VOCATIONAL ADJUSTMENT FOLLOWING SEPARATION FROM MILITARY SERVICE: A QUALITATIVE INVESTIGATION OF WORK INTEGRATION CHALLENGES FOR GULF WAR-ERA II VETERANS WITH PTSD

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Vocational Adjustment Following Separation from Military Service: A
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DEDICATION

This study is dedicated to United States military veterans who continue their struggles with the silent wounds of post-traumatic stress disorder. To those who returned from wars and were diagnosed with emotional trauma, have been treated, or are receiving treatment for psychological injuries, I salute you.
Great deeds are usually wrought at great risks.
-Herodotus
ABSTRACT OF THE THESIS

Vocational Adjustment Following Separation from Military Service: A Qualitative Investigation of Work Integration Challenges for Gulf War-Era II Veterans with PTSD
by
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Master of Science in Rehabilitation Counseling
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Post-traumatic stress disorder (PTSD) among Gulf War-era II veterans has resulted in psychological wounds attributed to military duty in Afghanistan and Iraq warzones. In the U.S., PTSD is now in fifth place trailing in prevalence more common psychological disorders of depression, attention-deficit/hyperactivity disorder, specific phobia, and social phobia as ranked in previous surveys, with social service and societal costs soaring into the billions of dollars. Many veterans returning from these wars are transitioning to civilian life after military separation without trauma stressor mitigation or jobs. Warzone-related stress disorders among veterans are sometimes responsible for struggles experienced with entering or reentering the workforce often requiring appropriate work adjustment and work integration.

The conceptual framework for this study was derived from three sequentially developing interactive specific subsystem components that comprise the model of work adjustment. The model was chosen to examine the work personalities, work competencies, and work goals of homeless and unemployed Gulf War-era II veterans with PTSD in relation to successful work adjustment and work integration. The purposes of the present investigation were to address the following questions (1) How do veterans with PTSD view their work competencies?, (2) What significant work integration and work adjustment challenges do veterans with PTSD experience?, and (3) To what extent have veteran’s work goals changed from pre- to post-military service? Participants were 10 Gulf War-era II veterans with PTSD, separated from military service at a minimum of one year preceding the investigation, and living in a southwestern city residential substance addiction treatment facility. The research consisted of 12 open-ended or semi-structured questions asked of the participants. Data revealed five emergent themes of: (a) veterans PTSD experiences; (b) overcoming homelessness; (c) motivation to change; (d) family support and quality of life; and (e) rehabilitation counseling, education, and career preparation strategies, resulting in 19 sub-themes. The sub-themes indicated congruence between each other and the participants’ perceptions, thoughts, and beliefs. Also strongly indicated were the participants’ employment capabilities after work adjustment, worth as viable assets in the workforce, ability to restore their work identities, re-establish self-sufficiency, and ability to attain an ample quality of life.

Study results emphasize the significance of recognizing and treating the effects of PTSD on veterans seeking workforce inclusion. Future research should incorporate more
sample population diversity and assess veteran PTSD barriers to employment from a longitudinal perspective.
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CHAPTER 1
INTRODUCTION

On the eleventh anniversary remembrance of September 11, 2001, again this nation somberly reflected on the tragic events wrought on Manhattan, NY, Washington, DC, and Shanksville, PA by terrorist attackers. These actions marked the U.S. Armed Forces entry into Gulf War-era II (Walker, 2008, p. 3) a new period of protracted conflicts in the age of terrorism and urban warfare in an ever changing world engaged in the Global War on Terror.

Less than one month after the attacks, on October 7, 2001, the U.S. invaded Afghanistan (Marmar, 2009, p. 494) and the war commenced when Operation Enduring Freedom (OEF) began assisting a newly established national government. McGaugh (2011, p. 226) stated that the threefold mission for the invasion included (a) defeating the ruling Taliban, in control since 1996, (b) eliminating the world’s most elusive terrorist mastermind, Osama Bin Laden (Pfarrar, 2012, p. 1), and (c) systematically dismantling al-Qaeda, which perpetrated the malevolent September 11, 2001 attacks (McGaugh, 2011).

Within two years of the attacks, on March 20, 2003, the U.S. invaded Iraq (Marmar, 2009, p. 494) during Operation Iraqi Freedom (OIF) which McGaugh (2011, p. 226) stated was organized with the (a) intent to eradicate alleged weapons of mass destruction, (b) depose Saddam Hussein, and (c) initiate a democratic government. Since the terrorist attacks, literally tens of thousands of men and women from all quarters voluntarily entered military service for a variety of personal reasons.

While deployed to Iraq in 2003-2004, I experienced trauma cues from stressors first encountered as a member of a maneuver support unit in a divergent warzone. Accumulated experiences sustained during deployment, a subsequent diagnosis of posttraumatic stress disorder (PTSD), and effects of return to work after release from active duty resulted in personal difficulties. These occurrences compelled interest in veterans separated from military service with untreated PTSD, followed by unemployment, struggles with substance abuse, violence, divorce, homelessness, suicide risk (Tanielian & Jaycox, 2008), and particularly with unique barriers to employment. My lived challenges and successful
readjustment to civilian life generated a vocational goal of assisting veterans achieve meaningful adjustment and integration into their communities with employment.

As a result of their literature review Ruzek et al., (2004, p. 35) attributed PTSD among veterans to elevated rates of job failure and struggles maintaining employment. However, employment stability serves as an indicator of positive future developments by encouraging (a) reduction of financial instability, (b) self-esteem through personal interaction, (c) incentive for friendship and camaraderie, (d) clinician support of veterans’ military or civilian work functioning by empowering them to obtain and maintain employment skill sets, and (e) facilitating participation in employment-related support groups.

Also, Ruzek et al., (2004, p. 35) found a nexus between chronic combat-related PTSD and “high rates of job turnover and general difficulty in maintaining employment often attributed by veterans themselves to anger and irritability, difficulties with authority, PTSD symptoms, and substance abuse.” Comparatively more research studies and empirical investigations exist regarding how PTSD affects functioning as self-reported difficulties in role performance (Schnurr, Lunney, Bovin, & Marx 2009). Therefore, I initiated this thesis research to investigate the barriers to civilian work adjustment, work integration, and career development encountered by veterans with PTSD. I addressed the importance and plan for this study as follows (a) context of the research, (b) research problem and significance (c) theoretical foundation, and (d) research questions.

**CONTEXT OF RESEARCH**

The psychological condition most commonly associated with trauma exposure (Vogt et al., 2011) is PTSD, acknowledged by the Department of Veterans Affairs as the most prevalent psychological injury linked to warzone veterans. PTSD affects approximately 11-20% of Gulf War-era II veterans, 10% of Gulf War-era I veterans, and 30% of Vietnam veterans (Department of Veterans Affairs [DVA], 2012). The costs associated with PTSD are daunting. In human terms it is estimated that PTSD-related and major depression-related monetary costs may vary from 4 billion dollars and could extend to over 6.2 billion dollars during just the initial two years after redeployment (Gates et al., 2012, p. 362). The *Diagnostic and Statistical Manual of Mental Disorders (DSM)* provides periodic revised
information by the American Psychiatric Association (APA) applied by mental health professionals to diagnose patients. The genesis of PTSD can be traced to the initial version of the DSM. PTSD was first codified as a diagnostic category in the DSM-III, according to Stein, Walker, Hazen, and Forde (1997, p. 1114) “to describe the range of syndromal responses to extreme stressors.” Categorized as a disorder subsequent to the Vietnam War, the causal relationship between PTSD and the individual as Friedman (2007, p. 699) acknowledged, was introduced into what March (1993, p. 37) described as the “nosology” (i.e., classification of mental illnesses and behavioral disorders) of the DSM-III, 1980 edition, and described as “a recognizable stressor that would evoke significant symptoms of distress in almost anyone” (American Psychiatric Association [APA] 1980, p. 238).

During the current era approximately 2.6 million American service members from active duty, National Guard, and Reserve components have separated from military service (United States Congress Joint Economic Committee, 2011). Overall, a group of approximately 21.2 million living American veterans account for higher unemployment rates than their civilian counterparts (Bureau of Labor Statistics ([BLS], 2013a). Richardson, Frueh, and Acierno (2010, p. 4) found that the long-term effects of PTSD are being felt by 21% of U.S. veterans with PTSD symptoms. Over the past 11 years, service members have deployed to protracted warzone duty increasing the risk of blast injuries and combat stress with additional ensuing neurological and psychological trauma. As a consequence of multiple deployments Cozza et al. (2004) reported that service members are sustaining an unprecedented level of physical and mental trauma. The psychological, social, and psychiatric toll of warzone stressors resulting from sustained counterinsurgency efforts, terrorist activities, and guerilla warfare tactics from remotely detonated improvised explosive devices (IEDs), car bombs, mortar and rocket attacks, and being fired upon can be immediate, acute, and chronic. Also, (McGaugh, 2011) declared that the public now understands that, more so than mortality, the signature image of war today is disability, whether it is physical or psychological (McGaugh, 2011).

Before resuming relationships with their spouses, families, friends and employers following military separation veterans must confront the eventuality that their warzone experience resulted in (a) PTSD-created marital discord, (b) substance abuse, (c) homelessness, (d) unemployment, (e) suicide risk, (f) barriers to civilian work integration and
work adjustment, and (g) career development. The barriers to employment can lead to additional unfamiliar workforce integration challenges for the veteran in initial entry-level civilian employment or the veteran reentering a previously held position (Hoge et al., 2004; Ruzek et al., 2004; Tanielian & Jaycox, 2008). According to Gates et al. (2012) and Schnurr et al. (2009) the majority of PTSD studies span a variety of domains to include social and interpersonal functioning, marital functioning, parental and family functioning, and occupational functioning.

**Research Problem and Significance**

Within the noted studies there is no mention of any investigation into task performance, work role behavior, or work satisfaction of veterans with PTSD entering the workforce after military service. Neither does the very sparse literature on this population address work adjustment, work integration, career implications, or the attainment of a significant quality of life through the essential process of work identity restoration (Power & Hershenson, 2003).

In one study example Aloi (2010, p. 6) relied upon qualitative methods as they apply to “constructionist theory to examine the effect of societal acknowledgment on the post-war readjustment of combat veterans.” This theory is useful as the foundation for meaning-making and the conduit by which constructing an articulate narrative account assists the combat veteran with attributing making sense and deriving benefit from the experience. However, Aloi’s study acquired knowledge from: (a) direct individual challenges experienced by 10 male participants; (b) all in successful reintegration and readjustment to civilian life; (c) all of a dissimilar veteran population from multiple eras; and (d) none of whom were affected by PTSD, which was not a study criterion. The relevance of Aloi’s design allowed for comprehensive exploration of veterans experiences with integration into the civilian world, adjustment, and work.

Similarly, in a second example, Peterson (2010, p. 2) utilized a qualitative approach to explore quality of life measures viewed from the social worker frame: (a) within a multiracial cohort of 18 male OEF/OIF Army and Marine veterans; (b) deployed to war-combat zones, (c) all of whom experienced PTSD; (d) are homeless, exhibiting at risk behaviors; (e) all receiving mental health services and referrals, living or working in a 12-bed
pilot residential program; and (e) who responded to research questions by the researcher and
the program director. Peterson (2010, p. 3) reasoned that with the abundance of social
workers working in counseling agencies they can assume a role in developing supportive
services for veterans to attain an improved quality of life following stressful and traumatic
deployment to a warzone. Peterson (2010, p. 72) also stated that there is a need for social
workers to assist OEF/OIF veterans transitioning from military service into civilian life.

To distinguish from Aloi’s and Peterson’s research this study will utilize the
theoretical framework for organizing research conceptualized in David B. Hershenson’s
(1996) model of work adjustments as it applies to a markedly different population that
includes veterans of both genders. The conceptual framework of the present study is
structured to adapt Hershenson’s model to investigate the effects of military incurred PTSD
on (a) work adjustment, (b) work integration, and (c) career development of disabled combat,
combat support, and combat service support veterans with PTSD recently separated from
military service.

The frustration for many of the present veteran cohort is that they entered military
service when stable work opportunities were available and separated from active duty during
an economic recession. The acknowledgement that jobs are difficult to obtain for this
population takes on new meaning for veterans whose skills must not only be carefully honed
but must evolve to be competitive with those who have already acquired an acceptable level
of employment. A few years ago the Secretary of the California Department of Veterans
Affairs asserted that competition for jobs in an uncertain economic environment against
others who have years of private sector experience seems insurmountable (Gravett, 2011).
This thesis research contributed to the literature on veterans with PTSD conforming to
society after military separation and more comprehensively strives toward understanding the
unique challenges to employment they face. Specific determinants (e.g., ability to become
employed) for successful work adjustment and work integration are explored in this study
through veterans expressed words describing (a) work competency, (b) work personality, (b)
work preparation, (c) work motivation, and (d) work goals.

The present investigation took place at a veterans’ residential treatment center in a
major southwestern city where a growing number of recently separated veterans are
integrating into the civilian community at a higher rate than other large U.S. urban centers
(Iraq and Afghanistan Veterans of America [IAVA], 2011). A faction of this sizeable group has the capacity to create an acute need for early assessment to determine the potential for PTSD. It also signals the need for treatment options to help diminish further psychological barriers for the veteran without PTSD.

**Research Questions**

In this qualitative study I addressed various challenges for Gulf War-era II veterans encountering difficulties with work adjustment and work integration as the result of PTSD acquired in the warzone. I also explored veterans’ perceptions concerning factors most closely aligned with the reasons why recently separated veterans with PTSD are not being hired. Factors that were investigated included (a) employability status of recently separated veterans with PTSD, (b) joblessness of veterans with PTSD in a recession with no significant increase in hiring rates in the foreseeable future, (c) overcoming work and work adjustment challenges, and (d) successful performance capability of veterans with PTSD in occupational functioning. Research questions to be answered included: (1) How do veterans with PTSD view their work competencies? (2) What significant work integration and work adjustment challenges do veterans with PTSD experience? (3) To what extent have veterans’ work goals changed from pre- to post-military service?

Significant work related questions probing the perceptions of this cohort of veterans were asked of 10 veterans with DVA recognized PTSD disability ratings. The study identified the perceptions, thoughts, and beliefs of veterans’ concerning joblessness, employability, career development, work adjustment, and work integration.

