Spring 5-2014

Bridging the Gap: Understanding, Anticipating, and Responding to the Needs of Student Veterans in a Bachelor of Science in Nursing Program

Larry Michael Stowers
University of Southern Mississippi

The University of Southern Mississippi

BRIDGING THE GAP: UNDERSTANDING, ANTICIPATING, AND RESPONDING TO THE NEEDS OF STUDENT VETERANS IN A BACHELOR OF SCIENCE IN NURSING PROGRAM

by

Larry Michael Stowers

Abstract of a Capstone Project
Submitted to the Graduate School
of The University of Southern Mississippi
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Nursing Practice

May 2014

ABSTRACT

BRIDGING THE GAP: UNDERSTANDING, ANTICIPATING, AND RESPONDING TO THE NEEDS OF STUDENT VETERANS IN A BACHELOR OF SCIENCE IN NURSING PROGRAM

by Larry Michael Stowers

May 2014

The passage of the Americans with Disabilities Act Amendment Act (ADAAA) of 2008 and the Post-9/11 Veterans Assistance Act of 2008 have afforded veterans the opportunity to pursue post-secondary education. Since October 2001, over 2 million American men and women in uniform have deployed in support of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). While thousands of returning combat veterans take advantage of recent legislation that helps pay for their education, they face new challenges in the classroom. This nation's veterans represent a group of diverse individuals who bring different experiences, thus different perspectives than traditional college-aged students. However, the additional burden of adjusting to the effects of combat, often after multiple tours in combat zones, may interrupt veterans' transition from the military back into civilian life and the classroom. The personal and cultural characteristics common to returning veterans need to be an essential element for postsecondary institutional faculty development. Focusing on student retention through prevention and early identification of service-related problems and, when appropriate, early referral to University and community resources is critical. Understanding student veterans means understanding military culture, battlefield skills, and deployment related

stressors. It also means listening to students' stories and understanding the unique stressors faced by student veterans on campus. The purpose of this Doctor of Nursing Practice (DNP) capstone project was to develop a program to educate University of Southern Mississippi (USM) College of Nursing (CoN) faculty and staff about the issues and challenges of serving veteran students, especially those with diagnosed or undiagnosed Post-Traumatic Stress Disorder (PTSD) and service-related disabilities.

The University of Southern Mississippi

BRIDGING THE GAP: UNDERSTANDING, ANTICIPATING, AND RESPONDING TO THE NEEDS OF STUDENT VETERANS IN A BACHELOR OF SCIENCE IN NURSING PROGRAM

by

Larry Michael Stowers

A Capstone Project
Submitted to the Graduate School
of The University of Southern Mississippi
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Nursing Practice

Approved:

Karen L. Rich
Director

Anita D. Boykins

Sarah M. Powell

Maureen A. Ryan
Dean of the Graduate School

May 2014

ACKNOWLEDGMENTS

The printed pages of this capstone project hold far more than the culmination of years of study. These pages also reflect the relationships with many generous and inspiring people I have met since beginning my post graduate work. To all my professors for showing me by example and through challenging coursework how to think, teach, and teach others to think, thank you. To my colleagues for sharing their enthusiasm for and comments on my work, I would like to express my heartfelt thanks.

I would like to express the appreciation to my committee members, Dr. Anita Boykins, Dr. Karen Rich, and Sarah Powell who were so patient with me throughout this process. I would like to express my deepest gratitude to my chair, Dr. Karen Rich, for her excellent guidance, caring attitude, extreme patience, and for providing me with an excellent, supportive scholarly atmosphere for completion of this nursing intervention. Special thanks to Ms. Sarah Powell who gave me direction when it was most needed. She provided support and instilled mental stimulation as a content expert in regard to this project. Without her guidance and expertise, this project would not have been possible.

TABLE OF CONTENTS

CHAPTER I

INTRODUCTION

Problem Statement

The passage of the Americans with Disabilities Act Amendment Act (ADAAA) of 2008 and the Post-9/11 Veterans Assistance Act of 2008 has afforded veterans the opportunity to pursue post-secondary education. Many veterans are seeking to either start or finish their college education, especially during the economic downturn that this nation is currently experiencing. It is estimated that more than 2 million veterans of the Afghanistan and Iraq wars will enroll in post-secondary education (American Council on Education, 2008). Many universities have already seen and will continue to see a dramatic influx in the registration of veteran students returning from Afghanistan and Iraq, and the numbers are expected to increase as military personnel transition back into civilian life. While thousands of returning veterans take advantage of recent legislation that helps pay for their education, they face new challenges in the classroom. This nation's veterans represent a group of diverse individuals who bring different experiences, thus different perspectives to the post-secondary education setting than the traditional college-aged student.

Since October 2001, over 2 million American men and women in uniform have deployed in support of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). Recent developments in the national security environment have led to unprecedented strains on the all-volunteer military forces. Since the Cold War, there has been a 36% reduction in the size of the U.S. Armed Forces. This reduction in the armed forces coupled with the extended nature of OEF/OIF wars, has resulted in service

members being deployed to combat in unprecedented numbers (Bruner, 2006). Not only is there a higher proportion of armed forces members being deployed, but deployments have been longer, redeployment to combat has been common, and breaks between deployments have been infrequent and shorter (Hosek, Kavanagh, & Miller, 2006). Advances in both medical technology and body armor means that more service members are surviving experiences that would have led to death in prior wars (Warden, 2006). However, casualties of a different kind have emerged, with "invisible wounds" (Tanielian & Jaycox, 2008, p. 3) related to mental health conditions and cognitive impairments that result from deployment experiences.

Invisible wounds are those neurological and psychological insults related to the numerous atrocities that active duty, reserve, and National Guard military members' experienced and endured related to war. The development of Combat and Operational Stress Reactions, Acute Stress Disorder, Traumatic Brain Injury (TBI), and Post-Traumatic Stress Disorder (PTSD) are some of the most significant psychological and neurological risks of combat exposure. Evidence supports that the long term psychological and neurological toll of these deployments, many involving prolonged exposure to combat-related stress over multiple rotations, may be disproportionately high compared with physical injuries of combat. Cognitive injuries are among the most prevalent of these battlefield injuries for today's returning service members (Tanielian & Jaycox, 2008).

Recent reports and increasing media attention have prompted intense scrutiny and examination of these invisible wounds. Never before in history has this nation been more willing to examine the sociocultural issues surrounding PTSD, and how symptoms can

directly impact the quality of life of veterans as they transition back into civilian life (Hoyt & Candy, 2011; Kline et al., 2010; Stecker, Forteny, Hamilton, Sherbourne, & Ajzen, 2010). Because of the numbers of military men and women entering post-secondary education, the characteristics of returning veterans with invisible wounds as a result of deployment experiences will need to be an essential element of innovative post-secondary faculty in-service education. Those veterans who demonstrate health risks related to combat stress injuries need surveillance services to identify the onset of symptoms of PTSD at an early stage. Post-secondary education faculty and staff are in a unique position to promote preventive measures, and a high level wellness and may be the first to recognize student veterans with suspected cognitive disabilities related to PTSD. They may also be able to encourage them to seek reasonable accommodations. In order to provide prevention measures, promote high-level wellness, and make a significant contribution to military service members and their families, it is essential that the worldview, the mindset, and the historical perspective of life in the military are understood.

Background and Significance

Military deployments

Military deployment is the movement of armed forces. Deployment includes any movement from a military personnel's home station to somewhere outside the continental U.S. and its territories. One example is when a unit based in the U.S. is deployed to another country to enter into a combat zone such as Iraq. Deployment is not restricted to combat; units can be deployed for other reasons such as humanitarian aid, evacuation of U.S. citizens, restoration of peace, or increased security.

Many stressors are associated with military life including those related directly to the military culture, an organization's mission, and those more specific to deployments and combat operations. During deployment, service members may live in austere, crowded living conditions with constant exposure to severe desert climate, sandstorms, toxins and insects with minimal shelter for protection. Additional challenges may include poor access to bathrooms or showers, disturbing smells, frequent or constant loud noises, living in unsanitary conditions, and short supplies or poor quality of food and water (Campbell & Nobel, 2009; Helmus & Glenn, 2005). Many service members suffer from fatigue related to sustained military operational tempo and lack of sleep due to extended work hours and limited manning. It is not uncommon that deployed service members work 15 plus hours a day, seven days a week.

Combat stressors during deployment relates to the pressures, obstacles, and challenges that confront a military service member during a contingency operation. These stressors can include combat intensity, initial and prolonged exposure to combat, the constant threat of death or injury to self or colleagues, facing an ambiguous enemy, being knocked out by an explosion, witnessing or participating in brutality toward others, being responsible for the death of a civilian, and other unforeseen obstacles (Helmus & Glenn, 2005). During deployments, service members are under constant threats of being attacked or ambushed, receiving incoming artillery, rocket, or mortar fire, and being shot at or receiving small-arms fire (Campbell & Nobel, 2009; Helmus & Glenn, 2005).

Throughout deployments, military service members maintain a constant heightened level of situational awareness. These service members are trained to identify threats, sometime of an ambiguous enemy, before the enemy has a chance to identify

them. This around the clock state of hypervigilance is necessary to maintain the safety and security for all personnel while serving in a hostile environment. Operational missions may require service members to conduct missions that are extremely dangerous. These missions may require long rides in convoys or patrol neighborhoods, and it is during these missions that service members are most susceptible to enemy attack. These military combatants are armed and ready for action with their adrenaline-pumping; their eyes are constantly scanning doors, windows, roof tops and cars for any movement or anything out of place that may conceal enemies' positions or improvised explosive devices (IEDs). They are suspicious of all people including women and children, the same people they were sent to protect (Wong & Gerras, 2006).

Post-traumatic stress disorder

The mental and physical challenges of participating in war are many and vary in intensity, duration, rules of engagement, leadership, effective communication, unit morale, unit cohesion, and perceived importance of the mission. Some challenges related to combat are powerful enough to overwhelm most people almost immediately. Traumatic stress injuries involve literal damage to the brain and mind due to experiences of real or threatened death or serious injury or its aftermath. The human body and mind is conditioned to deal with and handle stress, but not everyone who is exposed to real or threatened death or its aftermath is damaged by that experience. In fact, most service members return to normal. But everyone is susceptible to experiencing intense terror, horror, or helplessness when confronted with their own or their peers' mortality, and susceptibility varies over time due to the accumulation of stress from other causes (Helmus & Glenn, 2005).

