be added to structured clinical interviews, as the MMPI includes a built-in PTSD component. Social workers who perform interviews would refer the client for the MMPI or add another psychological testing option for a more thorough assessment. One weakness of psychological testing is based on the limits of skills and background of the evaluator and the interviewer's failure to adopt best practices (Keane, 2009). Likewise, social workers would need in-depth training and continuing education in this area. A well-trained social worker would be able to identify a Veteran suffering from a traumatic brain injury (TBI), and refer for a neuropsychological assessment (National Center for PTSD, 2012).

Implications for Policy

This section will outline implications for implementing a proposed change to the DSM-V, which is scheduled to be released in May 2013. It will review the proposed changes and implications for diagnosing Veterans with PTSD. The new DSM adds another cluster of symptoms, yet symptoms remain the same. Further, Criterion A2 will be removed. PTSD is proposed to be reclassified to "trauma and stressor-related disorders" versus anxiety disorders. Lastly, the National Center for PTSD will revise PTSD assessment measures and make them available to the mental health field. For the purposes of this study, the researcher will focus on the additional cluster and revised

assessment measures. Another implication for policy is renaming post-traumatic stress disorder in order to remove negative stigmas and allow for appropriate healing and adjustment.

Currently, the DSM lists three clusters of symptoms: re-experiencing, avoidance and arousal. Although the symptoms are predominately the same, DSM-V adds a new cluster: negative cognitions and mood. Likewise, DSM-V lists 21 symptoms across four categories of symptoms versus 17 symptoms within 3 categories in DSM-IV-R. The difference is that according to the criteria that must be met for a PTSD diagnosis, DSM-V allows 10,500 different symptom combinations. The DSM IV-R allowed for 1,750 combinations to meet the criteria for PTSD diagnosis (Rosen, Lilienfeld, Frueh, McHugh & Spitzer, 2010). If revised assessment measures are adopted as mentioned above, another level of precision would be added in diagnosing for PTSD. Additionally, the number of diagnosed PTSD cases could greatly increase, as well as the level of confusion based on the extra symptom combinations.

The National Center for PTSD will revise PTSD assessment measures, specifically Clinician Administered PTSD Scale (CAPS) and the PTSD Checklist for Military (PCL-M) to align with the changes in the DSM-V. The revised changes should better serve the growing military population that suffers from PTSD symptoms (Insel, 2007).

Another proposed change is expected to reduce the stigma of PTSD. The Army Vice Chief of Staff, General Peter Chiarelli, supports renaming PTSD for military members and Veterans to post-traumatic stress *injury* (PTSI) (Sagalyn, 2011). Justification for the change centers on the belief that post-traumatic stress is an injury

military members receive during their service and it is not a pre-existing condition. The change to PTSI is intended to address the potential negative connotations and shame, as well as potential effects on career paths associated with seeking mental health treatment for PTSD.

Implications for Research

This section will discuss implications for research. Specifically, this section will outline the need for further research to validate effectiveness of treatment modalities for Veterans diagnosed with combat-related PTSD. Another implication for research is delving into success stories of prior military members who sought treatment. This area of the research could identify how Veterans address the shame of seeking help and how career military members deal with the consequences of getting mental health care.

This study identified VRET as therapy that might have some effect on treatment outcomes. Social workers could conduct studies within the military treatment community to compare cognitive processing therapy (CPT), prolonged exposure (PE), eye movement desensitization and reprocessing therapy (EMDR) and virtual reality exposure therapy (VRET) treatment outcomes.

Future research involving success stories would highlight experiences of military members who received treatment and are thriving. For example, as reported by Rosario (2010), Hector Matascastillo, an 18-year decorated Army Veteran who deployed to Kosovo and Iraq, was diagnosed with combat-related PTSD. A flashback six years ago involved him armed with unloaded guns which he aimed at police. After addressing his trauma and receiving treatment, Mr. Matascastillo now speaks to Veterans throughout the U.S. and is scheduled to graduate with a social worker degree this summer. He helps

extinguish the stigma associated with the diagnoses and is a role model for other Veterans suffering from PTSD (Rosario, 2010). Undoubtedly there are more stories like this, that if documented, would provide positive examples of and motivation for the benefits of seeking treatment.