Unemployment barriers for this cohort of veterans are not uncommon and continue to be persistent. Finding employment is difficult as well with 1.8 million veterans currently living in California and over two hundred thousand living in the southwestern city where for three days each July a national veterans’ event is held. During that time a significant number of homeless and jobless veterans with elevated unemployment rates are identified as unable to secure work because of the physical and psychological experiences to which their civilian counterparts have not been exposed (IAVA, 2011).

In 2012 the U.S. population consisted of 2.6 million veterans who served during Gulf War-era II, including 17% women. Roughly half of those who served were between the ages
of 25 and 34 years of age. Notably, recent national unemployment status for younger veterans is at 20% for the 18 to 24 age range which is higher than their non-veteran counterpart at 16.4% unemployment. Figures for the 25 to 34 age group indicate 10.4% and for the non-veteran population 8.1% (BLS, 2013a). Currently, the national unemployment rate for May 2013 stands at 7.3% and for Gulf War-era II veterans at 10.9% with male veterans at 6.9% and females at 8.3% jobless (BLS, 2013a). Current unemployment figures for the State of California in April 2013 reflect a rate 8.5% with the southwestern county where this study’s sample members reside at 7.0% joblessness (State of California Labor and Workforce Development Agency, 2013). While at first blush this information is encouraging, it pales in regard to the fact that post-September 11, 2011 veterans average a lower employment rate than the overall population. Concern for the younger service-connected disability veteran cohort focuses on their unemployment rate as the highest among all service-connected disability veterans at 9.6% in May 2013 (DVA, 2013).

**DEFINITION OF TERMS**

- **Global war on terror (GWOT).** The fight against terrorists that was later renamed Overseas Contingency Operations. (Department of the Army Personnel Policy Guidance for Overseas Contingency Operations, 2012, p. 19).
- **Gulf War-era II veteran.** A person who served on active duty in the U.S. Armed Forces anywhere in the world between September 2001 and the present time (BLS, 2012).
- **OEF/OIF.** Military nomenclature designating specific warzones or theaters of operation. OEF – Operation Enduring Freedom (Afghanistan), OIF – Operation Iraqi Freedom (United States Army, 2010).
- **Posttraumatic stress disorder (PTSD).** PTSD results from exposure to a traumatic event where the individual: “(a) experienced, witnessed, or was confronted with… death or serious injury or a threat to the physical integrity of self or others; and (b) that inspires intense fear, helplessness or horror” (APA, 2000, p. 467) in the recipient.
- **Deployment.** On order, a logistical movement of forces including support infrastructure, to an operational area, generally the warzone (United States Army, 2007).
- **Redeployment.** Persons on active duty in the Armed Forces are excluded from the labor force (BLS, 2011). For purposes of this study reentrants to the labor force are defined as “jobseekers who have worked before, but not immediately prior to their job search” (BLS, 2013b, p. 5).
- **Warzone.** An area in which armed forces engage in violent conflict or wage war within an area required for conducting operations (United States Army, 1985).

- **Re-entrant.** Persons on active duty in the Armed Forces are excluded from the labor force (BLS, 2011). For purposes of this study reentrants to the labor force are defined as “jobseekers who have worked before, but not immediately prior to their job search” (BLS, 2013b, p. 5).

- **New entrant.** Persons on active duty in the Armed Forces are excluded from the labor force (BLS, 2011). For purposes of this study new entrants to the labor force are defined as “individuals who have entered the labor force for the first time” (BLS, 2013a, p. 5).

- **Combat.** Engagement by combat arms elements in direct, tactical confrontation with the enemy. In close combat it is “carried out with direct fire weapons, supported by indirect fire, air-delivered fires, and nonlethal engagement means” (United States Army, 2008, p. 4-5).

- **Combat support.** Elements of the Corps of Engineers, Military Intelligence Corps, Chemical Corps, and Signal Corps provide direct support for combatants on the battlefield (United States Army, 1985).

- **Combat service support.** Defined by U.S. Army Field Manual 4-0 as providing “the essential capabilities, functions, activities, and tasks necessary to sustain all elements of operating forces in theater at all levels of war” (United States Army 2009, p. 1-6).

- **Separated/separation.** Inclusive term used in this study to identify service members who reached their expiration of term of service (ETS), were demobilized from active duty, completed their military reserve obligation, and were honorably discharged essentially terminating a binding employer/employee relationship (United States Army: (Rapid Action Revision), 2011).

- **Nosology/nosological.** Emphasis within the DSM for determining distinct definitions of mental disorders and deciding if the disorder should be in the nosology, or branch of medicine concerned with classification and description of known diseases (Stein et al., 2010, p. 1).
CHAPTER 2

LITERATURE REVIEW

The long-term effects of PTSD have been methodically researched with countless articles written presenting a vast array of complex data on homelessness, addiction, relationship issues, and other adjustment struggles. However, few identify the need for further research of veterans’ barriers to employment complicated by a psychiatric condition. As previously stated, this study investigated the many and varied challenges faced by recently separated Gulf War-era II veterans encountering difficulties with their mental health conditions in relation to (a) work adjustment, (b) work integration, and (c) career development as the result of PTSD acquired in the warzone. This study also explored the tenets of work adjustment drawn from a variety of theoretical perspectives.

In any discussion of PTSD initially it is imperative to explain the difference between two acknowledged battlefield conditions that have varying effects on service members. In his recent book McGaugh (2011, p. 230) characterized the condition of Combat and Operational Stress Reaction (COSR) as a naturally occurring emotional reaction to combat stress that is generally accepted as short term. Additionally, the DVA clarifies that COSR is a reaction to the cumulative effects of environmental conditions during prolonged combat (Department of Veteran Affairs [DVA] 2010, p. 22). In contrast, PTSD is identified as a prolonged psychological condition classified as the most common and potentially long-lasting direct predictor of injury in the Gulf War-era II warzone.

The plausibility that PTSD can result in long-lasting effects provided rationale for this study research. Specifically, it was essential to address quality of life concerns: (a) in a review of this disorder within the context of the general population compared with Gulf War-era veterans; (b) understand how consequences of PTSD trauma affect interpersonal and family relationships; (c) recognize how Gulf War-era II veterans differ from veterans of the last protracted conflict (i.e., Vietnam War); and (d) from a research perspective, ascertain how social scientists developed and applied theories and methodologies to occupational choice and work adjustment as predictors of self-sufficiency through employment.
Therefore, this literature review focused on the following areas (a) PTSD symptoms in the general public and Gulf War-era II veterans, (b) an overview of Gulf War-era II and Vietnam veteran cohorts with PTSD, (c) post-deployment adjustment barriers faced by Gulf War-era II veterans with PTSD, (d) an overview of career development theories, and (e) application of Hershenson’s model of work adjustment to Gulf War-era II veterans with PTSD.

**PTSD Symptoms in the General Public and Gulf War-Era II Veterans**

Susceptibility to the injuries resulting from natural and other disasters, automobile accidents, rape, ongoing victimization, the loss of a loved one, or job loss within a segment of any population can present a risk factor for incurring PTSD. Generally, this condition is not distinguished by the preexisting health and socioeconomic levels of the affected population or proximity to the danger (Heslin et al., 2012). In the U.S., PTSD is now in fifth place trailing in prevalence more common psychological disorders of depression, attention-deficit/hyperactivity disorder, specific phobia, and social phobia (Kessler et al. 2005; Zanarini et al., 2011).

In their literature review, Ganzel, Casey, Glover, Voss, and Temple (2007, p. 227) discovered that exposure to trauma in the U.S. is quite common. Over 50% of women and 60% of men in one epidemiological study of 5,877 participants reported experiencing at least a single trauma while more than 25% of the sample reported experiencing two or more traumas in their lifetime. And, although PTSD is a common reaction to a traumatic event, many people completely recover over several months. However, for a substantial subgroup symptoms can persist for a period of years (Ehlers & Clark, 2000). Classified as an anxiety disorder PTSD is a response that by definition occurs following a traumatic or frightening event or near-death experience (APA, 2000), and involves a range of emotional criteria. Notably, in their research Gates et al., (2012, p. 374) reported that PTSD has high potential as a disabling mental disorder. Based on the results of their national survey, Schuster et al., (2001, p. 1507) remarked it is rare that “the immediate mental health effects of a national catastrophe experienced from afar, especially one that carries the threat of further attacks,” have been examined. However, based on their review of the literature, Neria, DiGrande, and Adams (2011) ascertained that a rich body of research in the past 11 years focused on the
most recent and insidious man-made disaster to occur on American soil – the terrorist attacks of September 11, 2001. Additionally, they found that exposure to the trauma of disasters, specifically the terrorist attacks, resulted in “a wide range of mental and physical health outcomes, with PTSD the most commonly studied” (p. 429). They also ascertained that prior to the terrorist attacks national figures reflected that more than 15% of women and 19% of men reported exposure to disasters during their lifetimes.

Neria et al. (2011, p. 429) noted that in community studies conducted prior to September 11, 2001, although the consequences of disasters include a wide range of psychopathology, PTSD is the most common type experienced, and the most frequently researched disorder, in the aftermath of large-scale traumatic events. This disorder can often lead to significant functional impairment and often coexists with such mental health conditions as generalized anxiety disorder substance abuse, and depression.

Based on their review of the literature Benotsch et al., (2000) reported that victims of civilian disasters are subjected to significantly more stress-related symptomatology associated with inadequate levels of social support. This might result in the person who is experiencing PTSD symptoms exhibiting emotional distress and avoidance behavior that may alienate the family as a legitimate source of continued support.

In their literature review Tanielian and Jaycox (2008) found that combat-related stress, variously known historically as traumatic neurosis, soldier’s heart, shell shock, battle fatigue, and at times malingering, is an understood and accepted consequence of warfare. Although no formal PTSD diagnoses was officially defined and adopted until the 1970s, the existence of psychiatric casualties is deeply ensconced in antiquity and traces its roots to warfare itself. Military field commanders have long observed the debilitating effects of combat-related stress disorders on their war fighters. The earliest descriptions of this condition were contained in written references by Homer of veterans returning from the Trojan War and an account by Greek historian Herodotus of an Athenian soldier being struck blind on seeing a fellow soldier killed in battle (Marmar, 2009; Satel, 2010). Each era identified the condition with a specific designation and responded with various rudimentary treatments, attempting to relieve the symptoms (Keane, Marshall, & Taft, 2006; Monson & Friedman, 2006). What the commanders did not understand then is that combat-related stress disorders, known today specifically as PTSD, are diagnosed as a disabiling anxiety disorder
within the military population which develops as a predisposed response to combat induced trauma (Cigrang, Peterson, & Schobitz, 2005). Through various forms of media a combination of dramatic and disturbing events have conveyed the significance of PTSD to public attention, the most predominant among them being: (a) the soaring increase of active duty military and veteran suicides; (b) the rising casualties of the ruinous Syrian civil war; (c) the 2012 Newtown, CT school shootings; (d) the 2001 terrorist attacks; and (e) the drawn out Iraq and Afghanistan conflicts (Joseph & Gray, 2011; McGaugh, 2011).

While the majority of veterans return from warzones intact both psychologically and physically, many will gather strength by the challenges of combat and will readjust successfully (Friedman, 2006), while others will respond with a changed self-image and altered worldview. Tanielian and Jaycox, (2008) noted that with attention concentrated on service members returning from these conflicts with well-defined traumatic wounds, which are fewer than in earlier extended engagements, increasing concern is directed to those returning with the invisible psychological and cognitive wounds connected with the warzone. Psychological wounds attributed to war lead to higher risk of associated mental health conditions among veterans and needed mental health and rehabilitation services which increase during lingering conflicts and multiple warzone deployments.

The experiences incurred by numerous Gulf War-era II veterans whose mettle was tested by exposure to extremely dangerous and traumatic events on deployment dramatically increased their risk for physical and psychological impairment during forever life-changing occurrences (Hoge, Terhakopian, Castro, Messer, & Engel 2007; Sayers, Farrow, Ross, & Oslin 2009; Schnurr et al., 2009). In a recent literature review, Gates, et al., (2012, p. 362), confirmed that warzone returnees with PTSD generally encounter serious physical health problems coupled with substance abuse, anxiety, depression, and additional mental disorders. Furthermore, they are apt to encounter emotional and cognitive PTSD symptoms, legal difficulties, marital and family problems, and job instability.

**PTSD Stressor Criteria**

From the time of its introduction, diagnosis of the PTSD stressor criterion has been a controversial concept that has weathered numerous revisions. The first two versions of the *DSM* emphasized stress reactions which were seen as acute and transient (APA, 1952; APA,
The belief then was that the individual reacted strongly during a traumatic event, and recovered soon after the stressor was removed. Failure of the stressor being removed often resulted in the individual being re-diagnosed under a different disorder. The *DSM* third edition represented a breakthrough in the field of traumatic stress as the disorder was no longer thought to be caused by a weakness inherent in the victim, but rather resulted from an extraordinary event (APA, 1980; Yehuda & McFarlane, 1995). Based on their research of the literature Mayes and Horowitz (2005, p. 251) posited that an essential characteristic of the new guidebook was its use to define mental illnesses as a categorical, symptom-based diagnoses. Through continued revisions of the *DSM* the stressor criterion has begun to include subjective emotional norms and become less focused on the objective event (APA, 1987; APA, 1994).

Currently, formulation of the stressor criterion requires that two different components have been satisfied (a) Component (A1): “the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others;” and (b) Component (A2): “requires the individual to experience fear, helplessness or horror at the time of the event.” Serving as the gatekeeper for the PTSD diagnosis is the “A” criterion, or stressor, criterion. Without meeting this criterion the individual cannot be diagnosed with PTSD even while meeting the remaining criteria (APA, 2000, p. 467).

**PTSD Paradigm Shift**

By the end of the 1970s when American psychiatrists began articulating a more refined notion of mental disorder contained in the *DSM-III*, PTSD research grew rapidly. With the definition of PTSD in the *DSM-III* a new conception of psychological trauma developed at a turning point in the 1980s that significantly differed from the previous theory of traumatic neurosis. Although similar in clinical features, the political and sociological meanings of trauma differed noticeably. The invention of PTSD at that time was not a scientific discovery as such but the end result of a broad change in approach that introduced a new moral perspective in trauma studies. The result of this change in the mid-1990s ushered in trauma studies around the time that a proliferation of epidemiological surveys focused new
information and fresh hypotheses on the distribution and physiopathology of trauma (Rechtman, 2004).