Society values and teaches the importance of self-reliance, inner strength, and the ability to overcome adversity. It is common for people to feel that no matter what they have faced or lived with, no matter how extreme the ordeal, they should be able to carry on. After traumatic experiences, people may have problems they did not have before the event. At first, some people experience a high level of distress and find that they are unable to think or concentrate on things other than the trauma. These reactions can last for days or even weeks and are common normal reactions. But regardless of how competent people may believe they are, personally or professionally, sometimes they face trauma of such magnitude that they become unable to cope and function in their daily lives. Some people become so distressed by memories of trauma that will not go away that they begin to live their lives trying to avoid any reminders of what happened to them. Over time, if the reactions remain frequent and intense, last for months, and cause problems in living, they may develop a more debilitating anxiety disorder such as PTSD (Helmus & Glenn, 2005).

PTSD is classified under the Trauma and Stress-Related Disorder and is characterized by behaviors and physiological responses that result after an exposure to a psychologically traumatic event (American Psychiatric Association [APA], 2013). PTSD is a relatively new diagnostic category in the history of psychology. Throughout history, in the military context, PTSD has been called a number of different names such as *soldier's heart* after the Civil War, *combat fatigue* or *shell shock* for soldiers after World War I, and *battle fatigue* or *gross stress reaction* for soldiers after World War II (Hoge et al., 2004).

PTSD did not receive inclusion in the U.S. as a formal diagnosis until 1980 as countless Vietnam veterans began experiencing a host of psychological problems, many persisting upon their return home. The American Psychiatric Association (APA) officially added PTSD to its Diagnostic and Statistical Manual of Mental Disorder III (APA, 1980). Although a controversial diagnosis when first presented, PTSD has filled an important gap in psychiatric theory and practice. This is predominantly because the PTSD diagnosis stipulates that the etiological agent is outside the individual (i.e., the traumatic event) rather than a personal weakness or flaw (i.e., neurosis) (Marsella, Friedman, Gerrity, & Scurfield, 1996).

Since PTSD's inclusion in 1980, several revisions have been made. The criterions that the APA (2013), the *Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5)*, uses to diagnose PTSD includes: (Criterion A) exposure to an actual or threatened death, serious injury, or sexual violence either through directly experiencing or witnessing the traumatic event, learning that a traumatic event occurred to close family member or friend that must have been violent or accidental in nature, or experiencing repeated or extreme exposure to aversive details of the traumatic events such as those endured in combat or as first responders. The symptoms required for the diagnosis of PTSD are divided into four criterions. Symptoms include: (Criterion B) re-experiencing intrusive memories of the traumatic event that occurs unexpectedly. These memories may include nightmares, disturbing mental images or extreme emotional distress, and/or physiological reactivity on exposure to reminders of the traumatic event. (Criterion C) avoidance of people, places, thoughts or activities that reminds a person of the traumatic event. (Criterion D) negative alterations in cognitions and mood associated

with traumatic events; these may include the inability to recall specifics of the traumatic event, exaggerated negative beliefs, distorted cognition and self-image, feeling of intense fear, horror, guilt, diminished interest, and feelings of detachment and inability to experience positive emotions. (Criterion F) includes a marked alteration in arousal and reactivity such as increased irritability and angry outbursts, poor impulse control, reckless or self-destructive behaviors, constant feeling of hypervigilance, exaggerated startle response, difficulties concentrating, and sleep disturbance. Symptoms of criterion B,C,D,E should be present for at least one month (Criterion G), and (Criterion H) the disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. (APA, 2013).

Many people have gone through traumatic events and had difficulties adjusting and coping for short periods of time; the majority of these people may have reactions that include shock, nervousness, anger, helplessness, fear, and even guilt. These reactions are common for most people, and with time and self-care, they usually recover fully without medical or psychological assistance. In some cases, however, having the symptoms worsen and last for months or even years; these individuals may have developed PTSD (Roberts, Kitchiner, Kenardy, & Bisson, 2009). Symptoms of PTSD typically start within three months of a traumatic event, but in a small number of cases, PTSD symptoms may not appear until years after the event. There are three specifiers for PTSD used for diagnostic purposes. Specifiers indicate when the symptoms began and how long they have been present. An acute specifier is used when the symptoms are present for less than three months. The chronic specifier is employed when symptoms last for at least three months or longer. Delayed-onset PTSD describes a situation where a person

does not develop a PTSD diagnosis until at least six months or longer after a traumatic event. In some cases, people may not begin to experience symptoms consistent with a PTSD diagnosis until years after the experience of a traumatic event (APA, 2013).

Military culture

Many Americans' knowledge about the military is limited to what is presented in the media. Few outside the military truly understand the culture, values, or people who make up the most powerful military force on earth. For civilians with little or no personal exposure to military culture, the Armed Forces may seem overwhelming, incomprehensible, esoteric, or even archaic (Dunivin, 1997). Because of the numbers of military men and women entering post-secondary education, university faculty and staff will need to have a basic understanding of the characteristics of returning veterans. In order to promote high-level wellness and make a significant contribution to military service members and their families, it is essential that the worldview, the mindset, and the historical perspective of life in the military are understood. Learning about service members' experiences and sacrifices could complement university faculty and staff efforts to promote diversity among students and provide a broader commitment to social understanding (Church, 2009).

Military culture is the philosophy that is ingrained in all military personnel from the start of their careers. All service members begin life in the military, whether active or reserve component, with some type of initial training. These new members of the Armed Force learn about the history of their service, military customs and courtesies, military values and ethics, military justice, proper wear of the uniform, military bearing, warrior

training, and other information that is critical to their success in the service and the success of the Armed Forces (Dunivin, 1997).

The warrior culture of the U.S. military is one that instills strength, resilience, courage, and personal sacrifice. The military indoctrinates an identity of elitism and superiority, perhaps best stated by various military's slogans: *Army Strong; The Few, The Proud; Do Something Amazing; A Global Force for Good.* Mental toughness, resiliency, and an expectation to master stress without difficulty are developed and reinforced as a cultural norm in the military, with emphasis on inner strength and self-reliance (Tanielian & Jaycox, 2008). When considering the context of the warrior mentality, one can see how this message is fundamentally at odds with service members seeking out mental health.

The current mental health approach for service members with symptoms related to mental health issues is encouragement to self-identify for treatment. Because the warrior identity is based on strength and elitism, the warrior's mindset may serve as a disconnect between the service member and seeking mental health treatment. This mindset further reinforces barriers for self-reporting of mental illness and inadvertently contributes to stigma. These barriers include (1) socio-cultural environment, (2) trauma-related avoidance symptoms, (3) lack of knowledge, (4) belief that treatment is not needed, (5) belief that the symptom will resolve over time, and (6) the perception of stigma associated with seeking mental health care (Hoge et al., 2004; Hoyte & Candy, 2011; Sayer et al., 2009; Warner et al., 2011). The most salient of these barriers among combat veterans is the stigma associated with seeking mental health and concerns about social consequences (Paige et al., 2011).

Postsecondary education legislation

The ADAAA became effective on January 1, 2009 and extended the protection of the Americans with Disability Act (ADA) of 1990. The ADA's intent was to protect individuals with disabilities, but the interpretation set by the federal courts for who qualifies as an individual with a disability created numerous roadblocks. Prior to the passage of the ADAAA, an individual who suffered a leg amputation may not be covered under the ADA because of the use of a prosthesis. With prostheses in place, the individual could have been evaluated to walk as well as the average person in the general population and, therefore, not qualify with a disability. The terminology identifying what is a disability used in the ADAAA provides a clearer description for Congress's initial intent for the ADA coverage to be all-encompassing. The ADAAA (2008) describes disability as a physical or mental deficiency that substantially limits one or more major life activities. The ADAAA also included those individuals who are perceived as disabled. People who are perceived as disabled will be covered if treated adversely, whether or not the impairment actually limits or is perceived to limit a major life activity (ADAAA, 2008).

Of equal importance, the ADAAA made significant impact on campuses, likely pertaining to individuals with psychological or cognitive disabilities. These disabilities were historically excluded from coverage due to extenuating effects of medication, episodic nature of impairment, or various interpretations of major life activities such as concentration and thinking that were not recognized by the courts. The ADAAA has addressed these barriers and now makes it more likely that war-related impairment such as PTSD will qualify an individual for coverage under the ADA (ADAAA, 2008).

The Post-9/11 Veterans Educational Assistance Act of 2008 was passed on August 1, 2009 and provides benefits for veterans who have served on active duty in the U.S. military since September 11, 2001. Veterans are eligible to receive educational benefits based on their length of service, with maximum benefits reached after 36 months of active duty service. Veterans who qualify for the Post-9/11 coverage are eligible to receive the full amount of tuition and fees charged by a college or university, a monthly housing stipend, a yearly book fee allowance, $500.00 funding for relocation expenses, financial benefits for tutorial assistance, and reimbursement for licensing and certificate tests. These benefits are available for a period of 15 years and are transferable to spouses and dependents (Department of Veteran Affair, 2008).

Needs Assessment

In the summer of 2013, The University of Southern Mississippi (USM) College of Nursing (CoN) faculty submitted a grant proposal to Health Resources and Services Administration (HRSA) to facilitate veteran students with medical experience in obtaining a Bachelors of Science in Nursing (BSN) degree when they separate from active duty military service. The aim of this grant is to give veterans credit for their military health care experience and expedite their graduation from a BSN program. Texas A & M Corpus Christi has a similar grant to facilitate veterans entering a BSN program. Personnel at Texas A & M advised USM faculty that, in order to prevent a *"crash and burn"* scenario with veteran students, additional faculty and staff education is needed to address issues and barriers to veteran success in a higher education program.

The USM veteran's representative identified approximately 700 students who attend USM and are enrolled under the post 9/11 GI bill or military tuition (B. Cooley,

personal communication in April, 2013). Of these, 13 are currently enrolled in the CoN. Veterans entering the USM CoN program may not realize they have PTSD or may have the belief that symptoms will resolve over time, while others fail to seek out assistance due to the stigma related to mental health. Either way, veteran students' mood, self-esteem, and self-image can be affected, causing a social disconnect between professors, classmates, and peers. In a university setting, where interactivity is essential among learners, military veteran students may be emotionally numb and unable to fully participate in classroom activities or group study with other students. The veteran student may even be disassociated with the environment, which could easily be mistaken by professors as someone who is apathetic and disengaged with the course material. If the instructor acts upon that false perception, this could result in unnecessary and damaging consequences such as an administrative removal from class or a failing grade.