In the conduct of this study, establishing common ground was important in building rapport (Berg & Lune, 2012). One clear implication for research was that the researcher and participants had a shared experience: military duty. In this study, some degree of common ground was already established through this experience. The participants voiced their comfort level due to the shared experience and felt a bit more at ease in building rapport with the researcher and sharing treatment experiences as evidenced by statements such as, *I know you know what I mean* and *You were in, you know what it's like.* One committee member noted that military members value therapists who have had prior military experience. Minimally, therapists must demonstrate a capacity to empathize with the military members' experiences.

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APPENDIX A

Dear Ms. Priestley,

I understand that you are currently seeking a master's degree at the School of Social Work at St. Catherine University and University of St. Thomas. As part of your graduation requirements, you are conducting a research study under the supervision of Dr. Carol Kuechler at the school. Upon approval from St. Catherine University's Institutional Review Board, this letter will serve as XXXXXXXXXXXXX consent to contact me and solicit participation in your research project.

Purpose/Procedure

I understand that the purpose of this exploratory study is to explore from Veterans' perspectives, their experiences with combat-related PTSD treatment and to report their advice to social workers involved in treating Veterans and their families.

The study will focus on three specific issues surrounding the Veteran's experience with combat-related PTSD: 1. Issues surrounding Veteran's experience with treatment; 2. Experience with PTSD symptoms before and after treatment; and, 3. Veterans' advice for social workers who treat Veterans with combat-related PTSD. With this study, it is your hope that the subjective experience of Veterans who received combat-related PTSD treatment will be a focus of future services and that including the voice of Veterans who received this treatment will strengthen, empower, validate and acknowledge them while providing an opportunity to collaborate with social work practitioners and share and learn from the Veterans' treatment experiences.

Upon approval of XXXXXXXXXXXXX and that of St. Catherine University Institutional Review Board, Ms. Priestley will give me flyers describing the research and ask me to invite clients to participate. After clients have read the flyer, they will have the option of taking a tab that states Ms. Priestley's contact information. All potential participants who contact Ms. Priestley will be screened for eligibility. In order to be eligible to participate, the Veteran must have deployed to a combat zone; been diagnosed with combat-related PTSD; and completed outpatient treatment prior to July 1, 2012. Those who are eligible and still willing to participate will then schedule a time to be interviewed. On the day of, but prior to, the interview the participants will be asked to sign consent forms. Afterwards, Ms. Priestley will conduct individual audio taped interviews with participants lasting approximately 1 to 1 ½ hours at a private meeting room where people will be nearby, such as a meeting room in a hall or local library. A telephone will be available at the site. Interviews will begin taking place January 10, 2013 pending approval.

Risks/Benefits

The study has identified risk to participation. Talking about combat-related PTSD treatment experiences may be uncomfortable and may trigger memories of the traumatic events. If that happens, the participants may request to skip a question, pause the interview, or terminate the interview. I will provide resources at any time, if they want to talk with someone. At the time of the interview, participants will receive a 2" x 4" magnet from the VA Crisis Line, which lists their crisis line phone number (1-888-273-8255). Based on their response to the query about how they learned about the study, participants from XXXXXXXXXXXXXXXXX.

The interview will stop if participants experience any discomfort. There are no direct benefits to participants in this study. Participants will receive no payment for participation in this study.

Confidentiality

Any information obtained in connection with this research study that can identify the participant will be disclosed only with the participant's permission. Otherwise, results will be kept confidential. In any written reports or publications, no one will be identified or identifiable and only group data will be presented. Ms. Priestley will keep the research data in a locked file cabinet in her home office in XXXXXXXXXX. Electronic data will be stored on a flash drive and kept in the same locked file cabinet. Only Ms. Priestley or her faculty advisor will have access to the records during this study. Ms. Priestley will finish analyzing the data by June 1, 2013 and then destroy all original reports and identifying information that can be linked back to participants. Tape recordings will not be presented to others for educational purposes. The recordings will be erased by June 1, 2013. A copy of the results of the study without identifying information will be given to XXXXXXXXX upon request. Results will also be furnished to study participants upon request.