Viewing the concerns of vulnerability and risk factors that the earlier version of PTSD withdrew, this second conception raises questions of the political and social context of the 1970s and 1980s acceptance in the U.S. of the new lay category. Furthermore, Rechtman (2004, p. 913) determined this presents an unusual circumstance in psychiatry because there is no existing comparable psychiatric diagnosis with the exception of multiple personality disorders, or dissociative identity disorders in a dissimilar context. Therefore, PTSD is the only acceptable diagnosis an individual wants as the best means to avoid the stigma connected to mental illness and attached to the mental disorders of anxiety and depression. This criterion now allows for a psychiatric label that (a) does not suggest a moral condition, (b) does not lead to moral suspicion, and (c) does not assign blame to the victim. This then becomes a valid consequence of the external etiology of this specific disorder, the pathology of which is created wholly by an event outside the scope of normal human experience. It removes moral suspicion and the reason for blaming the victim previously attached to the theoretical framework of traumatic neurosis. Regrettably, as Rechtman noted, with the earlier concept of traumatic neurosis this was not the case. Along with new changes in the 1970s and 1980s, PTSD and traumatic neurosis shared criteria that were the consequence of a specific event. While epidemiology offers strong support for this new conception of trauma, there are no specific epistemological data that explain why PTSD lies so distant from traumatic neurosis.

The epistemological breakthrough in the 1980s introduced the conception of trauma after a breakthrough analysis or ‘invention’ of PTSD, but not that PTSD has no separate existence. The term ‘invention’ emphasizes the profound change introduced to the conception of trauma, and specifically in the traditional relationship between pathology and moral fault. After conducting their literature review Charuvastra and Cloitre (2008) concluded that to date, however, there are no known studies that have examined criteria that provide protection against specific stressors and depressive symptoms in OEF/OIF veterans.
OVERVIEW OF GULF WAR-ERA II AND VIETNAM VETERAN COHORTS WITH PTSD

A grateful nation, inspired chiefly by increased media exposure and other reports, began vigorously scrutinizing the scope of identifying approaches to assist veterans in their recovery from the psychological injuries caused by traumatic battlefield events. Ongoing research and analysis continues however, limited evidence exists to suggest the best therapeutic outcomes to meet the increased needs of this population (Tanielian & Jaycox, 2008).

Several central traits of PTSD symptoms are common among veterans of different eras. Certain characteristics of this disorder share a kinship with various anxiety disorders; however, they are differentiated from them by symptoms of re-experiencing, hyperarousal, avoidance behaviors, flashbacks, and intrusive memories, all symptoms that to some degree must impair the normal functioning for at least one month (Cigrang et al., 2005; Satel, 2010).

Unequivocally, the number one causal determinant of a severe warzone stressor for Gulf War-era II and Vietnam veterans involved grave personal risk under demanding battlefield conditions to include engaging in a highly concentrated, sustained operational tempo. War is an imminently fear evoking activity in a setting where Afghanistan and Iraq combatants confronted the threatening possibility of unannounced serious injury, loss, and death in an instant anywhere within the searing desert and arid mountainous operational theater. The decidedly violent and helplessness invoking nature of the stifling jungle warzone environment, described by Creamer and Forbes (2004, p. 395) as climatically unpleasant, is also associated with Vietnam War veterans societal adjustment problems. Tied to probable psychologically injurious factors (e.g., the sight of dead or dying comrades and handling human remains), emotional distress, sounds, and smells (Friedman, 2006; Schnurr et al., 2009; Aloi, 2010; Kennedy, Leal, Lewis, Cullen, & Amador, 2010) all coalesce into what Benotsch et al., (2000, p. 205) expressed as predictors that increase the intensity of stress with uncharacteristic capacity for contact with upsetting physical threats. Common to both of these cohorts is the length of the conflicts in which they participated, each of which exceeds 10 years in duration.

A distinction between these cohorts is that many Vietnam-era inductees who became Army and Marine combatants experienced 12-13 month in-country tours of duty according to
what Teachman (2004, p. 712) identified as an unpopular, involuntary military draft system. Service members in this category served two years and, unless voluntarily extending a current tour or reenlisting, returned home and on fulfillment of a current obligation or ending their tour of service, separated from the military. Today, the accelerated operational tempo experienced by an all-volunteer fighting force results in multiple unit and individual tours in Afghanistan and has imposed a limit on Iraq deployments since the present draw-down status was invoked.

**Life Course Disruption**

Contingent on the nature of the mission, many Gulf War-era II service members with specialized skills deployed multiple times. In her review of the literature McDevitt-Murphy (2011, p. 40) suggested life course disruption to the veteran and those in his/her network may be imminent during a warzone tour of duty.

With increasing age and continued warzone duty veterans incur sustained exposure to physical and mental war wounds and the disruption of their life course. In his literature review Teachman (2004, p. 712) stated that roughly one quarter of Vietnam-era veterans were subjected to being drafted into military service. An important factor to consider is age criteria by which social institutions are gauged and from which the individual is effectively removed upon entering military service. For the younger draftee cohort without any established life-path expectations, and whose role transitions were still being formed, military duty was not a noteworthy impediment because of uncommitted personal relationships, educational goals, or a significant occupation.

In their research Elder, Gimbel, and Ivie (1991, p. 218) found the younger an individual is mobilized increases options for: (a) life course variation through growth maturity; (b) delayed adult role assumption; and (c) enriching opportunities for socioeconomic advancement, future work, and family. Teachman (2004, p. 712) asserted that entering military service at an older age, as with the all-volunteer force, nevertheless can be considerably disruptive to those with established careers and personal relationships and for that reason more destructive. Elder et al. (1991, p. 216) observed that entry into military service by individuals during their early 30s can create sweeping life adjustments for spouses, children, and parents of those deployed. The resulting impact on life trajectory
involves spouses becoming heads of households or resettling with parents until their counterpart returns from duty. Significant during this time is the consequent loss of income in many instances during a period when significant career advancement must be curtailed.

Additionally, Teachman (2004, p.712) found in his literature review that the effects of life course disruption are imperceptible. He notes that several authors are of the opinion that the effects of life course disruption connected with military duty are temporary in nature but do represent a basis for tension in the career market for veterans separating from active duty that generates only an interim barrier. Eventually, a majority of affected veterans will return to their previous ties within the community and restore (a) economic growth, (b) social networking, (c) labor market awareness, and (d) resolute job seeking skills. The result is that in time veterans negatively affected by military duty will eventually reach the level of their working counterparts without military service. Teachman (p. 713) concluded that in either case, military service is a momentous change agent that adjusts status attainment by separating individuals from disadvantaged socioeconomic environments and equipping them with resources and opportunities that level the playing field. To those otherwise disadvantaged individuals military service is advantageous for furnishing them opportunities previously unattainable by encouraging making confident labor market decisions. Therefore, Teachman’s (2004, p. 713) research supported the underlying assumption that military service symbolizes a change in trajectory for status attainment along the life path. However, status attainment contingency is not limited to age indicators or the idea of life course disruption. Indicators are that former service members could have the opportunity to prevail over boundaries imposed by disadvantaged or tumultuous backgrounds and reach desired status attainment.

The Vietnam Legacy

The National Vietnam Veterans Readjustment Survey (NVVRS) found that 500,000 Vietnam veterans are currently diagnosed with PTSD and that likely nearly two million more might exhibit some stress symptoms during their lifetime (Hendrix, Jurich, & Schumm, 1995). Outcomes for the Vietnam cohort, which continues to endure PTSD symptoms acquired decades ago, indicate mixed results. Based on his literature review Marmar (2009, p. 494) concluded deployment-related PTSD in veterans who served in Vietnam is a primary
health problem that affects between one-fifth and one-third of men and women. For this cohort the resulting condition creates for them the experience of (a) higher levels of depression, (b) substance abuse, (c) problems with family adjustment, and (d) increased interpersonal violence. Essentially, as Marmar states, these veterans have current multiple difficulties caused by (a) misdiagnoses, (b) chronic psychiatric problems, (c) psychosocial impacts on their families and social support networks, and (d) delays in timely treatment seeking. The biggest tragedy for this cohort was the under-resourced mental healthcare system and the inability of the DoD and the DVA for the first two decades after the war to expedite care to veterans with psychological injuries and their families. Further worsening efforts for successful recovery of traumatized veterans was the antagonistic political environment to which they returned and encountered blame for the war. Because of untreated chronic symptoms, late onset treatments for this aging group of veterans have little or no efficacy while indicating marked success in the civilian population. In truth, treatment of chronic PTSD with outmoded programs in an older cohort of veterans needs restructuring to accommodate younger veterans returning from Iraq and Afghanistan (Erbes, Curry, & Leskela, 2009; Bradley, Greene, Russ, Dutra, & Westen, 2005). This age of rapidly evolving technology, environmental and lifestyle changes, plus the disparity of problem presentation styles could dramatically contribute to health care professionals considering alternative therapies.

**Lessons for Gulf War-Era II Veterans**

As the preceding review indicates, a clear understanding of a prompt commitment to veterans during their homecoming reintegration phase and prior to the onset of PTSD symptoms is of paramount importance. When symptoms become chronic they are latent resistant to therapy. Early intervention by trained clinical staffers may significantly reduce symptoms and help eradicate a lifetime of constantly remembering traumatic events, as has occurred with a significant percentage of Vietnam veterans (Erbes et al. 2009).

With a younger, more acute cohort of veterans returning from Afghanistan and Iraq, Erbes et al. (2009) clarified that widespread differences in veterans exist in both cognitive and affective predictors of trauma treatment outcomes. Firmly, this group of veterans does not identify with causal connections of PTSD and tends to view therapy as a stigma. Further,
Erbes et al., established that this new veteran group chooses to evade lengthy periods of treatment and is prone to drop from care altogether. This finding gave credence to additional studies that shift the responsibility for successful outcome from treatment providers to the tentative veteran who is likely predisposed to circumvent treatment.

As a result of their literature review Hoge et al. (2004) found few professional studies exist that specify a method by which mental health care is accessed and delivered to younger Gulf War-era II veterans. However, screening for possible psychological problems in a younger cohort of veterans is now customary for pre- and post-deployment, and is promoted as a priority in primary care facilities. Also, Hoge et al. emphasized that any studies assessing mental health care facilities, or any need for them, as obstacles to pre- and post-deployment treatment among veterans, are nonexistent.

The available literature on Vietnam veterans with PTSD describes the chronic nature of their condition. Based on their literature review Murphy, Thompson, Murray, Rainey, & Uddo (2009, p. 264) examined the steadfast resistance to behavioral change (i.e., hypervigilance, substance use cessation) of this group. They found that reliance on readiness-to-change concepts and the stages of change on which the transtheoretical model is built resulted in disappointing responses to PTSD treatment. Ambivalence or lack of awareness appears to be the primary challenge for veterans about need to change by altering inadequate responses. Murphy et al., (2009) also found that ineffective interventions or biologically determined symptom chronicity is not the culprit but rather the veteran who perpetuates poor treatment engagement. In particular, they specified that traumatized warzone veterans do not often view maladjusted behaviors and coping styles as mental health symptoms but as decidedly useful coping strategies for survival in what they perceive as a world full of treacherous individuals wanting to harm or kill them. Many veterans with this perception consider treatment interventions as irrelevant to their problems, which could lead to conflict with treatment providers, marked unwillingness to learn or practice coping skills, unsatisfactory treatment attendance, and drop out from therapy, all of which increase the likelihood of inadequate treatment outcome.

Unfortunately, much remains unknown about the association between treatment engagement and PTSD treatment outcome. However, Murphy et al., noted that recent studies provide a modicum of support for the concept that veterans in PTSD treatment programs are
ambivalent about the need to change symptoms and problem behaviors. The phenomena are not isolated within the younger cohort but are shown to be generational.

**Stigma and Mental Health Concerns**

Frequently, as McGaugh (2011, p. 222) asserted, many Gulf War-era II combat wounded recognized by an increase in survivability and disability are now burdened with what some view as particularly damning after voluntary service. Also, McGaugh (2011, p. 229) stated traditionally, war is a test of manhood. Implications are that although PTSD has gained much wider acceptance, the invisible psychological wounds associated with the condition continue to effectively render the stigma of these wounds, as some acknowledge, shameful and less honorable than gunshot or shrapnel wounds.

Lamentably, the field of psychology cannot fully comprehend the experiences veterans have confronted or what type of support and treatment they need post-combat (Sammons, 2005). As concluded by an extensive review of the literature by the Department of Defense [DoD] (2007, p. 15), a survey of Gulf War-era II service members in Iraq and Afghanistan warzones indicated that 59% of the Soldiers and 48% of the Marines questioned believed seeking counseling for their psychological conditions would result in different treatment by leadership. Consistent with this finding, Hall (2008, p. 12) noted the extant literature finds that military culture dictates not revealing information about feelings and emotions. This manifests an atmosphere where Soldiers and Marines are less likely to request mental health services for stigma which must be unequivocally acknowledged during counseling. Thus, existence of significant evidence suggests the presence of stigma is pervasive in the military (DoD, 2007, p. 15). Unfortunately, this creates a major obstacle to Gulf War-era II veterans with PTSD admitting that they meet the criteria for a psychological problem upon separation from the military. For service members’ preparing to separate from the military, unaddressed stigma impedes access to care, quality of care, and continuity of care and can also prevent them from seeking appropriate treatment for mental health problems.

Before a great number of Gulf War-era II veterans who received diagnoses consistent with symptoms of mental illness can accept employment with any guarantee of wellbeing and enhanced quality of life, it will be necessary for them to acknowledge their initial
concerns about stigma. Several factors also contribute to propagating stigma among service members with primary concerns linked to individual perceptions including (a) seeking mental health care will lower the confidence of others in the service member’s ability, (b) career advancement and security clearances are threatened, and (c) requesting treatment can cause removal from one’s unit. The DoD (2007, p. 16) expressed that crucial to the health of service members, their families, and their unit readiness, is establishing and sustaining a suitable level of hardiness during times of stress through timely interventions. The DoD Task Force on Mental Health also endorsed timely, proactive intervention strategies for service members to counteract the effects of the three distinctive indicators of military generated stigma “(a) public stigma- public (mis)perceptions of individuals with mental illnesses, (b) self-stigma- individuals’ perceptions of themselves, and (c) structural stigma- institutional policies or practices that unnecessarily restrict opportunities because of psychological health issues” (p. 16).