As a result of their trauma related injuries, veterans may have difficulty with concentrating, completing assignments, forgetfulness, mental slowness, confusion, or thinking in a logical sequence. They may display a continuous negative attitude or thoughts and have a sense that life is overwhelming. Many veterans will have extreme emotional reactions such as irritation, frustration, jumpiness, over excitability; others will have a sense of helplessness, no sense of humor, and apathy. Somatic symptoms may include clenched jaw, grinding teethes, digestive upsets, increased heart rate, general restlessness, sense of muscle tension or actual muscle twitching, dizziness, lightheadness, hyperventilating, sweaty palms, high blood pressure, and lack of energy (Church, 2009; Tanielian & Jaycox, 2008).

There is currently no one reliable source to identify the percentage of returning veterans headed for post-secondary education who may be individuals with disabilities. However, an estimate of 40% is not unreasonable given the reported prevalence in the military and Veterans Affairs (VA) medical systems of OEF/OIF veterans identified with PTSD, depression, substance abuse, hearing and vision related injuries, and substantial mobility limitations owing to brain and orthopedic injuries (Church, 2009). Service members and veterans transitioning from active service to higher education bring with them a degree of maturity, leadership, diversity, and a mission-focused orientation that exceed those of nearly all of their peers; however, many veterans acquired these assets at pronounced personal expense, including battlefield injuries (Ackerman, DiRamio, & Mitchell, 2008).

An understanding of factors affecting treatment initiation for PTSD can inform strategies to promote help-seeking. The overreaching goal of this project is to *"stop the bleeding"* and provide early intervention in the mental, emotional, social, and spiritual domains thereby preventing the progression of symptom of PTSD and other potentially chronic trauma related disorder. Veterans who demonstrate health risks related to chronic trauma disorders need targeted risk reduction services and increased surveillance services to identify the onset of symptoms in the early stages. For many veterans leaving the combat zone and entering postsecondary education, university faculty and staff may be the veteran's first link for early recognition, intervention, referrals, and treatment despite barriers.

Objective of the DNP Project

Providing university faculty and staff with basic knowledge and understanding of military culture, challenges, stressors during deployment, and psychological and neurological injuries may provide a better appreciation of how the unique characteristic of military life impacts service members. Early intervention measures require faculty and staff to be familiar with common issues veterans with disability related adjustments bring to the classroom and to provide access to available school and community resources. Characteristics of returning veterans with invisible wounds as a result of deployment experiences will need to be an essential element of innovative post-secondary faculty in-service education. Veterans who demonstrate health risks related to combat stress injuries need surveillance services to identify the early onset of symptoms of PTSD at an early stage.

The intent for this nursing intervention is to Bridge the Gap, to help facility and staff understand, anticipate, and respond to the needs of student veterans in a bachelor's of science in nursing program. The capstone program utilizes Leavell and Clark's (1965) levels of prevention and Dunn's high level wellness theories and focuses on student retention through prevention and early identification of service-related problems and, when appropriate, early referral to University and community resources. Characteristics of returning veterans needs to be an essential element in the development of new innovative approaches for faculty in-service training focusing on early recognition and interventions within a classroom setting. Actively appreciating and valuing diversity on college campuses means knowing the backgrounds and experiences of veteran students. Understanding student veterans means understanding military culture, battlefield skills,

and deployment related stressors. It also means listening to students' stories and understanding the unique stressors faced by student veterans on campus.

CHAPTER II

REVIEW OF LITERATURE

An extensive literature review was conducted utilizing the following databases: Cumulative Index for Nursing and Allied Health Literature (CINAL), Cochrane Library, MEDLINE, EBCSO, PubMed and Google Scholar. Keywords for the search included stress disorder, military, post traumatic, mental disorder, diagnosis, psychological intervention, crisis intervention, and postsecondary education. The literature review produced numerous abstracts that were manually reviewed that potentially met the primary focus for the design and implementation of this capstone project. Several other studies were selected after the initial literature review. The review of literature has numerous implications for future research and reinforces the continued need for the development of effective treatment strategies, interventions, and the need for advocates for returning combat veterans. A systematic review of the literature was conducted and assessed using a rating system which determined a hierarchy of evidence (Appendix A).

PICO question

Will online education adequately inform College of Nursing faculty and staff about the issues and challenges of serving veteran students, especially students with diagnosed or undiagnosed PTSD and other service-related disabilities help facilitate students' sense of well-being during their time in a BSN nursing program?

Current Issue Affecting U.S. Military Veterans

Since October 2001, over 2.2 million U.S. troops have deployed to OEF/OIF (Tanielian & Jaycox, 2008). Active duty, National Guard, and Reserve members have endured intense guerrilla warfare, chronic threats of roadside bombs, and improvised

explosive devices (Seal, Bertenthal, Miner, Sen, & Marmar, 2007). The development of acute stress disorder (ASD), PTSD, and other combat and operational stress reactions are some of the most significant psychological risks of combat exposure (Engelhard et al., 2007; Hoge et al., 2004; Milliken, Auchterlonie, & Hoge, 2007; Tanielian & Jaycox, 2008). Evidence supports that the long-term psychological toll of these deployments, many involving prolonged exposure to combat-related stress over multiple rotations, may be disproportionately high compared with the physical injuries of combat (Karney, Ramchand, Osilla, Caldarone, & Burns, 2008). Cognitive injuries are among the most prevalent of these battlefield injuries for today's returning service members (Milliken et al., 2007). Predominant among these cognitive injuries are PTSD and TBI. Some estimates indicate that individuals who serve(d) in Iraq and Afghanistan have as much as a 40% chance of acquiring such an injury by the time they complete their service (Milliken et al., 2007; Tanielian & Jaycox, 2008).

The reduction in the size of the Armed Forces coupled with the extended nature of OEF/OIF wars has resulted in service members being deployed to combat in unprecedented numbers (Bruner, 2006). Not only is there a higher proportion of armed forces members being deployed for military service, but deployments have been longer, redeployment to combat has been common, and breaks between deployments have been infrequent and shorter (Hosek et al., 2006). Of the roughly 2.2 million Americans who have deployed, over 800,000 have been tasked to serve multiple deployments, and of those, one quarter has gone to fight three times or more. Moreover, those who were deployed more than once are at a 300 percent increased risk for devolving mental health outcomes (Hoge et al., 2004; Kline et al., 2010).

Numerous studies have been conducted on veterans returning from combat who are experiencing a variety of mental health conditions such as major depression, panic disorder, generalized anxiety disorder, and/or substance abuse (Kline et al., 2010; Stecker et al., 2010). The percentage of returning combat veterans who have been deployed to a combat location and have screened positive for depression, general anxiety and PTSD is estimated at 15% to 17% (Seal et al., 2007). This percentage reflects veterans who have been identified with a mental disorder, and it does not include those who fail to report symptoms of mental distress. Numerous studies have found that rates of PTSD among service members deployed in Iraq and Afghanistan may be as high as 40% (Hoge, et al., 2004; Warner et al., 2011). Many cases of PTSD may go unrecognized and consequently undiagnosed and untreated, both in the combat theater and once the service member returns home (Hoge et al., 2004).

Service members who have cognitive injuries frequently suffer from other comorbid psychiatric disorders such as depression, major affective disorders, other related anxiety disorders, and alcohol or substance abuse/dependence (Hoyt & Candy, 2011; Kline et al., 2010; Stecker et al., 2010). Based on a review of 289,328 records from the Department of Health, 37% of these veterans have received a mental health diagnosis; of these veterans, 22% have a diagnosis of PTSD, 17% depression and 7% alcohol abuse. In addition, one-third of these veterans have more than one mental health diagnosis (Seal et al., 2009).

Veterans are being released from active duty service at an alarming rate without receiving adequate treatment for mental health problems. A study conducted in 2007 by Veterans Affairs (VA) Health Care System identified 103,788 veterans who served this

country and who have since utilized VA services after discharge; of those, over 25,000 veterans have received one or more distinct mental health diagnoses. The average mean time from discharge to first visit with the VA was three months, and many veterans have been diagnosed with a mental disorder for the first time (Seal et al., 2007; Thomas et al., 2010). The failure to capture a significant portion of those returning combatants with a mental disorder prior to discharge from active duty services has resulted in an increased burden on VA and civilian providers (Hoyt & Candy, 2011; Kline et al., 2010; Peterson, Luethcke, Borah, & Young-McCaughan, 2011).

A generally accepted explanation for the limited success in mental health is often due to the service member stigma that surrounds behavioral health and stress problems. Psychiatric epidemiological studies provide insights into barriers to treatment seeking for mental disorders. Seeking mental health can be seen as a sign of weakness, disgrace, or discredit to service members, and if revealed, would expose them to shame and ridicule and ultimately be detrimental to a military career. Admitting to a psychological problem for service members is much more stigmatizing than admitting to a medical problem (Paige et al., 2011). This perspective is supported by research findings that up to one in five veterans of OEF and OIF screened positive for either depression, anxiety, acute stress, or PTSD symptoms; however, less than half sought help for their mental health problem, due primarily to concerns that leaders would treat them differently, that peers would view them as weak and have less confidence in their abilities, and that seeking mental health assistance would negatively impact their career (Capella University, 2008; Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009).

Suicide

Veterans make up 11% of the general adult population, yet they account for more than 22% of all suicides (Kemp & Bossarte, 2012). The Department of Veterans Affairs (2012) suicide data report revealed one active service member committed suicide each day. The rate of those who took their own lives hit a record high in 2012 when more active duty members died by suicide than in actual combat (Kemp & Bossarte, 2012). Veterans are twice as likely to commit suicide compared to their civilian counterparts. Research indicates that there is a direct correlation between trauma and suicidal behaviors. There is evidence that traumatic events such as those experienced in combat increase a person's suicide risk. Studies also suggest that suicide risk is higher in persons with PTSD (Kemp & Bossarte, 2012). For veterans back from war, a national average of 22.2 per day died by suicide. The suicide rate among 18- to 29-year-old men who have left the military has gone up significantly; the rate of suicide among young veterans in this age group is estimated two to four times higher than any other age group (Kemp & Bossarte, 2012).

The clinical diagnoses of psychotic disorders, depressive disorders, and PTSD were associated with suicidal ideation. Of these, depressive disorders carried the most elevated risk followed by PTSD. OEF/OIF veterans showed elevated risk of suicidal ideation with diagnoses of either PTSD or major depressive disorder (Jakupcak et al., 2009; Pietrzak et al., 2010). OEF/OIF veterans meeting criteria for the PTSD avoidance symptom cluster was significantly associated with increased suicidal ideation, with the re-experiencing symptom cluster trending towards significance. Either of these clusters had a greater than two-fold increase in their association with the presence of current

suicidal ideation, showing that avoidance symptoms are associated with psychosocial difficulties (Guerra & Calhoun, 2010; Pietrzak et al., 2010).