Voluntary Nature of the Study:

Participation in this study is entirely voluntary. Any decision whether or not to participate will not affect participants' current or future relations with XXXXXXXXXX. If clients decide to participate, they are free to withdraw at any time without penalty. Should clients decide to withdraw, only data already collected will be used in Ms. Priestley's research study.

Approval to request my clients' participation in this research project is demonstrated by this signed letter of authorization submitted to you on XXXXXXXXXXX letterhead.

Sincerely,

APPENDIX B

WANTED: Veterans who have been treated for combat-related PTSD

I am prior enlisted/retired Air Force major and social work graduate student at the University of St Catherine's/St Thomas University. I am conducting a study to better understand combat-related PTSD treatment AS TOLD BY VETERANS. There are plenty of studies available which were completed by clinicians and researchers, but very few studies telling how veterans feel about the treatment they received.

Our interview would last approximately one hour. I will ask you about the type of treatment you received and your personal experience with your symptoms and the treatment.

You meet the criteria for this study if you:

1. **Have you been deployed to a combat zone?**
2. **Have you ever been diagnosed with posttraumatic stress disorder?**
3. **Have you completed outpatient treatment for combat-related PTSD prior to July 1, 2012?**

******** Thank you for your service to our nation! ********

If you are interested in participating or have questions about your eligibility, please take a tab from below and contact me.

(This study is being conducted by Heidi Priestley under the supervision of Carol F. Kuechler, MSSW, Ph.D., LICSW)

Heidi Priestley xxx-xxx-xxxx	**Heidi Priestley xxx-xxx-xxxx**	**Heidi Priestley xxx-xxx-xxxx**	**Heidi Priestley xxx-xxx-xxxx**	**Heidi Priestley xxx-xxx-xxxx**	**Heidi Priestley xxx-xxx-xxxx**	**Heidi Priestley xxx-xxx-xxxx**	**Heidi Priestley xxx-xxx-xxxx**	**Heidi Priestley xxx-xxx-xxxx**	**Heidi Priestley xxx-xxx-xxxx**	**Heidi Priestley xxx-xxx-xxxx**	**Heidi Priestley xxx-xxx-xxxx**	**Heidi Priestley xxx-xxx-xxxx**	**Heidi Priestley xxx-xxx-xxxx**

APPENDIX C

SCREENING QUESTIONS

Thank you for responding to the invitation to participate in this study. Around the world, clinical social workers possess an opportunity to improve treatment experiences and help the Veterans reduce their symptoms. The purpose of this study is to better understand, from the voice of Veterans, the experiences of combat-related PTSD treatment and to report their advice to social workers who are engaged in their treatment. Are you still interested in participating? The following questions will clarify your eligibility for participating.

1. How did you find out about this study?

[The researcher provided additional contact information based on how the participant responded to how they were recruited.]

2. Have you been deployed to a combat zone?

3. Have you ever been diagnosed with posttraumatic stress disorder?

4. Have you completed combat-related PTSD treatment prior to July 1, 2012?

Do you have any questions regarding the study or your role in participating? I would like to give you the Veterans Administration Crisis Line contact information. The Crisis Line operates 24/7 and the phone number is 1-888-273-8255.

APPENDIX D

Veterans' Perspectives on Combat-Related PTSD Treatment

INFORMATION AND CONSENT FORM

Introduction:

You are invited to participate in a research study about your experiences with combat-related PTSD treatment and your advice to social workers who treat Veterans and their families. This study is being conducted by Heidi A. Priestley, a retired Air Force officer and graduate student at St. Catherine University and the University of St. Thomas, under the supervision of Dr. Carol F. Kuechler, a faculty member in the School of Social Work. You were selected as a possible participant in this research because you responded to an invitation to participate and self-identified as someone who has completed treatment for combat-related PTSD and meet the other criteria for this study. Please read this form and ask questions before you agree to be in the study.

Background Information:

The purpose of this study is to understand the effects of treatment for combat-related PTSD from the Veteran's perspective. Approximately 7-10 people are expected to participate in this study. I served in the Air Force for 22 years and retired as a Major in 2011, and I am interested in effective treatments for combat-related PTSD. I believe this knowledge is important for social workers who may be providing services to Veterans and their families in a variety of settings.