Counteracting stigma will involve service members mustering the same level of courage required in the warzone to confront their perceptions. The DoD (2007, p.17) suggested that some measures to better prepare these individuals to pursue mental health concerns are to: (a) oppose public-stigma through awareness that warzone exposure can wound the mind, can be disruptive to the behavior of anyone in the warzone, and can be just as devastating as a wound to the body; (b) educate and encourage change for those in positions to recognize early mental health warning symptoms and approaches to ensure successful rehabilitation; and (c) confront self-stigma by service members or family. Currently, the practice of mental health professionals is hampered by restrictions of the military model of service delivery that often confines them to mental health specialty clinics (DoD, 2007, p. 17). The result is that some service members are incapable of overcoming their concerns about seeking help and are apprehensive about the stigma and its potential for ending their careers. They are therefore unlikely to visit these clinics, and consequently, the practice of insulating mental health professionals in underutilized clinics deprives a major segment of this population of psychological health needs.

Hall (2008, p. 16) asserted that there is a valid concern with deeply established stigma within the military culture and a profound understanding is necessary to determine why military members have traditionally and historically rejected the pursuit of mental health
services. In their research study Stecker, Fortney and Sherbourne (2011, p. 614) acknowledged that previous data has documented stigma related to mental health problems that interfere with OEF/OIF veterans treatment seeking decisions. Modification of beliefs can result in an adjusted attitude regarding the need for treatment, helping to change the negative perception that treatment is only for the weak and potentially altering their behavior. Disappointingly, beliefs held by many Gulf War-era II veterans predispose them to negative attitudes toward mental health treatment with little intent to begin the healing process. Similarly, Friedman (2006, p. 589) posited that out of fear that PTSD-related problems might have an adverse effect on advancement in their careers, military returnees avoid medical record documentation. The result of this can have serious ramifications for vocational outcomes of veterans transitioning into civilian life.

In a literature review conducted by Khaylis, Polusny, Erbes, Gewirtz, and Rath (2011, p. 127) evidence was found that mental health difficulties, to include PTSD, began escalating for OEF/OIF returnees after their initial return from deployment. Several months after reintegration to their previous lives a substantial number of these veterans are not prepared to inquire about necessary mental health treatment because of concerns about stigma and other obstacles to care.

Help Seeking

Fortunately, as Marmar (2009, p. 496) stated, efforts were enacted by DoD and DVA to adopt strategies to de-stigmatize mental health services. Rather than referring to psychiatric treatment for mental health disorders the agencies reframed treatments as stress management training for combat trauma reactions.

In a literature review by Matsakis (2007 p. 3) it was found that approximately 85% of military personnel are young men, and this number is amplified in the warzone. Matsakis also recognized one noticeable improvement with the younger Gulf War-era II cohort is with national concern for enhanced treatment of veterans. The result is that several established programs are currently in place to assist today’s veterans confront personal anxieties through a variety of post-deployment medical evaluations, medical treatment, and counseling which are all accessible to service members returning from warzones. Most military personnel that
experience this process will require what Hall (2008, p. 202) described as the need for a healing process monitored by a team of expert primary care and mental health professionals.

Also, the Transition Assistance Program (TAP) addressed by Savino and Krammich (2009) offered information and education classes intended to assist exclusively with challenges met by individuals processing from military to civilian life with a variety of new concerns such as securing appropriate family housing, employment preparation, and educational endeavors. Another advantage for the younger cohort is access to electronic communication devices that were not available in Vietnam or when veterans were separated from military service. The ability to electronically file DVA claims for physical and psychological disabilities eliminates the communication barrier endured by earlier generations that have neglected to report their disabilities due to lack of awareness about the need for a healing process, unfamiliarity with veterans’ benefits, travel distances, disinterest, or inconvenience. Yet, both cohorts returned home with the same warzone injuries that have plagued war fighters since antiquity. Support services, as Wakefield (2007, p. 23) noted are imperative for this population because “our veterans and their families deserve nothing less” than they have earned.

**Post-War Adjustment Challenges Faced by Gulf War-Era II PTSD Veterans**

With a significant number of these service members returning from warzones bearing high rates of PTSD, the symptoms of depression, and related psychological problems causing impairments to their lives, social adjustment will present certain challenges (Pietrzak, Johnson, Goldstein, Malley & Southwick, 2009; Blevins, Rocca & Spencer, 2011). In their literature review Blevins et al., (2011) found veterans must have a need to seek effective evidence based PTSD and depression treatment to successfully reintegrate into society. They also found higher incidences of trauma inducing experiences in current warzones causing lasting emotional and physical challenges than ever reported in the past. Additionally, they noted a major challenge exists with engaging service members that have subclinical problems in treatment opposed to those with recognized clinical disorders. An outreach effort into their communities and later assimilation of service delivery into their routine activities can appeal to them and result in more successful treatment outcomes. Additionally, Pietrzak et al. (2009), found that little research exists that discusses many of the factors that mitigate
traumatic and depressive symptoms. Post-deployment screenings for physical ailments and, markedly, mental health conditions related to PTSD and depression, are normalized as indicated by the frequency with which the conditions appear as co-occurring among these veterans (Romanoff, 2006). Evidence that PTSD prevalence of this population has somewhat improved as indicated by early figures that reflect an onset range estimate of 10-25% within a year of deployment (Hoge et al., 2004), to the current figure indicating that 12% of veterans developed PTSD symptoms seven months after returning home (Meagher, 2007). Hence, not since the war in Vietnam have such a great many veterans challenged with acute PTSD symptoms returned from the warzone to resume their lives through post-warzone societal reintegration.

Ample evidence exists from veterans of every conflict that completion of duty in the warzone is only the beginning of the battle that continues on the home front (Hobbs, 2008). As public awareness grew with each deployment, timely and valid concerns persisted regarding U.S. involvement in the recently ended Iraq war. Presently, these concerns continue to mount with the ongoing Afghanistan war in which constant exposure to physical and psychological trauma results in returning injured service members that are currently in need of healthcare and employment services. Calhoun et al. (2007) indicated in their review of the literature that warzone deployment can affect the lives of service members and finding a job or returning to work can also be adversely impacted upon their return to civilian life.

Veterans returning with PTSD and experiencing the invisible wounds of psychological trauma will surely face social integration and work adjustment challenges which are often formidable for veterans who enjoyed relative calm pre-deployment lives. Their successful work adjustment and work integration will be determined by how well their PTSD symptoms are treated and managed (Carroll, Ruegar, Foy & Donahoe, 1985; Chalsma, 1998).

**Social and Interpersonal Functioning**

In their literature review Amaya-Jackson et al. (1999) concluded that PTSD impairments have a direct effect on several domains including psychological, physical, social and financial functioning. Additionally, these unseen wounds significantly influence psychological impairment related to traumatic events and impact community-based
posttraumatic stress outcomes. A review of the literature by Marmar (2009, p. 495) revealed the impact of PTSD on veterans and civilians relative to individuals with trauma exposure and non-trauma exposure without PTSD indicated (a) more than average negative health self-perceptions, (b) elevated self-reported medical difficulties, and (c) more physician documented medical problems. The toll for physical health within this group equates to what Gates et al. (2012, p. 362) described as an overall worse quality of life laden with greater symptoms for cardiovascular, gastrointestinal, respiratory, autoimmune, and nervous system risk factors and physical limitations. Also, (Marmar, 2009, p. 495) noted that higher levels of tobacco, alcohol, and medication use with increased risk of cholesterol and triglycerides levels. The Amaya-Jackson et al. (1999, p. 720) review also indicated that relative to other psychiatric disorders (i.e., major depression) the damaging quality of diagnostic PTSD is strongly indicated as well as service utilization patterns for this disorder.

Marmar (2009, p. 494) emphasized that studies were conducted by DoD and DVA to assess the impact of deployment on OEF/OIF Gulf War-era II veterans. Marmar (p. 495) described a study conducted by the DVA from April 2002 to March 2008 that gathered data on 289,328 Gulf War-era II veterans as first time users of the DVA healthcare system. The results indicated that study participants received one or more mental health diagnoses of PTSD, depression, and substance use disorders. The study concluded that within active duty, National Guard, and Reserve components rates of depression were higher in female veterans and the risk for substance use disorders was twice as high for male veterans.

Following separation from military service the veteran often resumes his or her former role in the community facing an array of complex life tasks while coping with serious physical impairments relative to severe psychological consequences of trauma exposure. Other factors that affect PTSD-borne social and interpersonal behavior functioning include insomnia, paranoia, nightmares, persistent anger and irritability, trauma-related hallucinations, alcohol abuse, and suicidality. The result is often imbued with uncharacteristic feelings of depression, detachment, and not belonging followed by attempts to mitigate effects of disrupted family dynamics. Symptomatically, this is a difficult time in the lives of not only the veteran but partners, families, friends, and employers who do not grasp the consequences of war and the unique challenges or conditions it generates for
stimulating the progression of posttraumatic psychological difficulties (Finley, Pugh, Noel & Brown, 2012; Schnurr et al., 2009).

**Marriage and Family Relationships**

Psychological trauma causes changes in life circumstances that add to the imbalance of family functioning and wellness. Often these changes necessitate a shift to reinvesting in quality relationships to strengthen the most important meaning in couple’s lives. Challenges to the social fabric of the nuclear or extended family presented by individuals with PTSD can: (a) lead to an array of psychopathology and domestic disruption; (b) provoke elements of trauma that initiate withdrawal, anxiety, and depression; and (c) can strain couple’s relationships and further erode personal growth. As Marmar (2009, p. 495) noted in his review of the literature the greatest risk for an incidence of domestic violence exists among younger couples and those with a preceding occurrence of domestic violence. Familial feelings of anxiety and depression also place strain on the relationship support network and can result in a therapeutic intervention between a mental health practitioner, the individual, and members of the social support system affected by PTSD.

In past decades the military was comprised primarily of young, unmarried men. It has evolved dramatically from the last prolonged conflict in which many servicemen were conscripted into the military, to an all-volunteer service. Furthermore, with a population shift a significant number of women now serve in the military and a majority of service members are parents (Drummet, Coleman, & Cable, 2003). Military roles are also shifting, with more military wives gaining independence and rejecting the rigid gender stereotypes to which the military had become accustomed (Matsakis, 2007). Also, Hall (2008, p. 78) attributed this difference to unrestricted change initiated by the women’s movement, higher rates of women participating in the labor force, increased educational levels, and a fluctuation in fertility patterns.

As observed by Calhoun et al. (2007) a large portion of the U.S. population is comprised of military veterans. Not only does a deployment to active duty in a warzone sometimes adversely affect their lives, but their families can also be negatively affected upon their return. Some returning veterans also engage in more dangerous activities in general further alienating family members. Solomon, Dekel, and Zerach (2008) concluded in their
review of the literature that “the traumatized veteran’s ability to trust, share, and be close to another is often compromised” (p. 659). Solomon et al., found this condition can also negatively impact on spousal support, marital quality, and satisfaction.

In their review of the literature Erbes, Meis, Polusny, and Compton (2011) determined that contemporary research identified OEF/OIF veterans with PTSD concerned with unstable relationships, poor communication, diminished intimacy, sexual dysfunction, and intimate relationship violence as were veterans of past generations. Specifically, Carroll et al., (1985) determined in their study that Vietnam veterans had significant changes in cognitive and behavioral attitudes, thus causing instability of their families. More specifically, Cameron et al., (2011) discovered that many veterans had difficulty with intimacy and self-disclosure of memories about their experiences and lacked problem solving skills. Some veterans responded with anger and aggression toward their spouses and children. In their research, Erbes et al., (2011, p. 479) also attributed to OEF/OIF veterans with PTSD relationship adjustment difficulties, problems with relationship confidence, positive bonding obstacles, stalled commitment, and negative communication.

Based on their review of the literature, Cameron et al., (2011, p. 289) concluded that returning veterans exhibiting characteristics of PTSD have not yet received adequate research and clinical attention on how their disorder affects sexuality. However, they also discovered that potential exposure to combat-related stressors that lead to PTSD can interfere with healthy intimacy and sexuality. In a summary of studies addressing sexuality and intimacy among veterans Cameron et al., (p. 293) emphasized that because PTSD has such a toxic effect on relationships, treatment that concentrates on (a) regaining emotional trust and intimacy, (b) anger and hostility reduction, (c) learning successful symptom coping, and (d) attention to sexuality concerns can result in richer relationship satisfaction for veterans and their partner.

Findings from a research study conducted by Khaylis et al., (2011) indicated that OEF/OIF service members develop a variety of family-related stressors and report concerns with cooperative spouse or partner relationships, and more dissatisfaction with intimate relationships. It is possible, as noted by Erbes et al., (2011), that impairments in intimate relationships might result from specific symptoms of PTSD or three specific clusters of symptoms defined in the *DSM-IV-TR* as, re-experiencing, avoidance, and hyperarousal
In a review of the literature conducted by Foa and Meadows (1997), they recognized the intrusion or re-experiencing cluster of PTSD symptoms as incorporating the characteristic signs of nightmares, intrusive thoughts, and flashbacks. The second, or avoidance symptoms cluster, includes a determination to avoid memories of the traumatic experience and emotional numbing symptoms. The third symptom cluster comprises symptoms of sleeplessness or hyperarousal, irritability, and hypervigilance.

By contrast, families with the ability to utilize supports and those that demonstrated high levels of cohesion and flexibility in family roles tended to achieve higher levels of functioning than families that did not (Figley, 1993). Also, Matsakis (2007) learned that families that regarded the absent parent as an integral part of the family, although experiencing more difficulty during separation, experienced a reunification that transitioned more smoothly than those families that did not. In addition the resulting reintegration process can last for months or years following reunification and can be a trying period for families.