Substance use disorder

Individuals with substance use disorders (SUDs) have disproportionately high rates of co-occurring PTSD. Self-medication (i.e., using substances to alleviate PTSD symptoms) is often cited to explain the process of PTSD and SUD comorbidity. Numerous studies have shown that people who have experienced a traumatic event may resort to maladaptive coping strategies as a result. Specific to veterans, more than two of ten veterans with PTSD also have SUD; war veterans with PTSD and alcohol problems tend to be binge drinkers; almost one out of every three veterans seeking treatment for SUD also has PTSD; and in the OIF/OEF wars, one in ten returning soldiers seen within the VA system have a problem with alcohol or other drugs (Back, Waldrop, & Brady, 2009; Zoricic, Kartovic, Buljan, & Marusic, 2003).

PTSD interacts directly with SUD to worsen SUD symptoms and make recovery less likely (Ouimette, Brown, & Najavits, 1998). Estimates suggest that 35–50% of people with a current diagnosis of SUD have comorbid PTSD, a much higher percentage than in the general population (Rash, Coffey, Baschnagel, Drobes, & Saladin, 2008). Veterans with SUD and PTSD present with greater drug use severity and show poorer SUD treatment outcomes than veterans with SUD without PTSD. Research suggests that an exacerbation of PTSD symptoms is the most important factor in predicting relapse following substance abuse treatment among veterans with comorbid PTSD (Ouimette et al., 1998). Interventions that successfully address the negative impact of comorbid PTSD could improve SUD outcomes significantly for a substantial proportion of SUD veterans.

Post-secondary Education and Disabilities

Veterans with disabilities have been a catalyst in the development of new services for students with disabilities in post-secondary institution. The Association on Higher Education and Disabilities (AHEAD) conducted an online survey on current practices in post-secondary education for serving veterans with disabilities. Participants included 2,500 members and affiliates of AHEAD, who were invited to participate in this online survey. The survey was comprised of 29 questions on current practices in post-secondary education for serving veterans with disabilities (Madaus, 2009). The respondents were asked to provide the numbers of wounded warriors by gender and disability type. Psychological, medical health challenges, mobility, and learning disabilities accounted for approximately 90% of all of the reported disabilities, with psychological disabilities comprising the highest percentage, with males at 34%, and females at 11%. Health and medical challenges composing Health-Medical, Burned and Mobility accounted for 24.7% of male disabilities and 5.2% of female disabilities. Learning Disabilities represented 16% of the total disabilities (Vance & Miller, 2009).

Post-secondary institutions are expected to experience an influx of returning OIF/OEF veterans enrolling in post-secondary education. It is estimated that over 2 million veterans will enroll in post-secondary education in the upcoming years (ACE, 2008). The Rand Corporation (2008) report predicts that as many as a quarter of these students will have hidden disabilities such as TBI, PTSD, and other emotional disorders. Of this group, many service members will have cognitive disabilities that impact their ability to succeed in colleges (Tanielian & Jaycox, 2008). According to Tanielian and Jaycox (2008), 20% of these service members returning to school will have PTSD or

major depression, while 19% have experienced TBI. Some of the cognitive difficulties associated with PTSD and TBI that may affect veteran's academic performance include: attention and concentration difficulty, information processing challenges, learning and memory deficits, sluggish abstract reasoning and slowed executive functions (problem solving, planning, insight/awareness, and sequencing). Other factors that may exacerbate PTSD symptoms may include health concerns and interpersonal issues such as dissolution of personal and marital relationships, sleep deprivation, alcohol and/or drug abuse, notice of redeployment, separation from battlefield and unit colleagues, difficulty with time management, panic attacks, and possible side effects of medications (Church, 2009; Madaus, Miller, & Vance 2009).

Veterans with PTSD bring more unique challenges than do traditional students, and these challenges may impact the veteran's ability to succeed in college. Veterans with PTSD bring with them not only the difficulties associated with acquired physical and mental challenges, but the additional burden of adjusting to the effects of serving in combat. Research supports that at least one-third of OIF/OEF veterans will have a mental disability of which only 53% would have sought out help from a provider (Tanielian & Jaycox, 2008).

Synthesis of the Literature

The transition from combat veteran to college student poses significant challenges for both the veteran and the educational institution. The characteristic of returning veterans, particularly those with disabilities such as PTSD, will need to be an essential element of faculty in-service training programs. Veterans attending post-secondary education with disabilities related to PTSD may not be as prepared as their civilian non-

disabled peers and may need university administrators and faculty to rethink and reframe existing paradigms if they intend to reintegrate, retain, and eventually graduate this population of students. The traditional methods of waiting for students to self-identify their problems and needs may no longer be effective with the current wounded veteran population. The university needs to take a more proactive versus reactive approach by educating faculty about the particular issues and challenges of serving the expanding student veteran population. Post-secondary institutions must be willing to learn more about these veteran students and introduce innovative supportive approaches that will provide methods for early recognition of PTSD (Vance & Miller, 2009).

Theoretical Framework

High level wellness

The term high-level wellness was first introduced by Dunn in 1961. Dunn describes high-level wellness as an integrated method of functioning that is oriented towards maximizing the full potential of the individual (Dunn, 1961). High-level wellness is consistent with a holistic view of health with the aim to balance physical, occupational, social, spiritual, intellectual, and emotional elements (Dunn, 1961). In this definition, there is no optimal level of wellness but rather recognition that wellness is a direction in the progress toward an ever-higher potential of functioning.

Included in Dunn's (1961) philosophy, high-level wellness is not static; an individual's wellness falls within a continuum between death and wellness and is dependent on an individual's particular environment or circumstances. Mental wellness is ultimately the responsibility of the individual and, therefore, cannot be delegated to

another. High-level wellness is about the potential to achieve the highest state of well-being (Dunn, 1961).

The relationship between self-concept and wellness is very important, especially for faculty in institutions of higher learning when they try to effect behavioral change in students to adopt healthier behaviors. The program development for this capstone is based on Dunn's High-Level Wellness model. Essential to the implementation of this proposed consulting project is sound education of the individual with PTSD so that proper information and motivation for initiating actions can be planned. University administrators, faculty, and staff play a major role and function as health mentors who need to be able to recognize the special hazards confronting military veteran students as they transition back into civilian life and postsecondary education.

Levels of preventions

The terms primary, secondary, and tertiary prevention were first documented in the late 1940s by Leavell and Clark (1965). Leavell and Clark (1965) described the principles of prevention within the context of the public health triad consisting of host, agent, and environment commonly referred to as the epidemiologic triangle model of causation of diseases. This model suggests that the natural history of any disease exists on a continuum, with health at one end and advanced disease at the other. This paradigm has served the development of public health, as it has been the standard framework that has informed the strategic development of policies, plans, and programs in the delivery of health services in most jurisdictions throughout the world (Burkart & Sommer, 2007).

Primary prevention includes understanding the concept of positive health and involves strategies that encourage the achievement and maintenance of an acceptable

level of health that will enable every individual to lead a socially and economically productive life. Deeply embedded core values form the basis; the spirit of adaptation is the precursor of a rational and sustainable preventive strategy. In this connection, values clarification together with the identification of norms and standards of human behavior within the existing culture at a particular point or period of time are necessary criteria for meaningful planning of preventive measures and strategies (Leavell & Clark, 1965). Primary prevention is the action taken prior to the onset of disease, which removes the possibility that the disease will ever occur. It includes the concept for positive health that encourages the achievement and maintenance of health that empowers all to lead a productive life. In order to make a significant contribution to military service members and their families, it is essential that the worldview, the mindset, and historical perspective of life in the military are understood. Providing university faculty and staff with basic knowledge and understanding of military culture, deployments issues, and understanding stigma and barriers as they relate to the behavioral health of service members can provide a better appreciation of how the unique characteristic of military life impacts service members and their families. Learning about military and service members' experiences and sacrifices could complement the knowledge of university faculty and staff and provide a broader commitment to diversity and social understanding as they relate to educating veteran students (Leavell & Clark, 1965).

Secondary prevention generally consists of the identification and anticipation of diseases that are present in the body but have not progressed to the point of causing signs, symptoms, and dysfunction. These preclinical conditions are most often detected by

disease screening (and follow-up of the findings). Individuals who have experienced a traumatic event often experience psychological stress reactions related to the incident.

Veterans who demonstrate health risks related to combat stress injuries need surveillance services to identify the onset of PTSD symptoms at an early stage. Veterans do not often self-identify as suffering with PTSD, and those with unrecognized PTSD are often difficult to treat because of poor rapport, anger, distrust, a focus on somatic symptoms, and other trauma-related problems. The ability of university faculty and staff to identify PTSD symptoms early may help facilitate development of rapport, suggest treatment options, and potentially improve outcomes for these veterans (Leavell & Clark, 1965).

Tertiary prevention occurs after a disease or disability has occurred. The intent is to halt the injury process by responding and assisting the veteran in obtaining an optimal health status. University faculty and staff may be the first to encourage student veterans with a suspected disability to seek reasonable accommodation. Early intervention measures require that faculty and staff are familiar with the common issues veterans with disability related adjustments bring to the classroom. Post-secondary institution personnel should identify a wide variety of both on-campus and off- campus resources in order to provide veterans with needed support (Leavell & Clark, 1965).

In the absence of understanding a framework, the application of preventive measures is open to serious errors. Indeed, whenever the application of preventive strategies occur in the absence of adequate information or analysis, these circumstances are more likely to lead to discrete, isolated, incoherent initiatives because critical core values that have evolved over time are missing.

CHAPTER III

METHODOLLGY

Purpose

The purpose of this Doctor of Nursing Practice (DNP) capstone project was to develop a program to educate The University of Southern Mississippi (USM) College of Nursing (CoN) faculty and staff about the issues and challenges of serving veteran students, especially those with diagnosed or undiagnosed Post-Traumatic Stress Disorder (PTSD) and other psychological and cognitive disabilities. The program was focused on student well-being and retention through prevention and early identification of service-related problems and, when appropriate, early referral to University and community resources. The program includes four audio-visual modules that utilize Dunn's (1961) high-level wellness and Leavell and Clark's (1965) three levels of prevention. Objectives were developed for each module, and written scripts were prepared for presentation recordings. Useful terminology and visual aids were utilized to help the viewer understand the intent of each module.