Procedures:

If you decide to participate, you will be asked to complete this consent form and a one-time personal, audio-taped interview with me including questions about your military duty background, type of PTSD treatment modality experienced, personal experience with PCL-M checklist items (PTSD symptoms) before and after treatment, any prescribed psychotropic medications, comorbid diagnoses (additional diagnoses other than PTSD) and support systems in place before, during and after treatment. The last question asks the participant for their advice for social workers who treat Veterans with combat-related PTSD. The interview will take approximately 1 1/2 hours.

Risks and Benefits of being in the study:

The study may have risk. It is likely that talking about combat-related PTSD treatment experiences may be uncomfortable and may trigger memories of the traumatic events. If that happens, you may request to skip a question, pause the interview, or terminate the interview. I will provide resources at any time, if you want to talk with someone. You will receive a 2" x 4" magnet from the VA Crisis Line, which lists their phone number (1-888-273-8255). [The researcher provided additional contact information based on what agency recruited the Veteran to participate.] The interview will stop if you have any discomfort. Any data collected up to that point will be used in the study. There are no direct benefits to you for participating in this study.

Confidentiality:

Any information obtained in connection with this research study that can be identified with you will be disclosed only with your permission; your results will be kept confidential. In any written reports or publications, no one will be identified or identifiable.

A professional transcriber will be transcribing the audio-taped interviews into text. No names will be associated with this process.

I will keep the research results in a locked file cabinet in my home office in XXXXXXXXXXX and only I or my faculty advisor will have access to the records while I work on this project. I will finish analyzing the data by June 1, 2013. I will then destroy all original reports and identifying information that can be linked back to you. I or my advisor will have access to all tape recordings. Tape recordings will not be presented to anyone. The recordings will be erased by June 1, 2013.

Voluntary nature of the study:

Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations with your referring agency or community organization, St. Catherine University or the University of St. Thomas in any way. If you decide to participate, you are free to stop at any time without affecting these relationships.

Contacts and questions:

If you have any questions, please feel free to contact me, xxx-xxx-xxxx or prie8927@stthomas.edu. You may ask questions now, or if you have any additional questions later, my faculty advisor, Dr. Carol Kuechler, 651-690-6719, cfkuechler@stkate.edu, will be happy to answer them. If you have other questions or concerns regarding the study, you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at 651-690-7739.

You may keep a copy of this form for your records.

Statement of Consent:

You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing this form, please know that you may withdraw from the study at any time.

I consent to participate in the study and agree to be audio-taped.

_____

Signature of Participant Date

_____

Signature of Researcher Date

APPENDIX D

TRANSCRIBER CONFIDENTIALITY CONSENT FORM

Veterans' Perspectives on Combat-Related PTSD Treatment

I am conducting a study involving experiences of combat-related PTSD treatment and advice to social workers involved in treating veterans, as told by veterans.

This study is being conducted by: Heidi Anna Priestley under the advisement of my chair, Carol F. Kuechler, Ph.D., St. Catherine's University and University of St. Thomas.

Confidentiality:

Confidential information includes all data, materials, products, technology, audiotapes, computer programs and electronic versions of files saved to portable storage devices. One-time audio taped interviews lasting approximately 1 ½ hours will be conducted by the researcher. The completed audio tapes will be hand delivered to you by the researcher for transcription. No personally identifying information will be attached to the audio tape recordings. Any transcriptions or electronic files produced by you will not include information that will make it possible to personally identify participants in any way. All audio tapes and transcriptions are to be kept in a locked file. No one else will have access to the records. No one else will have access to the computer on which transcriptions and electronic files will be prepared. All tape recordings, transcripts and electronically formatted transcripts will be returned in their entirety to the researcher. Once transcriptions have been completed and an electronic file compiled, you will contact the researcher who will then personally pick them up. Any and all electronic versions of transcripts will be deleted from your files upon delivery of records to the researcher. You will receive a payment of $10 per hour for transcription services.

Contacts and Questions

My name is Heidi Anna Priestley. If you have questions, you may contact me at xxx-xxx-xxxx or my research chair, Carol Kuechler Ph.D. at 651-690-6719. You may also contact the St. Catherine University Institutional Review Board at 651-690-7739 with any questions or concerns.

You will be given a copy of this form to keep for your records.