Erbes et al. (2011) confirmed that several recent studies view a dysphoria model of general distress or negative affectivity that theorizes PTSD includes four essential symptom clusters – symptoms unique to PTSD reexperiencing, avoidance, and hyperarousal, coupled with the fourth factor of dysphoria, which incorporates (a) impaired concentration, (b) nonspecific arousal symptoms of irritability and anger, (c) emotional numbing, and (d) sleep disturbance (p. 480-481). In their review of two PTSD studies Simms, Watson, and Doebbeling (2002) contended that dysphoria may actually function as an imprecise element of many disorders (p. 638). They also found that symptoms of impaired concentration, irritability, and sleep deprivation, attributed to dysphoria, more accurately indicate nonspecific general stress rather than being inclusive of hyperarousal prevalent in PTSD.

Further review by Erbes et al. suggested that examinations of couple and family functioning matters grouped trauma specific PTSD avoidance symptoms with general avoidance symptoms, identified as emotional numbing, including (a) incapacity to share emotions, (b) avoidance of interpersonal relationships, (c) disinterest in activities, (d) a sense of imminent demise, and (e) traumatic event amnesia (2011, p. 479).

Erbes et al. (2011) concluded that earlier research infers that there is a close association between family functioning among psychologically impaired family members and symptoms such as nightmares, flashbacks, and hypervigilance viewed by the couple as
being apparently caused by combat deployment. Less negative attribution among couples about the meaning or function of these trauma symptoms could result in increased short term tolerance, patience, and empathy while reducing blame and resentment, shielding the negative effects of PTSD on intimate relationships. Conversely, the symptoms of dysphoria can be perceived by partners as causing more negative changes in the relationship because of being under the control and responsibility of the partner with PTSD symptoms. Additional review findings by Erbes et al. indicated that when partners did not believe that their significant other experienced a significant level of combat, an inverse relationship between PTSD symptoms and relationship satisfaction was present. In contrast, in the absence of this explanation for symptoms, negative attributions about PTSD resulted in relationship impairment.

Schnurr et al., (2009) conducted an extensive literature review that concluded only two recent studies centered on functioning of OEF/OIF veterans with PTSD that examined both social-material conditions and life satisfaction. The studies scrutinized disparities of relationship patterns between clusters of PTSD and quality of life. Their supposition that an association between quality of life and PTSD exists, also found that this cohort parallels findings found in other military and civilian cohorts. The study confirmed that PTSD is associated with a reduced quality of life regardless of the recent onset of PTSD due to warzone deployments and despite efforts by the DoD and DVA to recognize and treat returning PTSD veterans.

Not only do veterans with PTSD report their relationship concerns upon returning home but according to a review of the literature conducted by Galovski and Lyons (2004) veterans’ wives also reported considerable escalations in marital problems. Aggressive behavior from the veteran, or their wives own aggressive behavior, reduced levels of happiness, quality of life factors, and caused a greater sense of demoralization that is more profound within this population than within wives of non-PTSD veterans. The findings reported by Galovski and Lyons (p. 481) indicated that largely, study results suggested the primary contributing factor in spousal distress and decreased psychological wellbeing is the veterans’ PTSD untrained coping skills. Additionally, research acknowledges two components within the constellation of PTSD symptoms that are particularly challenging for
families (a) visibly angry demeanor by the veteran, and (b) emotional numbing/interpersonal withdrawal.

Based on their literature review Galovski and Lyons observed that several studies over the past century provided extensive analyses of the direct impact caused by psychological trauma experiences. Their review also determined that the secondary impact of living with an individual with PTSD is a far less established field of inquiry which relied chiefly on data gathered from Holocaust survivor’s family members and surveys of veterans’ families.

Additionally, the review by Galovski and Lyons determined that the expression secondary traumatization, as compared to vicarious traumatization, refers to the occurrence of conditions expressed by indirect victims (i.e., spouses and children) who themselves might become traumatized living with victims of violent trauma. This form of traumatization develops when an individual not directly exposed to trauma has contact with someone directly traumatized. After becoming indirectly aware of an actual event experienced by that person the individual exhibits trauma symptoms of intrusive thoughts, nightmares, and flashbacks. The broader use of this term refers to any transmission of distress to those in close proximity to a traumatized individual from someone who experienced trauma. It also incorporates a wide range of anxiety symptoms, not only those that resemble PTSD.

In considering the responsibility of family functioning in the role of determining treatment outcomes for veterans Charuvastra and Cloitre (2008, p. 611) raised three possibilities of (a) a positive family environment can mitigate negative PTSD symptom change during treatment, (b) change during treatment can have a positive or negative family influence, and (c) PTSD symptoms can impact on family functioning or on PTSD levels and interfere with the veteran’s ability to benefit from treatment. Benotsch et al. (2000, p. 211) discovered that subsequent PTSD creates a negative relationship within family cohesion. This relationship does not exclusively contribute to the likelihood of subsequent PTSD symptoms when variance shared with early levels of emotional distress and avoidance was controlled statistically.

Based on their review of the literature Pietrzak et al. (2009) maintained that some social support in conjunction with positive characteristics of psychological resilience and hardiness may enable an individual to adapt to adversity and defend against the development
of psychopathology. Also, in their reviews of the literature Schnurr et al. (2009) and Kennedy et al. (2010) concluded that positive psychological resilience characteristics influence social and mental wellbeing and readjustment to civilian life.

**Employment Challenges**

In their review of the literature Wald and Taylor (2009, p. 254-255) confirmed that PTSD was categorized in the top 10 physical and mental disorders associated with work loss days in a recent epidemiological study. They also found a direct correlation between individuals identified with chronic PTSD and difficulties with time management, workload management, inability to concentrate, and difficulty maintaining interpersonal relationships. Additional factors that impact work-related impairment for individuals with PTSD are (a) their substantially lower production rates, (b) job loss, (c) demonstrated under employment, (d) habitually working below their skill and/or educational level, and (e) attributing trauma-related emotional difficulties to one’s employability status.

**Perspectives on Career Development Theories**

In the U.S. today the impact of an economic downturn and unparalleled job reduction present considerable career development challenges to potential workers seeking employment inclusion. In the past, individuals had greater expectations of securing careers that now elude many segments of the population. Persons with disabilities struggle to find acceptable work and many families must resort to menial jobs or settle with unemployment benefits for a defined time period while awaiting economic recovery. Threatening the current situation is (a) the presence of tens of thousands of Gulf War-era II veterans entering the workforce since the conclusion of the war in Iraq, (b) the current military service-wide reduction of personnel, and (c) the measured return of Afghanistan veterans. Found within these groups is a large contingent of veterans with PTSD, many anticipating initial entry into the workforce alongside their determined non-veteran counterparts.

As concluded in their literature review Patton and McMahon (2006, p. 7) determined that many authors have proposed theories defining career, occupational, and vocational elements that describe social and cultural shifts while remaining flexible, adaptive, and containing neutral terms. They concur that work and life are intrinsically bound and the enduring relationship between career and life has been acknowledged as essential to the
quality of life. Also, Patton and McMahon agreed that the concept of career development is significantly shifting from the formative discussion stage to actual development through life quality roles to include work.

Patton and McMahon (2006) suggested that by redirecting attention from linear career development to a more multidirectional, multileveled endeavor the individual in this era is now challenged to assume a proactive role of creating one’s own career. The result according to Savickas (1994, p. 44) involved some individuals taking an available job as the only option rather than reliance on a choice between options. Patton and McMahon (2006, p. 6) also emphasized the practice of encouraging younger workers to explore alternatives through development of personal initiative and skills. Preferably, the focus for individuals while learning responsibility is to concentrate on employability first and rely on job security after acquisition of job skills while evolving toward a specific career goal.

A brief study and review of the literature by Mannebach (1979, p. 3) found that in the field of career education many theoretical frameworks exist with no single theory preferred. Mannebach posited the necessity for theories of career development and occupational choice to be founded on a firm theoretical position. He specified that career education can only achieve its full potential when a larger audience of practitioners is made aware of career development and provide suitable supportive services to individuals seeking career guidance. For the practitioner, theories provide guidance on: (a) how an individual conceptualizes complex vocational behavior; and (b) how experience, education, and professional skills stimulate improved vocational choice and acceptable career development options.

Based on their literature review Bordin, Nachmann, and Segal (1963, p. 202-203) identified specific views that apply to all theories of occupational life through either structural or developmental notions. These notions of occupational life take either or both of the following views (a) the structural frame provides a basis for conceiving personality organization through analysis of occupations, and (b) the developmental frame describes personality by attempting to portray experiences that can shape organization with associated vocational patterns. Charting elements of meaningful individual components within the personal occupation format promotes comprehensive descriptions of relevant individual occupational personality characteristics.
Several studies (Bordin et al., 1963; Brown, 2007; Mannebach, 1979) all agreed that (a) there is no existing definitive theory to explain career development and disability, and (b) no one career development theory is regarded as the guiding concept by which individuals are measured for career attainment. For the purpose of this study two distinct models were identified that have direct bearing on persons with disabilities career development evolving over a lifetime. Szymanski’s and Hanley-Maxwell’s (1996) Ecological Theory and Hershenson’s (1996) model of work adjustment provided descriptions of how individuals with disabilities can achieve a richer quality of life attainment within the work environment. Both theories are reviewed to put into context specific occupational needs and challenges of Gulf War-era II veterans with PTSD.

**Szymanski’s Ecological Theory**

In their review of the literature Szymanski, Parker, and Patterson (2005) asserted that over the course of one’s life personal development encompasses the full spectrum of roles and is also directly related to one’s environment. Szymanski and Hanley-Maxwell (1996, p. 49) clarified that the ecological model for career development relies on a rich tapestry of contexts derived from the most prevalent existing theories. They explained that because no definitive career development theory exists no specific theory can be favored over another. Career development therefore is dependent on the diversity of one’s nature and the contextual setting in which one lives (Szymanski, Hershenson, Enright, & Ettinger, 1996). This notional, integrative, ecological model blends multiple theories and channels application to people with and without disabilities. Szymanski and Hanley-Maxwell (1996) noted that historically the continuing debate over career theory applicability to people with disabilities has (a) focused on the short comings of some relevant disability models, and (b) considered applicable theoretical approaches specifically drawn from one or more theories. Szymanski and VanCollins (2003, p. 52) suggested that when viewing the aggregate current career theories it becomes apparent that dynamic interaction of several factors influences how career development is determined.

Szymanski et al. (1996, p. 49-50) described the identifiable career development factors of desirable personal characteristics, work competencies, attributes, individual social, and environmental characteristics that all influence maturity of the overall work personality
and defines career expectations. Szymanski et al. explained that “the model is ecological because, like previous ecological models in rehabilitation and other disciplines, it follows the Lewinian tradition (i.e., person-environment fit theory) of emphasizing the dynamic interaction of individuals and their environments” (1996b, p. 49).

In a review of published studies Szymanski and Hanley-Maxwell (1996, p. 53) found that linking work and personality is a complex task that focuses primarily on the effects of personality on occupational choice and work adjustment. They concluded it is possible that the impact of various occupational stressors is reconciled all together by one’s personality. Work related factors that affect one’s work personality correlate to a worker’s (a) status in the organizational framework, (b) opportunities to exercise occupational independence, (c) feelings of anxiety due to job pressures, and (d) dependency on unnecessary job risks and rewards. Szymanski and Parker (1996, p. 2-3) asserted that applying the concept of motivation to how and what people think will affect the manner in which they behave, influencing their initiative to work. Syzmanski and Hershenson (1998) maintained that for delivery systems to achieve sustainable employment outcomes they must emphasize meaningful careers for people with disabilities rather than focusing just on job placement. They emphasize that the individual is inextricably linked to career the development process of one’s sequence of occupationally relevant choices and behaviors. This is particularly noteworthy as Power and Hershenson (1996) learned in their study that persons with traumatic brain injury can be more ambivalent or passive in their purpose to work. Szymanski and Parker (1996, p. 4) acknowledged that work motivation is viewed as the combined conditions and activities that explain encouragement, direction, degree, and upkeep of effort in an individual’s job. The authors also posited that extant studies of work motivation influence job performance and are important to organizations for purposes of decreasing job stress and improving performance and job satisfaction.

**Hershenson’s Model of Work Adjustment**

For the purposes of this study a broader conceptualization of return to work as described in research conducted by Power and Hershenson (2003) is adopted. Utilizing this approach captures the scope of the concept as articulated in the context of work-related quality of life. In addition, the utilization of this model is easily adapted to various studies as
it has efficacy in populations with and without disabilities. Hershenson (1996, p. 442) suggested work adjustment consists of an interaction between three interrelated components inherent to the person and the environment in which the person works. The individual’s work environment is rooted to (a) work personality or self-concept as a worker, (b) work competency, and (c) work goals.

Influenced by the family during preschool years the work personality develops first as asserted in Hershenson (1996). During the school years the component of work competencies is the next to develop and includes work habits, physical and mental skills, and interpersonal skills all related to work. Work goals, influenced to some degree by one’s peer group, becomes the central area of development as the person prepares to leave school. Over time, changes occur within the system components and the components blend to create a dynamic balance. Changes within the components will directly affect the development of work personality, work competency, or goals within the person.

Power and Hershenson (2003, p.1022-1023) proposed that the individual components, or domains, develop sequentially and interestingly this model is developed around the notion that the primary influence of disability is on the work competencies and then extends to the mutually joined domains of work personality and work goals. Moreover, it is hypothesized that there is a reciprocal effect among the three domains. This study examined the theoretical link and reciprocal effect between the individual domains of (a) work personality, (b) work competencies, and (c) work goals that develop early in life and are directly linked to task performance. A review of Hershenson's model of work adjustment defined and illuminated the relationship between these variables. An additional element in reaching a level of successful quality of life attainment is the domain of achievement: that of establishing a worker identity. An effort to understand the difficulties of veterans’ successful work integration, work adjustment, and an exploration of experiences after being diagnosed with PTSD is crucial to identify influences on their successful return to work. Power and Hershenson (2003, p. 1022) noted that specific variables for persons with disabilities are recognized as initiating either a positive or negative role in the return to work. Some examples are (a) level of social support, (b) overall significance of psychosocial problems, and (c) level of former occupation and educational attainment. They also state that return to work is increasingly predictable through a combination of significantly positive variables.
A result of pursing vocational rehabilitation for this population centered on the ability of veterans with PTSD to pursue a new life after experiencing the effects caused by their disorder. Many of these veterans remain jobless after separation from military service and alter their previous lifestyles due to a disruption of their work adjustment. Power and Hershenson stated that concerns arise among the population of persons with disabilities and also with rehabilitation counselors concerning the impact of the individual’s condition on work adjustment and work transition. They note that further questions focused on (a) determining the important factors on which to focus for this population, (b) determining what influences the work adjustment of this population, and (c) whether or not individuals can engage in effective work adjustment.