The project objectives are presented below. Evaluation of the objectives is addressed in the discussion section of this paper. Module Objectives:

Module 1: Introduction

Objective 1: Understand the background and significance of how the current military conflicts have affected service members and how postsecondary institutions may be impacted.

Objective 2: Understand challenges with re-integration back to civilian life.

Module 2: Primary Prevention

Objective 1: Achieve a basic understanding of military culture, values, and ethics.

Objective 2: Have an understanding of some of the common challenges and stressors veterans face during deployments.

Objective 3: Understand current methodology being utilized by the military for screening service member for pre and post-deployments.

Module 3: Secondary Prevention

Objective 1: Understand Combat Operational Stress Reaction, Acute Stress Reaction, and Acute Stress Disorder.

Objective 2: Understand the history, prevalence, biological basis, and DSM diagnostic criteria for PTSD as they relate to veterans.

Module 4: Tertiary Prevention

Objective 1: Identify those cognitive changes, behavioral changes, and social interactions related to post-trauma disabilities that may be identified by faculty and staff in a classroom setting.

Objective 2: How university faculty and staff may serve as potential facilitators for early intervention and referral of veterans with PTSD and connect the student to on-campus and community social support networks including resources that are available online.

Target population

All faculty and staff at the USM CoN who have direct contact with nursing students will be recruited to participate in program educational activities. During project

development, there were a total of 39 faculty and 14 staff members who worked in the CoN at both the Hattiesburg and Gulf Coast Campuses. All faculty and staff members are 21 years of age or older.

Setting

The modules will be offered online via a Blackboard platform and are available to participants at their convenience. Blackboard is a Web-based server software tool that enables educators to provide students with course materials, class discussions, assignments, and assessments. The estimated time required to complete each module ranges from 30 minutes to 40 minutes. Upon completion of each module the participants are prompted to complete an evaluation survey that may require an additional 10 minutes per module.

Detailed Procedures

After successful defense of the proposed capstone, approval for the project was requested and received from the Associate Dean and Assistant Professor at USM, CoN, Dr. Sandra Bishop. IRB approval was received for this project and protocol number: 13072402 was assigned to the project (Appendix F). In addition, Sarah Powell, MSN, a CoN faculty member was recruited as a key consultant and content expert for this project. Ms. Powell is a retired Army Lieutenant Colonel with more than 30 years as an Army Nurse Corps Officer. During her military service, Ms. Powell assisted in evaluating and supervised the evaluation of the medical and mental health needs for all soldiers in the Mississippi Army National Guard. As Chief Behavioral Health Officer while on active duty, she evaluated and supervised the evaluation of deploying and redeploying troops to Iraq and Afghanistan.

Based on the research, a written script that addressed specific issues for those objectives listed within each module was provided to Ms. Powell for review and content validity. Upon return, recommended changes were considered and addressed, and each script was re-submitted to her for additional modification or final approval. This procedure was implemented for all 4 modules.

After receiving approval for the content within each script, an audio video presentation was created. The filming of each module utilized a downloadable program called Screencast-o-matic pro. Screencast-o-matic pro is a Java-based web application used to create screencasts on Windows, Mac, and Linux operating systems. Each module contains both videos and photos to aid in the overall presentation. Specific videos and photos were selected for each module and were appropriately placed in the presentation. The videos and photos were obtained from several free public online sources. After completing the audio video presentation, it was viewed for its content and edited for clarity by the author.

An anonymous post survey questionnaire was created for each module utilizing Survey Monkey program to evaluate the overall content, effectiveness, and usefulness of the information within each module (Appendix B). Survey Monkey is an online tool that enables users to create professional online surveys, design questionnaires, control mandatory responses, and collect responses via web or email. Each module will have its own personal uniform resource locator (URL) number that allowed the author to determine which module was reviewed and evaluated. A separate survey utilizing the same steps was created for veteran students as they exit their nursing program. The students' surveys were designed to capture data about their satisfaction with the support

they received in achieving and maintaining high-level wellness during their time in the nursing program (Appendix C).

Upon completion of the audio video modules and survey questions, the final product was uploaded into USM Blackboard and made available for review by faculty and staff who choose to view the module. Blackboard is a web-based learning management system designed to enhance a teaching and learning environment by providing content management and sharing, online assessments, student tracking, assignment management, and virtual collaboration. After viewing each module, faculty and staff will be asked to complete an online program evaluation survey. Veteran students will be asked by faculty and staff to complete an online evaluation survey when they exit their nursing program. The completed surveys will be directed toward the author's USM email account and access to the data presented will be limited to the author.

Informed consent is implied by faculty and staff who complete the educational modules and complete the post module evaluations. Students' completion of an evaluation of their satisfaction with faculty and staff in helping them achieve and maintain high-level wellness associated with military-related issues, especially PTSD symptoms or other disabilities during their nursing program, is voluntary. Therefore, consent is implied. Both the Professional Program Evaluation Survey and the Student Veteran BSN Exit Survey are components of the DNP capstone project.

Ethics

There are no known risks for this professional development program. Participants are unlikely to experience any physical, psychological, or social risks due to the nature of

this program. The program is strictly voluntary, and participants are free to view the module without completing the evaluation survey. Participation in the educational activities represents implied consent. The program evaluation survey for faculty, staff, and students does not contain any personally identifiable information unless the respondent chooses to self-identify. The tools used to collect the online evaluation data are set to provide anonymity of the email address of each respondent.

CHAPTER IV

DATA ANALYSIS AND EVALUATION

This project does not involve data collection other than for program evaluation. Faculty and staff will be asked to complete an online program evaluation survey after finishing each program module. The online survey will be used to evaluate the format of the presentation and whether objectives were met for each module. Additionally, the post-survey will rate the overall content, effectiveness, and usefulness of the information presented. Prior to graduating from The USM DNP program in May 2014, arrangements will be made that allows this author continued access to USM Blackboard. The data from the post-survey questionnaire will be automatically directed to the author's USM email account, and this will allow the author to view the evaluation at his convenience. Throughout the course of the year, the author will review the post-survey questionnaire and address those issues that may require modification for program improvement.

Though not offered prior to the defense of this program development, these modules will be offered for viewing and evaluation by the Student Veterans of America-University of Southern Mississippi President, A. J. Rooney, in support of his goals to promote USM for designation as a nationally recognized military friendly school. Additionally, the modules will be offered for viewing and evaluation by The USM Student Counseling Service in support of its goal to provide quality services to students by promoting sound mental health and coping skills necessary for the successful pursuit of educational and life goals.

Assumptions

Since the prevalence of PTSD in the population of student veterans returning from OEF/OIF conflict is likely high, faculty and staff's ability to service the needs of these students becomes a salient issue. For The USM CoN faculty and staff, understanding the issues and challenges that veterans bring to a classroom will better serve to ensure student well-being and promote early intervention and school retention.

Timeline

The timeline for this project is presented in Appendix D.

Resource Requirements

The project required the use of and access to Blackboard. The program used in the creation of the audio-visual modules required the use of Screencast-o-matic pro, Microsoft Power Point 2012, and Survey Monkey.

DNP Essentials

Appendix (E) provides a list of DNP essentials as they relate to this project.

Results

This project has not been implemented as of the date of the author's capstone defense. Consequently, no current data is available from faculty, staff, and student evaluations. The project program was evaluated for content validity by Ms. Powell, a CoN faculty member with long-term military experience in the Army Nurse Corps. At the time of implementation of this project, the structure of the program was evaluated by all Capstone Committee members. The results for this project are pending the completion of post-module professional program evaluation survey by USM faculty and staff. In order to accurately determine the efficacy of this project, USM faculty and staff

will need sufficient time to review the modules and provide feedback. Veteran students will be asked to complete an online evaluation survey when they exit their nursing program. The students' survey will be designed to capture data about their satisfaction with the support that they received in actualizing and sustaining high-level wellness during their time in the nursing program. The results of these surveys will be reviewed throughout the upcoming year. Prior to receiving data from veterans students as they exit the CoN program, data will have to be received by faculty and staff in order to accurately determine the efficacy of the project.

CHAPTER V

DISCUSSION

Summary of Findings

The passage of the ADAAA and the Post-9/11 Veterans Assistance Act has afforded veterans the opportunity to pursue post-secondary education. Except with regard to learning disabilities, most universities will have only limited prior experience with the predominant disabilities related to those veterans who served in Iraq and Afghanistan. Cognitive injuries are among the most prevalent of these battlefield injuries for today's returning service members. By some estimates, individuals who serve in Iraq and Afghanistan have as much as a 40% chance of acquiring such an injury by the time they have completed their service (Milliken et al., 2007; Tanielian & Jaycox, 2008). The Association on Higher Education and Disability (AHEAD) has initiated steps in the direction of new innovation and collaboration to create campuses where veterans may successfully transition from the battlefield and persist to graduation. The member colleges and universities of AHEAD encourage the implementation of veteran-specific outreach activities (Church, 2009).

In order to best accommodate student veterans with PTSD and TBI assist the integration of student veterans into on-campus life, The American Counsel of Education provided tips for university faculty and staff. The American Counsel of Education (2008) identified that it is imperative that university faculty and staff keep in mind that veterans with newly acquired emotional and physical injuries (both seen and unseen) are just developing an understanding of their limitations and how it affects learning. Actively appreciating and valuing diversity on college campuses means knowing the

backgrounds and experiences of veteran students, understanding military culture, combat experience, idealistic views that service members have about their capabilities, and the meaning of emotional and physical injury. In addition, university faculty and staff should be empathetic regarding the heavy burden involved as service members and their families transition out of the military back into civilian life. It also means listening to stories and understanding the unique stressors faced by student veterans on campus. For university faculty and staff, this knowledge may provide the best opportunity for service members' successful journey from serving this country to securing their own future through higher education (Grossman, 2009).

Based on the summary of finding, this capstone project is designed to Bridge the Gap, to help educate USM, CoN faculty and staff to better understand, anticipate, and respond to the needs of student veterans in a bachelor's of science in nursing program. Based on Leavell and Clark's levels of prevention and Dunn's high level wellness theories, this project focuses on student retention through prevention and early identification of service-related problems and, when appropriate, early referral to university and community resources.

Limitations

The biggest limitation of this project is that the program was not implemented before the end of the capstone period. Consequently, faculty, staff, and student evaluation data is not available. Additional limitations may involve faculty and staff's pre-conceived notions about student veterans who may have symptoms of PTSD and the faculty and staff's perceived self-efficacy in order to address the special needs of veterans in the classroom who may influence their impressions about this project.