Statement of Agreement of Confidentiality:

I, _____, have read the above information and agree to confidentiality as stipulated above. I further agree not to disclose, publish or otherwise reveal any of the confidential information received from the researcher or interview participants.

_____ _____

Signature of Transcriber **Date**

_____ _____

Signature of Researcher **Date**

APPENDIX E

INTERVIEW QUESTIONS

Veterans' perspectives of combat-related PTSD treatment experience and their advice to social workers involved in treating veterans.

Assurance of Participant Understanding:
In order to ensure you understand what the study is about and what has been covered in the consent form, I will ask you three questions.

1. In your own words how would you explain the purpose of this study?
2. What can you do if you feel uncomfortable answering questions at any time during the interview process?
3. What happens if you decide to withdraw from the study?

The following questions relate to your military background:

4. Military background information:
    a. How many years did you serve in the military?
    b. What branch of service did you belong?
    c. Where you classified as Active Duty, Guard or Reserve?
    d. What was your job in the military?
    e. What was the location of combat duty?
    f. What were the inclusive dates you were involved in or near combat?
    g. What was your rank at the time of combat?

The next set of questions relate to your experiences with PTSD prior to treatment.

5. How did you know you had PTSD?
6. When did you decide to seek help?
7. If you didn't ask for help right away, why?
8. What did you do to cope with your symptoms until you got treatment?
9. What treatment did you receive?
10. What were the inclusive dates of your treatment (Month/Year to Month/Year)?
11. Where did you receive treatment?
12. What was treatment like for you?

Next, I'll ask you to describe your PTSD symptoms before and after receiving treatment by completing a PTSD checklist (Appendix E) and answering a few questions. I created a PTSD checklist that mirrors a checklist developed by the National Center for PTSD. When you complete the checklist, I will be able to better understand your symptom experiences before and after treatment.

- Participant will complete the PTSD checklist (Appendix E)

- Participant will then be asked follow-up questions, using the checklist as a guide, such as: "Tell me more about your answer to question #2…the decrease in repeated, disturbing dreams of a stressful military experience."

The next few questions relate to any support systems you may have had in place throughout your experience, such as friends, military comrades, or family members, who helped you cope with symptoms and treatment. I am also interested in any medications previously or currently prescribed and comorbid diagnoses you may have.

13. In addition to your treatment, what support systems were helpful during your experiences with PTSD?
14. What, if any, medications have you used to relieve your symptoms?
15. Have you been diagnosed with other psychological conditions, such as major depression?

Lastly, I am interested in your advice for social workers.

16. Based on your experience, what advice do you have for social workers who treat veterans with combat-related PTSD?

Now that we are finished, how are you doing?

APPENDIX E

INTERVIEW – PTSD CHECKLIST QUESTIONS

Interview #_____

Instructions: Below is a list of problems and complaints that veterans sometimes have in response to stressful military experiences. Please read each one carefully and indicate how much you were bothered by that problem before treatment and after treatment. Use the following numbers to indicate how much you were bothered.

(1)Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely

No.	Response	Before Treatment	After Treatment
1.	Repeated, disturbing *memories, thoughts,* or *images* of a stressful military experience?		
2.	Repeated, disturbing *dreams* of a stressful military experience?		
3.	Suddenly *acting* or *feeling* as if a stressful military experience *were happening again* (as if you were reliving it)?		
4.	Feeling *very upset* when *something reminded* you of a stressful military experience?		
5.	Have *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful military experience?		
6.	Avoid *thinking about or talking about* a stressful military experience or avoid *having feelings* related to it?		
7.	Avoid *activities or situations* because *they remind you* of a stressful military experience?		
8.	Trouble *remembering important parts* of a stressful military experience?		
9.	Loss of *interest in things that you use to enjoy?*		
10.	Feeling *distant* or *cut off* from other people?		
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?		
12.	Feeling as if your *future* will somehow be *cut short?*		
13.	Trouble *falling* or *staying asleep?*		
14.	Feeling *irritable* or having *angry outbursts?*		
15.	Having *difficulty concentrating?*		
16.	Being *"super alert"* or watchful on guard?		
17.	Feeling *jumpy* or easily startled?		

Weathers, F.W., Huska, J.A., Keane, T.M. *PCL-M for DSM-IV.* Boston: National Center for PTSD – Behavioral Science Division, 1991.