**WORK ADJUSTMENT THEORY APPLIED TO GULF WAR-Era II VETERANS WITH PTSD**

Many active duty service members who elect to leave the military after fulfilling their contractual service obligation, demobilized National Guard and Reserve members released from active duty, those separated with an honorable or general discharge, persons released from further obligation to serve, and others medically discharged or retired from military duty face joblessness on return to their respective communities. Also, a significantly increasing number of service members exiting the military with a variety of disabilities are joining an escalating group of jobless veterans that are already competing in the workforce.

**Quality of Life Significance**

A review of the literature by Geuze, Vermetten, de Kloet, Hijman, and Westenberg (2009, p. 12) indicated several distinct studies found that quality of life in patients with PTSD is significantly impaired. In their study and literature review Lunney and Schnurr (2007) concluded that PTSD is directly attributed to a poor quality of life and that after PTSD treatment quality of life improves. They also stated that “a major impediment to understanding the impact of PTSD on quality of life is the lack of consensus on how to define and measure it” (Lunney & Schnurr 2007, p. 995).

Scores of Gulf War-era II veterans with service-incurred PTSD, many with comorbid service connected or other disabilities, continue to struggle with achieving an acceptable quality of life. This may be due in part to mental health challenges and disrupted work
histories resulting from military service. Findings from a literature review by Flinn, Ventura, and Bonder (2005, p. 64) recognized that many veterans with physical and psychological war wounds often are prevented from working, thereby diminishing their full potential as community members and ultimately impacting participation in society as a whole. Although this population faces certain employment challenges, Sawyer (1992, p. 103) found in his literature review that our society reveres certain standards of achievement. Because of expectations to be a worker the resulting substantial reinforcements of quality of life, community respect, and self-esteem prevail to effectively encourage the psychological health and wellbeing of individuals on return from distant battles.

Furthermore, Geuze et al. (2009, p. 12) reported that the impairment of quality of life results in loss of social and occupational functioning linked with PTSD and is responsible for the immense societal costs of the disorder. Flinn, Ventura, and Bonder (2005) also related that each individual has unique skill sets, interests, and motivations that sometimes function as work challenges. Because of various personal attributes, barriers to experience obtaining, maintaining, and retaining employment suggests involvement in individual vocational training programs to encourage work participation. For this reason Flinn, Ventura, and Bonder (p. 69) stated it appears that providing meaningful group and individual activities during occupational therapy can play a vital role which can facilitate prospective worker participation.

Worth as a worker is a primary means of achieving a positive quality of life and can be supported by assisting the individual secure a real work situation. In his expansive literature review Blustein (2006) related that “working functions to provide people with a way to establish an identity and a sense of coherence in their social interactions” (p. 3). Bluestein also maintained that working adds largely to the socioeconomic wellbeing of a specified society through its efforts, activities, and expenditure of human energy in specified tasks.

**Work Adjustment Significance**

Based on their literature review Joiner and Sawyer (1992, p. 99) observed that individuals with PTSD receiving work adjustment services typically do so while relating to life and work in a relearning mode. Work adjustment significance for Gulf War-era II
veterans with PTSD must recognize that (a) many young veterans may never have worked outside military service and are initial entrants to the workforce, and (b) older veterans may desire occupational transition as they reenter the workforce. Joiner and Sawyer (1992, p. 102) acknowledged that in 1971 the first comprehensive discussion of work adjustment proposed a focus on integration of the individual with the work environment through newly defined fundamental types of adjustment services comprised of personal adjustment, social adjustment, and work adjustment.

Work Adjustment Fulfillment

Nolte (1992, p. 62) recognized the strength of matching jobs and people and of preparing individuals for work in the changing discipline of vocational assessment and adjustment. Nolte also acknowledged the changing arena in which the work adjustment profession is now inclined to provide services while viewing individuals in a holistic context within what is known as the larger ecological or holistic assessment and adjustment environment. Sawyer (1992, p. 104) inferred that in the spectrum of rehabilitation services work adjustment relates to providing value and importance to individuals that are (a) transitioning from a conscious dependent state of existence and disability-oriented position to engaging in productive work pursuits, (b) adding independence to personal functioning, and (c) quality of life enhancement.

Work Adjustment and Vocational Success

Based on a literature review by Dawis (1996, p. 242), improving existing vocational conditions for individuals and society was one objective advanced by the vocational psychology model. As the result of an extensive review of the literature Blustein, (2006, p. 10), asserted that vocational psychology evolved from the vocational guidance movement founded by Frank Parsons, a leading advocate of assisting individuals with career choices based on his own various employment insights. Today, vocational psychology is best described as the behavioral study of an individual’s behavior in selecting, training for, entering, advancing in, and eventually retiring from, his or her rewarding work experiences (Dawis, 1996, p. 229). For many in our society, their life work may consist of a job or vocation for which they are compensated and which is considered anything done to support a way of life. Also, Blustein (2006, p. 3), reminded us that individuals without an income
producing job, but who have chosen to provide care for their families, or those within their community, may deem this activity as their life work. Vocational psychology examines all life work; however, it primarily examines work for which remuneration is received (Dawis, p. 229). As Blustein, (2006, p. 3) observed, “working has been one of the constants in our lives; the experience of working unifies human beings across time frames and cultures.”

Additionally, Dawis (p. 237) discerned that research in the area of work motivation determined work adjustment results from combining the dual concepts of job satisfaction, and performance satisfactoriness. This research soon concentrated on job satisfaction and finally expanded to investigations on work motivation, needs, and values. Thus, job satisfaction as Dawis (p. 237) stated was “studied as a useful predictor of work adjustment… and also as a criterion variable of adjustment in its own right.” Dawis (p. 241) also found that with an emphasis on the individual discovering the worth of vocational potential within specific job clusters linked with occupational categories the individual’s probability of being satisfactory and satisfied is ideal. This awareness is notable in the current labor market with less job availability, changes in job content, unstable job tenure, and where job availability for which an individual has trained may no longer exist in a certain field. The nature of jobs in the current marketplace appears to be changing to being expressed as a process rather than tasks thereby assigning dividends to adaptability of work adjustment and acquired skills and emphasizes procuring newly created jobs quickly.
CHAPTER 3

METODOLOGY

The study concept was designed with a conventional data collection method in mind as the most direct process by which to gather information. The study goal to implement traditional research, focused through a neutral and objective lens, permitted a familiar relationship with the participants to voice their concerns.

RESEARCH DESIGN

This study used a qualitative research design to explore PTSD veterans’ post-military separation experiences transitioning to work adjustment and work integration. This approach also permitted participants to candidly inform on their lived experiences. The design offered the opportunity for gathering veterans’ rich descriptions of perceptions, thoughts, and beliefs. After determining the study parameters a proposal requesting permission to conduct interviews with qualifying veterans was presented to Western Veterans Treatment Center (WVTC): (a) a non-profit, non-governmental organization dedicated to providing a comprehensive continuum of care to all military veterans; and (b) offering prevention, intervention, treatment and aftercare to veterans in need. Assistance through WVTC for veterans and their families includes housing, food, clothing, substance abuse recovery, mental health counseling, job training, job search, and legal services support. Consent to conduct the study was granted by a program director with the stipulation that on-site participant interviews would occur within a conference room in the approving director’s department. This study was approved by the San Diego State University Institutional Review Board and informed consent was obtained from all participants (see Appendix A).

Grounded Theory

As noted by Charmaz (2006, p. 4) and Lacey and Luff (2001, p. 6) the genesis of grounded theory derived from early research by sociologists Barney G. Glaser and Anselm L. Strauss (1967) who developed the inductive method of qualitative research. LaRossa (2005, p. 839) explained that the intended consequences of procedures defined by Glazer and
Strauss was a tangible methodology by which neophyte and seasoned researchers could comprehend and pursue new theories. Charmaz (2006) and Lacey and Luff (2001) also agreed that Glazer and Strauss cultivated the concept by which social theory could be methodically generated from data obtained during observations and discussing ideas and was later adjusted to study various groups of individuals. Charmaz (2006, p. 9) related that “guidelines describe steps of the research process that provide a path through it,” making the process easily adopted or adapted by researchers to study assorted topics. Egan (2002, p. 278) favored a rigorous design methodology that permits contextual data collection during which time research theory emerges. This type of research according to Lacey and Luff (2001, p. 6) resulted in the advancement of new goals and the methodology of data conceptualizing and inquiry. Because of the inductive nature of grounded theory analysis the process of rigorous and structured inquiry results in a theory that emerges from the data. Charmaz (2006, p. 4) noted that grounded theory is now widely accepted as an analytical tool in mixed methods studies as well. According to Egan (2002, p. 278) it has been clearly established that time and culture are attributable contextual influences that likely contribute significantly to generalizable findings within this theory. Important to the overall development of the grounded research design is reliance on (a) congruence between theory and researched conditions, and (b) utility of the constructed theory after being developed. Also, Kolb (2012, p. 83) identified grounded theory as a fundamental qualitative research method that underscores theory development in which the researcher utilizes information contained in specific stages to record data. In each stage the researcher applies necessary strategies for making constant comparisons and applying theoretical sampling to develop grounded theory which, as Kolb (2012, p. 86) added, allows the creation of meaning through data generation.

**Research Questions**

The primary research questions of this study include:

1. How do veterans with PTSD view their work competencies?
2. What significant work adjustment and work integration challenges do veterans with PTSD experience?
3. To what extent have veterans’ work goals changed from pre- to post-military service?
These questions were formulated while providing vocational counseling to veterans residing at WVTC who encountered difficulty finding employment due to a variety of barriers. Many of the veterans seeking agency provided supportive services experience PTSD, and some present with comorbid disabilities, requiring significant rehabilitation prior to job training or job placement. Daily contact with the veteran population at WVTC provided an opening to discuss various problems and learn more about common concerns that these veterans hold. Of primary interest to them is how they will support themselves or their families upon completing their treatment programs. Hence, the questions are intended to investigate how the veterans resumed their lives through post-warzone societal reintegration.

**DATA COLLECTION**

Conforming to the established practice of contemplative personal interaction: (a) yields intimate and informative material; (b) informs the participants; and (c) affords an educational tool for the vocational rehabilitation field to become conversant with veterans psychological, work adjustment, and work integration concerns.

**Recruitment**

From December 2011 through March 2012, I recruited prospective study applicants on the campus of WVTC. I focused on candidates who visited the WVTC Employment and Training section, where I work, who sought information about job opportunities or occupational training. At the time of my initial contact I openly inquired of each candidate if they had PTSD. When I received a positive response I then asked each individual if they wanted to join a PTSD study. I was very satisfied with their replies and invited each candidate to a research study meeting in a private WVTC conference room in the Employment and Training section to review initial pre-study information. At that time I provided each candidate with a letter of introduction fully explaining the study in compliance with IRB Guidebook Section 4.10 (San Diego State University, 2008, p. 25; see Appendix B).

During brief introductory meetings I very clearly informed each applicant about the purpose, methods, and anticipated outcomes of the study. I also explained that at the time of the study interview, questions and answers would be audio-recorded to which I received no objections. During this time we also discussed individual military assignment and
background information to establish mutual trust relationships. Over approximately three months, 10 candidates expressed their interest in participation and were eager to join the study. Two of the original group later requested removal from the study for personal reasons, requiring additional candidate recruitment. Because of the high walk-in volume in the Employment and Training section I recruited two additional candidates relatively quickly. After recruiting each of the 10 candidates I asked them to sign consent forms for study participation and provided them with a demographic questionnaire from which key population descriptors were gathered. Associations with the candidates were cooperative, professional, and informative throughout the pre-study, study, and post-study phases. All participants were treated with equal dignity and respect during the study. Three of the candidates that enrolled for employment and training supportive services ultimately became my clients.

**Participants**

The population of interest for inclusion in this study comprises veterans that matched the following four criteria for participant inclusion: (a) Gulf War-era II veteran with a warzone duty assignment; (b) separated from military service no less than one year prior to the survey date; (c) satisfy DVA defined conditions of persistent re-experiencing, avoidance, and increased arousal symptoms of the traumatic event for service-incurred PTSD; and (d) meet DVA elements for combat trauma exposure by identifying clinically significant stressors (DVA, 2010, p. 23-24).

The population characterizes veterans who have encountered struggles similar to those discussed in the literature review. Table 1 provides both an overview of the participants’ study qualifications and replaces their names with pseudonyms to protect anonymity.

Further descriptive information on the participants included that: (a) two were US Navy Hospital Corpsmen trained in hands-on skills when dealing with traumatic combat injuries while assigned to the US Marine Corps; (b) four received discharges identifying their character of service as Other than Honorable; (c) all have PTSD with comorbid mental or physical conditions; (d) all experienced a variety of post-military difficulty obtaining, maintaining, and retaining jobs; (e) six served various terms of incarceration after military
<table>
<thead>
<tr>
<th>Participants</th>
<th>Military Branch</th>
<th>Warzone</th>
<th>Assignment</th>
<th>PTSD Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Kim - Female</td>
<td>Army</td>
<td>OEF</td>
<td>Combat Support</td>
<td>10%</td>
</tr>
<tr>
<td>2. Jenna -Female</td>
<td>Navy</td>
<td>OEF/OIF</td>
<td>Combat Service Support</td>
<td>10%</td>
</tr>
<tr>
<td>3. Richard - Male</td>
<td>Navy</td>
<td>OIF</td>
<td>Combat Service Support</td>
<td>30%</td>
</tr>
<tr>
<td>4. Todd - Male</td>
<td>Navy</td>
<td>OIF</td>
<td>Combat</td>
<td>30%</td>
</tr>
<tr>
<td>5. Danny - Male</td>
<td>Marines</td>
<td>OIF</td>
<td>Combat/Combat Support</td>
<td>30%</td>
</tr>
<tr>
<td>6. Scott - Male</td>
<td>Navy</td>
<td>OEF/OIF</td>
<td>Combat Service Support</td>
<td>70%</td>
</tr>
<tr>
<td>7. Martin - Male</td>
<td>Army</td>
<td>OEF</td>
<td>Combat</td>
<td>70%</td>
</tr>
<tr>
<td>8. Robert - Male</td>
<td>Navy</td>
<td>OIF</td>
<td>Combat</td>
<td>100%</td>
</tr>
<tr>
<td>9. Damon - Male</td>
<td>Navy</td>
<td>OEF</td>
<td>Combat</td>
<td>70%</td>
</tr>
<tr>
<td>10. Seth - Male</td>
<td>Marines</td>
<td>OIF</td>
<td>Combat</td>
<td>70%</td>
</tr>
</tbody>
</table>
service; (f) six were homeless before entering the treatment center; (g) four are married; (h) five were divorced or separated prior to enrolling at the treatment center; (i) five have children; (j) three were court ordered into the program; (k) all presented as drug and alcohol dependent upon entering treatment; (l) three relapsed and were discharged from treatment; and (m) two returned to WVTC after initial discharge for a second treatment and rehabilitation opportunity.