Implications

Post-secondary institutions are seeing an unprecedented number of service members returning to school after having served in Iraq and Afghanistan. These modules are not an exhaustive list, but they serve as a starting place for university faculty and staff to begin their work educating veterans. A particular advantage to this project is its focus on barriers that affect veteran students and its emphasis on early treatment of hidden wounds as veterans transition from military to postsecondary institutions. These factors may promote new insight for help-seeking among veteran students. It is hoped that this project serves as a platform for future studies examining the complex interplay between student veterans and university faculty in regard to help-seeking behaviors for PTSD.

This project provides a variety of additional campus and community collaborative resources to better serve this veteran population in order to better prepare the campus to provide veterans a seamless transition into the classroom. Additionally, this project may serve for the development of an in-service training program devoted to student veterans as it addresses those cognitive issues related to entering a postsecondary institution.

Conclusion

Achieving the goal of creating a positive learning environment requires a coordinated effort among faculty and staff members. The first element is promoting an understanding about what PTSD is and how its symptoms can affect student behavior. Because PTSD is certainly not limited to military and veteran students, this knowledge is useful on many levels. A student may exhibit disruptive behavior in class or with a staff member on the telephone. Therefore, a general understanding of how such behavior may be linked to PTSD can be useful for the instructor or staff member. Because of the size

of the military and veteran student population, some degree of knowledge about military institutions, the culture, and the people is important, so that when a student talks about his or her situation, there is a level of empathy and understanding.

Plan for dissemination

This project will be made accessible on-line via Blackboard for The USM CoN. Additional dissemination of the material will be re-evaluated following the results of the post-program surveys and resultant modifications. Further dissemination could include sharing these modules via USM Blackboard for other areas within USM. The module could be placed on I-tunes University. Future plans to conduct oral presentations about the content of this project will be considered upon the request from other colleges, universities, or other academics settings.

Funding

This capstone project did not receive funding. The project cost was minimal because the resources provided were all volunteered or available on-line.

APPENDIX A

LITERATURE REVIEW TABLE

Authors and dates	Level of study	Study type	Sample	Data collection	Key findings
Back, Waldrop, & Brady, (2009)	V	Qualitative	423 clinicians	Survey	The findings underscore the significant challenges that exist on multiple levels in treating comorbid SUDs and PTSD.
Capella University, (2008)	V	Qualitative	Service members and veterans Families of service members and veterans, and Mental health profession-als	Survey	Learned that there are many simple things that families, friends, and neighbors can do to ease the transition of returning service members.
Church, (2009)	V	Qualitative	Military members	Survey	Growing numbers of returning military personnel attending higher education based on emerging national trends, including the new GI Educational Bill, amendments to the ADA, and rising unemployment rate.
Engelhard et	III	Cohort	Dutch	Questionnaire	There was a

al., (2007)			troops	pre- and post-deployment	specific effect of deployment on mental health for a small minority. Questionnaires eliciting stress symptoms gave substantial overestima-tions of the rate of PTSD.
Guerra & Calhoun, (2010)	IV	Quantitative	393 U.S. Armed Forces members who served in the military subsequent to September 11, 2001	Structured clinical interview, along with a battery of questionnaires related to a range of possible post-deployment adjustment problems	The empirical evidence of a link between deployment to a war zone and an elevation of suicide risk subsequent to that deployment.
Hoge et al., (2004)	III	Quantitative	Combat veterans	Post-deployment questionnaire	Identified significant mental health problems and barriers to receiving mental health treatment
Hosek, Kavanagh, & Miller, (2006)	II	Quantitative	Veterans	Survey	Personnel returning from deployments report facing a range of personal work, and combat-related stressors while on deployment. For some, the

					effects of these stressors are more long-term and significant than for others.
Hoyt & Candy, (2011)	V	Non-research	Combat veterans	Observation	Treatment services for PTSD.
Jakupcak et al., (2009)	II	Quantitative	Combat veterans	Survey: Post-deployment questionnaire	Results of the study indicated that veterans who screened positive for PTSD were four times more likely to report suicide-related thoughts relative to veterans without the disorder.
Karney, Ramchand, Osilla, Caldarone, & Burns, (2008)	II	Qualitative	Veterans	Critically appraised topic	The studies indicates only that service members who return from their deployments with PTSD or MDD disorders are at increased risk for these negative outcomes.
Kemp & Bossarte, (2012)	I	Qualitative	Veterans	Systematic overview of data obtained from the State Mortality Project, Suicide Behavior	While the numbers of Veterans who die from suicide each day has remained relatively

				Reports for fiscal years 2009 – 2012, and Veterans Crisis Line.	stable over the past 12 years (varying from 18 -22 per day). The percentage of people who die by suicide in America who are Veterans has decreased slightly.
Kline et al., (2010)	IV	Quantitative	New Jersey National Guard	Pre-deployment questionnaire	Previous/fre-quently deployed soldiers were three time more likely to develop PTSD than those being deployed for the first time.
Madaus, Miller, & Vance, (2009)	VI	Qualitative	Veterans attending school	Observation	The influx of veterans with disabilities who will bring new challenge. It may be easy for the DS to become overwhelmed meeting the needs of veterans with disabilities with the prospect of new responsibilities at a time of receding budgets and resources.
Milliken, Auchterlonie,	III	Cohort	88, 235 US soldiers	Post-Deployment	Soldiers reported more

& Hoge, (2007)				Health Assessment (PDHA) and a Post-Deployment Health Re-Assessment (PDHRA)	mental health concerns and were referred at significantly higher rates from the PDHRA than from the PDHA.
Ouimette, Brown, & Najavits, (1998)	VI	Case series report	Veteran with PTSD and SUD	3 months Longitudinal Study	SUD-PTSD patients reported more average daily alcohol consumption, more problems from substance use, and less remission.
Peterson, Luethcke, Borah, Borah, & Young-McCaughan, (2011)	II	Critically appraised topic	U.S. Army Soldiers and Marines returning from a deployment in support of OEF/OIF	Anonymous survey	Best practice approach for treatment.
Pietrzak et al., (2010)	III	Quantitative	272 OEF/OIF veterans	Survey containing measures of psychopath-ology, resilience, and social support.	Interventions for PTSD, depression, and psycho-social difficulties. To bolster post-deployment social support and resilience may be helpful in preventing suicidal ideation in OEF/OIF veterans.
Pietrzak, Johnson,	III	Quantitative	Sample of 272	Veterans Needs	Negative beliefs about

Goldstein, Malley, & Southwick, (2009).			reservist and National Guard OEF-OIF veterans in Connecticut	Assessment Survey	mental health care, particularly psychotherapy, and decreased perceived unit support predicted increased perceptions of stigma and barriers to care. Negative beliefs about mental health care were also associated with decreased likelihood of mental health counseling and medication visits in the past six months, even after adjustment for demographic characteristics, psychiatric disorders, and support variables.
Rash et al., (2008)	V	Quantitative	Sample of 124 substance dependent individuals	Impact of Event Scale Revised survey	Participants with comorbid PTSD reported significantly more symptoms of anxiety, depression, and PTSD compared to substance dependent individuals

					without PTSD.
Rielage et al., (2010)	III	Quantitative	Combat veterans	Post-deployment questionnaire	Higher rates of co-morbid diagnosis (depression, anxiety d/o and substance abuse).
Roberts, Kitchiner, Kenardy, & Bisson, (2009)	I	Quantitative	Veteran	Systematic review and meta- analysis	Early interventions following traumatic events.
Sayer et al., (2009)	II	Qualitative	Veterans	Survey: Post-service questionnaire	A qualitative study of determinants of PTSD treatment initiation in veterans.
Seal, Bertenthal, Miner, Sen, & Marmar, (2007).	III	Quantitative	Newly released veterans who experienced combat	Database: OEF/OIF roster database	25% of OEF/OIF veterans are seen in the VA for multiple mental health diagnosis.
Seal et al., (2009)	III	Quantitative	Combat veterans entering VA health care	Database: National VA database	Mental health diagnoses increased substantially after the start of the Iraq War among combat veterans.
Stecker, Forteny, Hamilton, Sherbourne, & Ajzen, (2010)	IV	Quantitative	150 OIF National Guard soldiers who screened positive for depression, posttraumatic stress disorder, generalized	The MINI short structured diagnostic interview	Findings from this study suggest that interventions developed to increase engagement for mental health treatment should focus

			anxiety disorder, panic disorder or alcohol abuse disorder		on cognitive factors associated with treatment-seeking behavior.
Sudin et al., (2010)	I	Quantitative review	US Army Soldiers and Marines who experienced combat	Meta-analysis	Prevalence of PTSD in members of the Coalition Forces who have served in Iraq since 2003.
Tanielian & Jaycox, (2008)	II	Quantitative and Qualitative	Veterans with PTSD, TBI, and Depression	Peer review	A comprehensive study of the post-deployment health-related needs associated with PTSD, major depression, and TBI among OEF/OIF veterans. The health care system in place to meet those needs and gaps in the care system.
Thomas et al., (2010)	III	Quantitative	18,305 US Army soldiers from 4 Active Component and 2 National Guard infantry brigade	Anonymous mental health surveys were collected at 3 and 12 months following deployment	Persistent or increased prevalence rates at 12 months compared with 3 months (post-deployment) illustrate the persistent

			combat teams		effects of war zone service and provide important data to guide (post-deployment) care.
Vance & Miller, (2009)	VI	Expert Opinion	Veterans attending school	Observation	Changes are needed to meet the challenges of incoming veterans with disabilities.
Warner et al., (2011)	III	Quantitative	Army Infantry Brigade returning from Iraq	Survey: voluntary anonymous post-deployment survey	PTSD, suicidal ideation, and interest in receiving help are 2-fold to 4-fold higher on the anonymous survey compared to PDHA.
Zoricic, Kartovic, Buljan, & Marusic, (2003)	III	Cohort Study	123 soldiers with PTSD, PTSD comorbid with alcohol addiction, and alcohol addiction	Aggression rating scale A-87	Alcohol addiction is a severe factor in increasing aggression levels in soldiers with PTSD.

APPENDIX B

PROFESSIONAL PROGRAM EVALUATION SURVEY

In order to evaluate the overall content, effectiveness, and usefulness of the information presented within this module. Please answer the following questions with one of the provided responses.