Data Extraction

The data gathering measure of systematized interviewing was employed in conversations with participants to elicit specific research data. This practice assisted in an insightful awareness of the usefulness of each participant’s views and perspectives.

Trauma Exposure Substantiation

For reader clarification, substantiation of warzone combat trauma exposure relied on measures found in previous research studies and adapted to the following yes/no questions: (1) “Did you serve in a warzone (e.g., combat, combat support, combat service support?)” (adapted from study by Milliken, Auchterlonie & Hoge, 2007, p. 2141). An affirmative answer to this question prompted each participant to attest to military assignment orders to a recognized Gulf War-era II warzone – Iraq, Afghanistan or sea/air duty in support of ground operations, and (2) was your combat exposure direct or vicarious? (e.g., witnessing the traumatic event while involved in air, sea, or ground operations vice hearing or discussing details of a traumatic event experienced by another (adapted from study by Hoge et al. 2004, p. 16).

PTSD Substantiation

Service-incurred PTSD status required two verification measures. Criterion (1): Each participant completed a demographic questionnaire that compared their responses about having PTSD to information listed on their DVA documented PTSD disability ratings. Criterion (2): Each participant provided verbal verification by self-reporting answers to two questions described under Combat Trauma Exposure designed to elicit responses regarding service-incurred trauma. All participants desired to participate in the study and each gave forthright answers to the referenced question.
PARTICIPANT QUESTIONNAIRE

The demographic questionnaire was designed to gather specific information about each participant. Information was gathered in the following areas (see Appendix C):

Section I

Personal Information – gender, ethnicity, age, marital status, education, living arrangements, military service, service in a warzone engaged in combat, combat support, combat service support, operational area – Iraq or Afghanistan, years of active service, years of reserve service, total combined service years, and if medically retired.

Section II

Disability information – (a) service connected disability for DVA percentage rating of comorbid disability (e.g., TBI; bipolar disorder, etc.); (b) DVA percentage rating of comorbid disability, coupled with non-service connected disability, for a total combined disability percentage (service- non-service connected with comorbidity).

Section III

Employment Information – employment status, current employment income, last civilian job held (public sector/private sector), pending job application, position for which applied. Table 2 shows a full description of participant demographic characteristics.

INTERVIEW PROCEDURE

Prior to initiating interviews the following preliminary questions were asked of each participant to screen for study inclusion: (1) Are you currently taking any type of medication? This question was asked to obtain responses to prepare for unexpected consequences resulting from any participant’s physical or psychosocial reaction to medication, and (2) Do you anticipate that any of the medications you take will adversely impact your ability to participate in the interview for an extended period of time (i.e., 45 minutes to one hour)? This question was asked to determine safety concerns and whether any participant required special accommodations or structured breaks during the interview. Based on responses to the screening questions none of the participants was eliminated from the study.
Table 2. Participant Demographic Items

<table>
<thead>
<tr>
<th>Item</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>8</td>
<td>80%</td>
</tr>
<tr>
<td>Female</td>
<td>2</td>
<td>20%</td>
</tr>
<tr>
<td>2. Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;25</td>
<td>1</td>
<td>10%</td>
</tr>
<tr>
<td>25-35</td>
<td>6</td>
<td>60%</td>
</tr>
<tr>
<td>36-40</td>
<td>1</td>
<td>10%</td>
</tr>
<tr>
<td>40+</td>
<td>2</td>
<td>20%</td>
</tr>
<tr>
<td>3. Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>6</td>
<td>60%</td>
</tr>
<tr>
<td>Black</td>
<td>2</td>
<td>20%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>2</td>
<td>20%</td>
</tr>
<tr>
<td>4. Marital status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>4</td>
<td>40%</td>
</tr>
<tr>
<td>Single</td>
<td>1</td>
<td>10%</td>
</tr>
<tr>
<td>Separated/divorced</td>
<td>5</td>
<td>50%</td>
</tr>
<tr>
<td>5. Current education level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school graduate/GED</td>
<td>4</td>
<td>40%</td>
</tr>
<tr>
<td>Some college/professional school</td>
<td>6</td>
<td>60%</td>
</tr>
<tr>
<td>6. Military Branch</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Army</td>
<td>2</td>
<td>20%</td>
</tr>
<tr>
<td>Navy</td>
<td>6*</td>
<td>60%</td>
</tr>
<tr>
<td>Marines</td>
<td>2</td>
<td>20%</td>
</tr>
</tbody>
</table>

Note. *Two Navy personnel were Corpsmen assigned to and deployed with the Fleet Marine Force engaged in ground combat operations.
Eight of the interviews were conducted at a private WVTC conference room and two were conducted at a private office in the WVTC family center to accommodate female participants with child care needs and transportation difficulty. Each interview lasted 35 to 60 minutes. Utilizing the semi-structured interview format permitted freedom and flexibility for the participants to inform on their lived experiences without imposition of rules or restrictions. This allowed me the opportunity to gather rich descriptions of perceptions and experiences of each individual (Kolb, 2012, p. 84; Smith & Osborn, 2003, p. 57). For this study I developed a set of purposeful questions to elicit responses from participants that permitted them to construct an account of their own interests and experiences. This practice generated extensive data that may not have been collected through the course of a structured interview (Aloi, 2010, p. 83; Kolb, 2010, p. 84). The 12 contextual semi-structured questions that appear in Table 3 are numbered in the order in which they were asked of each study participant.

As shown in Table 4 the questions asked of the participants are grouped in three corresponding domains described in Hershenson’s (1996) model. The numbers in parentheses indicate the order in which the question was asked during the interviews. Given the semi-structured format of the interviews, when needed, each participant was prompted to respond to follow-up questions that are designed to provide an opportunity to clarify, modify, or give explanation of meaning to any answer. Examples include (1) Can you tell me more about that?, (2) What was that like for you?, and (3) Is there anything else you would like to add? After each interview I asked participants the following: Please describe the extent of family support you receive to help you achieve your vocational goals.

Answers given by the participants indicate their concerns and are intended to convey to the reader their personalities, individual manner of expression, and experiences in their own words. Transcribed answers to the questions were modified only as needed to ensure privacy and pseudonyms were designed to provide anonymity to those veterans whose identities may be compromised inadvertently if revealed.

Participants provided a personal narrative of experiences and all expressed their perceptions of post-military hardships. Some participants were more reluctant than others to share detailed experiences while others provided disproportionate amounts of information. During interview sessions I monitored schedules and remained mindful of the time factors,
Table 3. Questions Asked of Participants

<table>
<thead>
<tr>
<th>Interview Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What are your career goals?</td>
</tr>
<tr>
<td>2. What kind of employment are you actively seeking?</td>
</tr>
<tr>
<td>3. Can you describe what jobs you are prepared to accept?</td>
</tr>
<tr>
<td>4. Can you describe or tell me how you have planned for a specific job?</td>
</tr>
<tr>
<td>5. What are the most important reasons why you want to work?</td>
</tr>
<tr>
<td>6. Do you have a proposed timeline for starting work?</td>
</tr>
<tr>
<td>7. What concerns do you have about working?</td>
</tr>
<tr>
<td>8. How will your disability affect your work competency?</td>
</tr>
<tr>
<td>9. What are the advantages or disadvantages working will have on your disability?</td>
</tr>
<tr>
<td>10. How much additional rehabilitation do you need to prepare for work?</td>
</tr>
<tr>
<td>11. How are you preparing for employment?</td>
</tr>
<tr>
<td>12. Can you describe the sense of purpose you will derive from employment?</td>
</tr>
</tbody>
</table>

nevertheless, some of the interviews surpassed the portioned time periods. When required I reminded the participants that their time allocation was about to expire. In a few instances I accommodated interview completion times accordingly and continued collecting dialogue beyond the hour rather than rescheduling a partial interview for a later date. This practice was agreeable to, and did not result in any negative consequences, for the participants.

Data Analysis

The investigation is significant in many regards because it aimed to put into context the perceptions of this population. The manner of analyzing the data gathered during this study resulted from the inductive method of grounded research with a less formal open-ended process design for in-depth, semi-structured interviews. I completed a qualitative analysis to assure trustworthiness of the findings about: (a) work personalities as barriers to obtaining work; (b) ability to achieve specific work adjustments; (c) work competencies in relation to obtaining work; (d) work goals for maintaining employment; (e) ability to successfully
<table>
<thead>
<tr>
<th>Domain</th>
<th>Corresponding Domain Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Work Personality</td>
<td>(7) What concerns do you have about working?</td>
</tr>
<tr>
<td></td>
<td>(9) What are the advantages or disadvantages working will have on your disability?</td>
</tr>
<tr>
<td></td>
<td>(12) Can you describe the sense of purpose you will derive from employment?</td>
</tr>
<tr>
<td>2. Work Competencies</td>
<td>(2) What kind of employment are you actively seeking?</td>
</tr>
<tr>
<td></td>
<td>(3) Can you describe what jobs you are prepared to accept?</td>
</tr>
<tr>
<td></td>
<td>(5) What are the most important reasons why you want to work?</td>
</tr>
<tr>
<td></td>
<td>(8) How will your disability affect your work competency?</td>
</tr>
<tr>
<td></td>
<td>(11) How are you preparing for employment?</td>
</tr>
<tr>
<td>3. Work Goals</td>
<td>(1) What are your career goals?</td>
</tr>
<tr>
<td></td>
<td>(4) Can you describe or tell me how you have planned for a specific job?</td>
</tr>
<tr>
<td></td>
<td>(6) Do you have a proposed timeline for starting work?</td>
</tr>
<tr>
<td></td>
<td>(10) How much additional rehabilitation do you need to prepare for work?</td>
</tr>
</tbody>
</table>

integrate into the workforce; and (f) ultimately, retaining a job. This method permits the data obtained from participant interviews to generate and acquire descriptions of the meanings attributed to their experiences resulting in 53 single-spaced pages of text. I analyzed each answer in its context to all answers and subjected the answers to several of the stages associated with qualitative data analysis.

I became familiar with responses to the questions by (a) listening to the data immediately after it was recorded, (b) carefully transcribing the recording when the interview material was fresh, (c) reading and re-reading the text, and (d) organizing notations during data review in the event re-coding became necessary. Following every interview a summation of each narrative was transcribed, data were initially coded, analytic memos were written, and notes were compared across each case to develop a framework through which this population interprets their worldview.

Upon completion of transcriptions I reviewed all narratives in context, identified, and analyzed each emergent theme for possible associations. For practical purposes the transcript review process of identifying emergent themes was accomplished by (a) importing interview narratives into the Saturate web-based collaborative qualitative analysis tool computer program, (b) placing coded references in the right margin of each interview, (c) conducting a search for emergent themes by comparison of the coded references, (d) electronically highlighting passages containing specific themes, (e) arranging emergent themes into categories, and (f) identifying in which category the coded clusters are contained in the program database. After reviewing previously coded material I recoded data and subsequently coded a large amount of data that I identified and highlighted as quotes.

As with any new tool, the more I applied it to my study the easier the program became to navigate and I saw themes, sub-themes, codes, and quotes developing the more I utilized my new found navigational skills. My early frustration with the seemingly overwhelming amount of collected data subsided once I organized the information into chunks and cross-referenced codes and quotes with the various themes.

After developing temporary categories the connections between themes became apparent and resulted in refining some themes by combining compatible categories. The more refined categories easily accommodated original quotes and allowed for better connectivity within the sub-themes.
As I became more familiar with the written data a theory emerged that incorporates existing information gathered from the interviews.

### Member Check

To establish trustworthiness of the study and verify the accuracy of the findings, following the interviews, a participant was invited to examine the data and comment on whether or not the codes accurately reflect the themes of the interview findings. Through this process the participant corroborated the data gathered during the study.

Participant Danny submitted the following memo commenting on his interpretation of the information supplied during the study.

My experience participating in a PTSD study:

As a United States Marine Corps Veteran, my experiences in life and in military service have been all but common. I have had amazing adventures often encountering situations that might make a person break down and render them unable to cope or make hasty decisions that affect their entire way or life. I had the pleasure of serving honorably for eight years, also fighting for my country overseas during Operation Iraqi Freedom. My life is in no way an extreme case as compared to those that I’ve known and lost in my military service… however, compared to my civilian friends and family it definitely was not the least. Last summer I was approached by a kind gentleman [at WVTC] intent on completing a study on post-traumatic stress disorder (PTSD or PTS as it may be referred to veering away from the “disorder” part), who asked me if I would be willing to sit for an interview to gain some insight on my military service, possible hardships, and how that may relate to my past, current, or future employment. To be honest I was hesitant to participate as I have had problems speaking about this subject in the past, but through counseling, therapy, family and colleague support and above all time, I found myself at ease speaking to another veteran about this topic. I was asked simple and complex questions like, “How does your PTSD affect you in your personal and professional life?” and, “Do you feel like you have significant barriers to obtaining your professional goals due to your military experiences or PTSD?” To each question, I was often caught off guard sometimes reliving events in my head only momentarily but yet enough to probably create an extended pause. Usually I wouldn’t even notice that I had to think for a minute or two on forming a response… but eventually came up with answers generally in the form of a story expounding on the events that congealed into a single thought. It is difficult to be put on the spot and forced to think about all of the things that you try to put behind you… but in that lays the truth… you never put it behind you. One learns to live with it as best one can.