1. How well does this module meet its objectives?

- Extremely well
- Very well
- Moderately well
- Slightly well
- Not at all well

2. How clearly is the information organized and presented to aid in learning?

- Extremely well
- Very well
- Moderately well
- Slightly well
- Not at all well

3. How well did the visual aids enhance your overall learning experience?

- Extremely well
- Very well
- Fairly well
- Slightly well

Not well at all

4. How satisfied are you with the level of information detail presented in this module?

Extremely satisfied

Quite satisfied

Moderately satisfied

Slightly satisfied

Not at all satisfied

5. How useful do you believe this information will be for you in working with military veteran students?

How useful do you believe this information will be for you in working with military veteran students? Extremely useful

Very useful

Fairly useful

Slightly useful

Not useful

6. What is your impression of the knowledge of the presenter in regards to the information provided in the module?

What is your impression of the knowledge of the presenter in regards to the information provided in the module? Extremely knowledgeable

Very knowledgeable

Moderately knowledgeable

Slightly knowledgeable

Not at all knowledgeable

7. How well does the module reflect a population health emphasis?

How well does the module reflect a population health emphasis? Extremely well

Very well

Fairly well

Slightly well

Not well

8. Did you learn new information from the module?

Did you learn new information from the module? Yes

No

9. What changes would most improve this module?

What changes would most improve this module?

10. Do you have any other comments, questions, or concerns?

APPENDIX C

USM NURSING EXIT SURVEY FOR VETERANS

Student Veteran BSN Exit Survey

This students' survey was designed to capture data about your satisfaction with the support you received in achieving and maintaining highlevel wellness during your time in the nursing program. Please answer each of the questions with one of the responses provided

1. What is your gender?

   - Female
   - Male

2. Which range below includes your age?

   - 18-20
   - 21-29
   - 30-39
   - 40-49
   - 50-59
   - 60 or older

3. Which of the following best describes your current relationship status?

   - Married
   - Widowed
   - Divorced
   - Separated
   - In a domestic partnership or civil union
   - Single, but cohabiting with a significant other
   - Single, never married

4. Which of the following categories best describes your employment status?

   - Employed, working 40 or more hours per week
   - Employed, working 139 hours per week
   - Not employed, looking for work
   - Not employed, NOT looking for work
   - Disabled, not able to work

5. In which branch of service did you serve?

    - U. S. Army
    - U. S. Navy
    - U. S. Marine Corps
    - U. S. Air Force
    - U. S. Coast Guard

6. In which military component did you serve?

    - Active Duty
    - Reserves
    - National Guard

7. Are you currently serving in the United States military?

    - Yes
    - No

8. What is your total years of military service?

    - 14 years
    - 5-10 years
    - 11-15 years
    - 16-20 years
    - Greater than 20 years

9. What is the total number of your military deployments?

    - Never deployed
    - 12 deployments
    - 35 deployments
    - Greater than 5 deployments

10. Are you utilizing your GI Bill or other military benefits for your education?

    - Yes
    - No

11. Are you currently registered or have you been registered in the past 10 years with the Veteran Affairs Health Services?

- o Yes
- o No
- o Unsure / Don't know

12. Rate your transition from military service to your academic setting while attending College of Nursing at the University of Southern Mississippi.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
My transition from military to the Southern Miss College of Nursing was a smooth transition.	o	o	o	o	o
My military experiences (deployments, military culture, values, training etc…) did not interfere with being a student in the College of Nursing at USM.					
My military experiences (deployments, military culture, values, training etc…) did not interfere with my ability to form friendships with other nonmilitary students in the College of Nursing at USM.	o	o	o	o	o
My military experiences (deployments, military culture, values, training etc…) did not cause any significant distress throughout the course of being a student in the College of Nursing at USM.	o	o	o	o	o
I was able to relate well to nonmilitary students, faculty and staff in the College of Nursing at USM.	o	o	o	o	o

I was able to work cohesively with other students in group projects.	o	o	o	o	o
I felt comfortable in my classroom setting in the College of Nursing at USM.	o	o	o	o	o
I did not witness an military biases on the USM campus, within the course material, or from other students, faculty or staff.	o	o	o	o	o
I was aware of available campus resources (Counseling Center, VA rep, veteran student organization etc…) on USM.	o	o	o	o	o

13. How would you rate faculty and staff awareness of your military experiences and available resources?

- o Excellent
- o Very good
- o Good
- o Fair
- o Poor

14. How comfortable are you with approaching faculty and staff for help, in regards to military related issues?

- o Extremely comfortable
- o Very comfortable
- o Comfortable
- o Not comfortable
- o Extremely uncomfortable

15. Would you like to share any experiences related to veterans attending USM College of Nursing?

APPENDIX D

PROJECT TIMELINE

Month	Activities
June 2013	Capstone proposal draft provided to chair Capstone proposal refined
July 2013	Capstone proposal presented to chair and other committee members for final approval Successful defense of capstone proposal IRB proposal submitted and approved
August 2013 - February 2014	Continued effort to implement capstone project Create script and audio visual modules
March 2014	Submit and defend capstone project Submit final paper Submit hard copy of capstone project to graduate reader Address recommended changes by board members, to modules
April 2014	Address recommended changes by board members, to modules
May 2014	Graduate

APPENDIX E

MEETING THE DOCTOR OF NURSING PRACTICE (DNP) ESSENTIALS

DNP Essentials	DNP Essential Outcome
Essential I – Scientific Underpinnings for practice	Used Dunn's high-level wellness and Leavell's and Clark's principle of prevention theories and concepts to develop and evaluate new practice approaches in a postsecondary institution for the recognition and early interventions of PTSD.
Essential II – Organizational and System Leadership for Quality Improvement and Systems Thinking	Developed delivery care approach for veterans entering a postsecondary institution to meet current and future needs of a veteran population based on scientific findings in nursing and other clinical sciences, as well as organizational, political, and economic sciences.
Essential III – Clinical Scholarship and Analytical Methods for Evidence-Based Practice	Continue to critically appraise literature and other evidence based practice. Function as a facilitator (specialist) in the designing and implementation of a quality improvement for veteran needs entering in a postsecondary institution with disabilities related to PTSD.
Essential IV – Information Systems/Technology and Patient Care Technology for the improvement and Transformation Health Care	In order to promote high-level wellness and make a significant contribution to military service members and their families, it is essential that the worldview, the mindset, and the historical perspective of life in the military are understood. Developed and designed faculty in-service education modules using blackboard for CoN faculty and staff at The University of Southern Mississippi.
Essential V – Health Care Policy for Advocacy in Health Care	Analyzed current Americans with Disabilities Act Amendment Act and the Post-9/11 Veterans Assistance Act health policies and related issues for veterans as they enter a postsecondary institution. Utilized skills as an APN to function as a leader and as an advocate for change.

Essential VI – Interprofessional Collaboration for Improving Patient and Population Health Outcomes	Employed effective communication and collaborative skills with the Veteran Affairs in Biloxi in the development of this capstone project. Additional collaborative efforts with Sarah Powell retired USA
Essential VII – Clinical Prevention and Population Health for Improving the Nation's Health	Analyzed epidemiological, biostatistical, environmental, and other appropriate scientific data related to veteran population health. Synthesized concepts, including psychosocial dimensions and cultural diversity, related to clinical prevention and population health in developing, implementing, and evaluating interventions to address health promotion, disease prevention, improve health status/access patterns, and bridge the gaps in care of individuals with PSTD entering a postsecondary educational institution.
Essential VIII – Advanced Nursing Practice	Designed a therapeutic intervention based on nursing science and other sciences to address the need for early recognition and intervention for veterans entering a postsecondary institution with mental disorder such as PTSD. The product of this project will educate and guide CoN faculty and staff at USM through complex health and situational transitions of veterans entering a postsecondary educational institution.

APPENDIX F

IRB APPROVAL LETTER

INSTITUTIONAL REVIEW BOARD
118 College Drive #5147 | Hattiesburg, MS 39406-0001
Phone: 601.266.6820 | Fax: 601.266.4377 | www.usm.edu/irb

NOTICE OF COMMITTEE ACTION

The project has been reviewed by The University of Southern Mississippi Institutional Review Board in accordance with Federal Drug Administration regulations (21 CFR 26, 111), Department of Health and Human Services (45 CFR Part 46), and university guidelines to ensure adherence to the following criteria:

- The risks to subjects are minimized.
- The risks to subjects are reasonable in relation to the anticipated benefits.
- The selection of subjects is equitable.
- Informed consent is adequate and appropriately documented.
- Where appropriate, the research plan makes adequate provisions for monitoring the data collected to ensure the safety of the subjects.
- Where appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of all data.
- Appropriate additional safeguards have been included to protect vulnerable subjects.
- Any unanticipated, serious, or continuing problems encountered regarding risks to subjects must be reported immediately, but not later than 10 days following the event. This should be reported to the IRB Office via the “Adverse Effect Report Form”.
- If approved, the maximum period of approval is limited to twelve months.

Projects that exceed this period must submit an application for renewal or continuation.
PROTOCOL NUMBER: **13072402**
PROJECT TITLE: **Bridging the Gap: Understanding, Anticipating and Responding to the Needs of Student Veterans in a Bachelor's of Science in Nursing Program**
PROJECT TYPE: **New Project**
RESEARCHER(S): **Larry Stowers**
COLLEGE/DIVISION: **College of Nursing**
DEPARTMENT: **Advanced Practice Nursing**
FUNDING AGENCY/SPONSOR: **N/A**
IRB COMMITTEE ACTION: **Expedited Review Approval**
PERIOD OF APPROVAL: **07/29/2013 to 07/28/2014**

Lawrence A. Hosman, Ph.D.
Institutional Review Board

REFERENCES

Ackerman, D., DiRamio, D., & Mitchell, R. (2008). Transitions: Combat veterans as college students. *New Directions for Student Services*, (126), 5-14.

American Council on Education. (2008). Serving those who serve: Higher education and America's veterans. Retrieved from http://www.acenet.edu/Content/Navigation Menu/ProgramsServices/MilitaryPrograms/serving/Veterans_Issue_Brief _1108.pdf

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental Disorders*. Washington, DC. Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC. Author.

Americans with Disabilities Act Amendments Act of 2008, Public Law 110 325, Stat. 3406 (2008).

Back, S., Waldrop, A., & Brady, K. (2009). Treatment challenges associated with comorbid substance use and post traumatic stress disorder. *Clinicians' Perspective American Journal on Addictions, 18*(1), 15-20. doi:10.1080/10550490802545141

Bruner, E. F. (2006). Military forces: What is the appropriate size for the United States? Retrieved from http://fpc.state.gov/documents/organization/60575.pdf

Burkhart, L., & Sommer, S. (2007). Integrating preventive care and nursing standardized terminologies in nursing education: A case study. *Journal of Professional Nursing*, *23*(4), 208-213.

Campbell, D. J., & Nobel, O. B. (2009). Occupational stressors in military service: A review and framework. *Military Psychology, 21*(2). doi:10.1080/08995600903249149

Capella University. (2008). Joining forces America report. Retrieved from http://joiningforcesamerica.org/JFA_report.pdf

Church, T. E. (2009). Returning veterans on campus with war related injuries and the long road back home. *Journal of Postsecondary Education and Disability, 22*(1), 43-52.

Department of Veterans Affairs. (2008). The Post-9/11 Veterans Education Act of 2008. Retrieved on from http://www.gibill.va.gov/GI_Bill_Info/benefits.htm

Dunivin, K. O. (1997). Military culture: A paradigm shift? *Air War College, Maxwell Paper No. 10.* Alabama: Maxwell Air Force Base.

Dunn, H. L. (1961). *High level awareness.* Arlington VA: R.W. Beatty Ltd.

Engelhard, I. M., Van den Hout, M. A., Weerts, J., Arnitz, A., Hox, J., & McNally, R. J. (2007). Deployment-related stress and trauma in Dutch soldier returning from Iraq. *British Journal of Psychiatry, 191*, 140-200.

Grossman, P. (2009). Forward with a challenge: Leading our campuses away from the perfect storm. *Journal of Postsecondary Education and Disability, 22*(1), 4-9.

Guerra, V. S., & Calhoun, P. S. (2010). Examining the relation between posttraumatic stress disorder and suicidal ideation in an OEF/OIF veteran sample. *Journal of Anxiety Disorder, 25*(1), 12-8. doi:10.1016/j.janxdis.2010.06.025

Helmus, T. C., & Glenn, R. W. (2005). Steeling the mind combat stress reactions and their implications for urban warfare. Retrieved from http://www.rand.org/content/dam/rand/pubs/monographs/2005/RAND_MG191.pdf

Hoge, C. W., Castro, C. A., Messer, S. C., McGurk, D. D., Cotting, D. I., & Koffman, R. L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine, 351*(1), 13-22. doi:10.1056/NEJMoa040603

Hosek, J., Kavanagh, J., & Miller, L. L. (2006). How deployments affect service members. Retrieved from http://www.rand.org/pubs/monographs/MG432/

Hoyt, T., & Candy, C. (2011). Providing treatment service for PTSD at an Army FORSCOM installation. *Military Psychology, 23*, 237-252. doi:10.1080/08995605.2011.570564

Jakupcak, M., Cook, J., Imel, Z., Fontana, A., Rosenheck, R., & McFall M. (2009). Posttraumatic stress disorder as a risk factor for suicidal ideation in Iraq and Afghanistan War veterans. *Journal of Traumatic Stress, 22*, 303-306. doi:10.1002/jts.20423

Karney, B. R., Ramchand, R., Osilla, K. C., Caldarone, L. B., & Burns, R. M. (2008). Invisible wounds: Predicting the immediate and long-term consequences of mental health problems in veterans of Operation Enduring Freedom and Operation Iraqi Freedom. Retrieved from http://www.rand.org/content/dam/rand/pubs/working_papers/2008/RAND_WR546.pdf

Kemp, J., & Bossarte, R. (2012). Suicide Data Report, 2012 Department of Veterans Affairs Mental Health Services Suicide Prevention Program. Retrieved from http://www.va.gov/opa/docs/Suicide-Data-Report-2012-final.pdf

Kline, A., Falca-Dodson, M., Sussner, B., Ciccone, D. S., Chandler, H., Callahan, L., & Losonczy, M. (2010). Effects of repeated deployment to Iraq and Afghanistan on the health of New Jersey Army National Guard Troops: Implications for military readiness. *American Journal of Public Health, 100*, 276-283. doi:10.2105/AJPH.2009.162925

Leavell, H. R., & Clark, H. G. (1965). *Preventive medicine for the doctor in his community: an epidemiological approach* (3rd ed), New York: McGraw-Hill Book

Madaus, J. W. (Eds.). (2009). Veterans with disabilities. [Special issue]. *Journal of Postsecondary Education and Disability, 22*(1), 1-74.

Madaus, J. W., Miller, W. K., & Vance, M. L. (2009). Veterans with disabilities in postsecondary education. *Journal of Postsecondary Education and Disability, 22*(1), 10-17.

Marsella, A. J., Friedman, M., Gerrity, E., & Scurfield, R. (1996). *Ethnocultural aspects of post-traumatic stress disorder: Issues, research, and clinical applications.* Washington, DC: American Psychological Association.

Milliken, C. S., Auchterlonie, J. L., & Hoge, C. W. (2007). Longitudinal assessment of mental health problems among active and reserve component soldiers returning from the Iraq war. *The Journal of the American Medical Association*, *298*(18), 2141-2148

Ouimette P. C., Brown P. J., & Najavits L. M. (1998). Course and treatment of patients with both substance use and posttraumatic stress disorders. *Addictive Behavior, 23*, 278-789. doi.org/10.1016/S0306-4603(98)00064-1

Paige, O., Vogt, D., Wade, M., Tirone, V., Greenbaum, M. A., Kimerling, R., Laffaye, C., & Fitt, J. E. (2011). Perceived barriers to care among veterans health administration patients with posttraumatic stress disorder. *Psychological Services, 8*(3), 212-223.

Peterson, A. L., Luethcke, C. A., Borah, E. V., Borah, A. M., & Young-McCaughan, S. (2011). Assessment and treatment of combat-related PTSD in returning war veterans. *Journal of Clinical Psychology Medical Setting, 18*, 164-170.

Pietrzak, R. H., Johnson, D. C., Goldstein, M. B., Malley, J. C., & Southwick, S. M. (2009). Perceived stigma and barriers to mental health care utilization among OEF-OIF veterans. *Psychiatric Services, 60*, 118-1122. doi:10.1176/appi.ps.60.8.1118

Pietrzak, R. H., Goldstein, M. B,. Malley, J. C., Rivers, A. J., Johnson, D. C., & Southwick S. M. (2010). Risk and protective factors associated with suicidal ideation in veterans of Operations Enduring Freedom and Iraqi Freedom. *Journal of Affective Disorders, 123*, 102-107. doi:10.1016/j.jad.2009.08.001

Post-9/11 Veterans Assistance Act of 2008, Public Law 110-252, (2008).

Rash C. J., Coffey S. F., Baschnagel J. S., Drobes D. J., & Saladin M. E. (2008). Psychometric properties of the IES-R in traumatized substance dependent Individuals with and without PTSD. *Addictive Behaviors, 33*, 1039-1047.

Rielage, J. K., Hoyt, T., & Renshaw, K. (2010). Internalizing and externalizing personality styles and psychopathology in OEF–OIF veterans. *Journal of Traumatic Stress, 23*(3).

Roberts, N. P., Kitchiner, N. J., Kenardy, J., & Bisson, J. I. (2009). Systematic review and meta-analysis of multiple-session early interventions following traumatic events. *American Journal of Psychiatry, 166*(3), 350-357. doi:10.1176/appi.ajp.2008.08040590

Sayer, N. A. Friedemann-Sanchez, G., Spoont, M., Murdoch, M., Parker, L. E., Chiros, C., & Rosenheck, R. (2009). A qualitative study of determinants of PTSD treatment initiation in Veterans. *Psychiatry, 72*(3), 238-255. doi:10.1521/psyc.2009.72.3.238

Seal, K. H., Bertenthal, D., Miner, C. R., Sen, S., & Marmar, C. (2007). Bringing the war back home. *Archives of Internal Medicine, 167*, 476-482.

doi:10.1001/archinte.167.5.476

Seal, K. H., Metzler, T. J., Gima, K. S., Bertenthal, D., Maguen, S., & Marmar, C. R. (2009). Trends and risk factors for mental health diagnoses among Iraq and Afghanistan veterans using Department of Veterans Affairs Health Care 2002-2008. *American Journal of Public Health, 99*(9), 1651-1658. doi:10.2105/AJPH.2008.150284

Stecker T., Fortney, J., Hamilton, F., Sherbourne, C. D., & Ajzen, I. (2010). Engagement in mental health treatment among veterans returning from Iraq. *Patient Preference and Adherence, 4*, 45-49.

Sudin, J., Fear, N. T., Iversen, A., Rona, R. J., & Wessley, S. (2010). PTSD after deployment to Iraq: conflicting rates, conflicting claims. *Psychological Medicine 40*, 367–382. doi:10.1017/S0033291709990791

Tanielian, T., & Jaycox L. H. (2008). Invisible Wounds of War: Psychological and cognitive injuries, their consequences and services to assist recovery. Retrieved from http://www.careforthetroops.org/reports/Report-AND CT321 Assessing%20PTSD%20Costs%20to%20Society%20March%202009.pdf

Thomas, J. L., Wilk, J. E., Riviere, L. A., McGurk, D., Castro, C. A., & Hoge, C. W. (2010). Prevalence of mental health problems and functional impairment among active component and national guard soldiers 3 and 12 months following combat in Iraq. *Archives of General Psychiatry, 67*(6), 614-623. doi:10.1001/archgenpsychiatry.2010.54

Vance, M. L., & Miller, W. K. (2009). Serving wounded warriors: Current practices in postsecondary education. *Journal of Postsecondary Education and Disability, 22*(1), 18-35.

Warden, D. (2006). Military TBI during the Iraq and Afghanistan wars. *Journal of Head Trauma Rehabilitation, 21*(5), 398-402.

Warner, C. H., Appenzeller, G. N., Grieger, T., Belenkiy, S., Breitbach, J., Parker, J., Warner, C.M. & Hoge, C., (2011). Importance of anonymity to encourage honest reporting in mental health screening after combat deployment. *Archives of General Psychiatry, 68*(10), 1065-1071. doi: 10.1001/archgenpsychiatry.2011.112

Wong, L., & Gerras, S. (2006). CU @ the FOB: How the forward operating base is changing the life of combat soldiers. Retrieved from http://www.strategicstudies institute.army.mil/pdffiles/PUB645.pdf

Zoricic, Z., Kartovic, D., Buljan, D., & Marusic, S. (2003). Comorbid alcohol addiction increases aggression level in soldiers with combat-related post-traumatic stress disorder. *Nordic Journal of Psychiatry, 57*(3), 199-202. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/12775294