Often times, I don’t get the opportunity to share on these topics, am encouraged not to by others, and often avoid it entirely due to aggravation from others in my past. However, this experience was the opposite, and overall I think that this study
did me some good on a therapeutic level, I was speaking to a professional, patient, and understanding fellow veteran who really wanted to just hear what I had to say. I hope that this study helps veterans reconnect with themselves and find better ways to embrace their military service even if it wasn’t so easy and get back into the workforce.

Semper Fidelis.
CHAPTER 4

RESULTS

This chapter presents dialogue on perceptions, thoughts, and beliefs obtained from the narratives of 10 veterans with PTSD and substance abuse challenges who participated in interviews for this study. All of the participants in this study were at WVTC either court-ordered or voluntarily because of their chemical dependency. All met the study criterion of having PTSD.

INTRODUCTION TO THE THEMES

During the data analysis five emergent themes were generated. The following are the themes that emerged in order of importance to the participants: Veterans PTSD Experience; Overcoming Homelessness; Motivation to Change; Family Support and Quality of Life; and Rehabilitation Counseling, Education, and Career Preparation all of which are illustrated in Table 5 and presented through descriptive narratives and quotes. Table 5 also presents the codes that undergirded each theme.

VETERANS PTSD EXPERIENCE

Repeated PTSD distress intensified by years of warzone deployments transformed veterans into experiencing and confronting unresolved, embedded psychological and emotional difficulties.

War-Induced Trauma Coping

Exacerbated by avoidance behavior and emotional numbing symptoms, PTSD conditions of anger, depression, and anxiety hastened chemical dependency reliance for some. This behavior disrupts family relationships and may result in law enforcement confrontations. Some participants had negative outcomes due to (a) the causal association with substance use disorders, (b) accepting a sedentary lifestyle to a previously active military one, and (c) poorer health. A primary thread woven through several of the interviews is the significance of the decision making process in which alcohol is chosen as
Table 5. The Five Emergent Themes and Coded Material

<table>
<thead>
<tr>
<th>Theme</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veterans PTSD Experiences</td>
<td>War-induced trauma coping</td>
</tr>
<tr>
<td></td>
<td>Co-existing health conditions</td>
</tr>
<tr>
<td></td>
<td>Affirming healthy behaviors</td>
</tr>
<tr>
<td>Overcoming Homelessness</td>
<td>The effects of substance abuse</td>
</tr>
<tr>
<td></td>
<td>Family disruption</td>
</tr>
<tr>
<td>Motivation to Change</td>
<td>Identification and acknowledgement of personal values</td>
</tr>
<tr>
<td></td>
<td>Modifying beliefs and attitudes</td>
</tr>
<tr>
<td></td>
<td>Personal development awareness</td>
</tr>
<tr>
<td>Family Support and Quality of Life</td>
<td>Positive family support</td>
</tr>
<tr>
<td></td>
<td>Reestablishing relationships</td>
</tr>
<tr>
<td></td>
<td>Treatment outcomes</td>
</tr>
<tr>
<td></td>
<td>Transition to community, interpersonal</td>
</tr>
<tr>
<td></td>
<td>relationships, and belonging</td>
</tr>
<tr>
<td></td>
<td>Current economic concerns</td>
</tr>
<tr>
<td></td>
<td>Societal contributions</td>
</tr>
<tr>
<td>Rehabilitation Counseling, Education, and Career Preparation Strategies</td>
<td>Rehabilitation support</td>
</tr>
<tr>
<td></td>
<td>Personal role in rehabilitation</td>
</tr>
<tr>
<td></td>
<td>Prioritizing and focusing on work and school</td>
</tr>
<tr>
<td></td>
<td>Decision making difficulty</td>
</tr>
<tr>
<td></td>
<td>Development of knowledge through skills</td>
</tr>
</tbody>
</table>
the drug most exploited for numbing, obscuring, or for some, eradicating the pain and confusion of depression, anxiety, or panic attacks as corollaries of PTSD. Moreover, the use of alcohol interfered with the ability of participants to successfully cope with PTSD. Participant Martin recognized his addiction and related that he thought his PTSD symptoms would abate over time:

I went years just basically thinking that PTSD was something that would go away, the anxiety of trauma, of flashbacks, and thinking that my career was actually a contributor to it. At first I would drink on my free time to escape the stress and also I drank to numb out the flashbacks and the panic attacks. I really never confronted the fact that I had a permanent condition until my diagnosis four years ago. From 2004 to 2008 I was basically working and going job to job, relationship to relationship and just going downhill, a DUI, altercations with the law, and then finally I went and sought help at the DVA. It wasn’t the last time because from 2008 until 2011, I thought I could just numb it out with DVA medications and seeing a doctor when I felt like it. So by 2011, I was once again in more trouble with the law and then realizing that I needed to go sober because the first time around I didn’t admit the fact that I was also an alcoholic. (Martin, personal communication, July 26, 2012)

Fortunately, Martin received significant therapy in his recovery program and learned that by abstaining from his addictions he feels better, is now managing his PTSD, functioning in a positive manner, and is living a fulfilling life.

Participant Scott, who experienced a very disturbing shipboard tragedy that left him severely traumatized, and for which he underwent intensive therapy found solace in alcohol:

If you are left alone you are left to do battle with your disease. My disease is drinking alcohol and sitting around the house everyday there is a possibility that I could fall back into the drinking trap. I do have some anger issues that I have worked on. It’s a risk right now because of medications but it’s good because if I stop taking my medications I could spin out of control which I have done before on several occasions. It’s a hard world. I find it difficult to deal with all the noise because I’m on medication and my anger is under control but at times it really does annoy me and bothers me. (Scott, personal communication, July 24, 2012)

Both participants have learned to be more aware of their environment and admit their limitations. They have a better understanding of their surroundings and have learned to accept newly acquired tools learned during rehabilitation to form better judgments and meaningful decisions.
Co-existing Health Conditions

Valid health concerns are prevalent within the group and some participants voiced apprehension about living with comorbid conditions along with PTSD and finding a path to addiction recovery absent an active lifestyle. Participant Scott identified his disability status and his addictive habit by relating:

I am bipolar and it’s annoying. I also have hypertension, diabetes, and lower back problems. Preventing an idle mind gives you something to get up and do every day, not just sitting around the house with nothing to do. Sitting around the house every day there is a possibility that I could fall back into the drinking trap that lead me here (WVTC) for treatment. (Scott, personal communication, July 24, 2012)

Participant Danny struggles with significant aspects of psychological conditions and mental health concerns attributed to PTSD with comorbid TBI, significant bi-lateral hearing loss, and damage to his lower back. After significant alcohol abuse attempting to mitigate his symptoms he sought professional DVA counseling:

I had a PTSD flyer just after I got divorced and out of the military a couple years after I came back from Iraq and I saw a therapist about two, three times a week. I was medicated. They kept me on Prozac for my depression and anxiety and I’ve done a lot for my own mental health to keep it right. I took a break and needed to focus on me and get myself straight. I’m still doing a lot of healing on my own from everything that has happened in my military life and coming to terms with that. (Danny, personal communication, July 17, 2012)

Being in the military was the most important aspect of Danny’s life. He is still doing a lot of healing on his own and still coming to terms with everything that happened in his military life. He remains in contact with several Marines with whom he shares military accounts and discusses his physical status:

When I talk to prior service members and others affiliated with the military they say that with the disabilities I have now—my, hearing loss, PTSD, TBI, and lower back injury, even if there were a high demand, and unless we were going to attack North Korea or something, even in high demand they can train somebody else, the [Marines] don’t need me. So, it’s taken a lot to put that together and deal with the fact that I’ve come to terms with that and it’s okay that I can put that behind me. I have it with me but I can kind of let go. (Danny, personal communication, July 17, 2012)

It was very disheartening for Danny to acknowledge the fact of this new persona because of the years it took for him to absorb his former military status. Danny is trying to moderate thoughts of his military experience but admits that it will always be present and
with additional therapy he can free himself from the resentment he harbors toward his physical condition.

**Affirming Healthy Behaviors**

Three participants accepted personal accountability for their own behavioral traits by acknowledging their sole responsibility for life choices and avowing positive alternatives which encourage healthy behaviors. Participant Richard said, “I’m just glad that I’m not using drugs and alcohol any more so it is not that pressing an issue now but anything can happen because PTSD is PTSD regardless and I’ve flipped out before and I’ve flipped out sober” (personal communication, July 13, 2012).

Participant Kim who experiences physical problems with her feet and back, migraine headaches, and stomach difficulty along with PTSD said, “If I have too much on my plate I do tend to get stressed out and a lot of my PTSD symptoms will start becoming more of a concern” (personal interview, August 10, 2012). She also revealed that she is fully committed to the Alcoholics Anonymous (AA) twelve-step recovery program in the treatment center setting and recognizes the value it provides for overall PTSD improvement. Kim is committed to adapting the tenants of a clean and sober lifestyle full-time. She radiates a positive attitude when expressing her feelings about her path to restoring an unencumbered lifestyle and informed that:

I’d also like to continue working the AA program as well for the rest of my life. That’s my goal. As far as this particular program at WVTC, I’d like to stay in here until I completely graduate and I’ve already made plans to stay here through the entire two years. I’ve already been here about three or four months so that would give me a year and nine months to remain in this program. I don’t want to get out until I know for sure that I’m straight and I don’t have to come back. (Kim, personal interview, August 10, 2012)

Kim’s disabilities preclude her from standing or sitting for prolonged periods of time and lifting or moving bulky objects. In spite of bearing many physical limitations Kim anticipates becoming self-sufficient when she leaves the program.

**OVERCOMING HOMELESSNESS**

Seven participants revealed substance addiction as the causal determinant to their homelessness and ascribed alcohol as their drug of choice.
The Effects of Substance Abuse

Participant Kim stated that she experienced chronic homelessness and alcohol abuse since separation from military service until she discovered the treatment center program. She is a single parent with two children who sought to enroll in a treatment center that provides needed rehabilitation for addiction and psychosocial difficulties and related that:

I have two children at home. Ever since I got out of the military I have been homeless, bouncing from place to place. The longest I’ve been at a place is at a shelter for eight months. I’ve been kind of depressed because I don’t have a job and I’m not providing for my children. We lived in my car, we lived out on the streets, we lived in a shelter, and now transitional housing in the family program. I don’t want my children to go back there or wind up in this position again. My number one concern is to get a job and give them the life they deserve rather than what they have had during the last year since I’ve been out. (Kim, personal communication, August 10, 2012)

Kim is responding well to the treatment program and is very satisfied with her therapeutic achievements. Her commitment to the program is for two years during which time she is seeking supportive services for short-term training and employment. After job stabilization she will search for permanent housing.

Participant Jenna, a single parent with one child, classified herself as a displaced person because of her homelessness. Her primary addiction also was alcohol before entering the family program. Although she was strongly encouraged to enroll for supportive services for short-term training and job search she chose to completely dedicate herself to journaling and practicing her short-story writing style anticipating publication of a story in the near future. Jenna related that she is concerned she may not possess the necessary transferable skills, experience or education to properly support her daughter:

I need a stable means to provide for me and my family and to also feel like I have a place in society and not displaced like I do now. My main concern is that my military experience is not going to set me aside from anyone else. My fear is that having a degree is not going to be enough. I have concerns about supporting and providing for my daughter. My concerns are that I’m not going to move forward as far as getting off of state aid. I’m afraid I’m not going to be able to provide an ample amount of time and effort in the development of my child. (Jenna, personal communication, August 14, 2012)

Jenna has an eclectic job background that spans her acquired military skills aboard naval vessels including working with armaments, administrative duties, stocking supplies,
parts inventorying, and quality assurance. One drawback she experiences is adapting to the civilian world. Jenna admitted that, “I have anxiety issues and being around a group of people makes me nervous. I prefer to work alone so it’s going to be difficult to find that not so fast paced environment” (Jenna, personal communication, August 14, 2012). Eventually, Jenna must adjust to the workforce, whether or not her preference is to work in a calm environment, to support her daughter and attain affordable housing.

The first court-ordered participant in this study, Scott, was referred for his persistent alcohol and drug addiction. “I’ve been here a total of probably 11 months. I am going to Veterans’ Treatment Court. They try and help individuals be solid members of society. They first have to get the drug and alcohol abuse arrested” (Scott, personal communication, July 24, 2012). Two years ago Scott relapsed after unsuccessfully attempting participation in the WVTC program due to experiencing flashbacks associated with the discovery of a close friend who committed suicide on active duty. While he presents with comorbid conditions he currently manages back pain and hypertension. Scott excels in the program and now strives to diminish the stressors that affect his PTSD, mild memory loss, and anger symptoms. While doing well in his program he laments his homelessness and is attempting to retrieve his former status as an earner. He concedes that, “I have to work in order to have a decent life. Without work I don’t have a source of income and it makes it impossible to live without that source of income, have a stable job, and own a home” (Scott, personal communication, July 24, 2012).

Participant Damon was also court remanded to the program for alcohol misuse after experiencing both PTSD and TBI on deployment. He admits that without entering a therapeutic regimen at the treatment center he would probably still be medicated in another structured residential treatment program. He endures survivor’s guilt and when under the influence of drugs and alcohol after separation from military service contemplated suicide:

With PTSD being the biggest issue in my life I would be just taking my mind off of sore stuff and focusing on something completely different than the combat. Living with some of the things I live with, PTSD being the biggest issue in my life, and I don’t like saying that because I don’t talk about it. I have it and it was hard for me to hear the doctor say, okay you have it, and it’s a severe case. So, that basically puts a block up and I really haven’t planned for anything. I’m in a program now where its court ordered which can be hard to do because of my charges, but it’s the best thing that’s ever happened to me. I’m fixing my brain, allowing my brain to heal and I’m allowing myself to focus my energy on getting
back to where I was before the trauma started. (Damon, personal communication, August 1, 2012)

Damon is doing well in the treatment center program and is anticipating graduating and joining his entrepreneurial partner to begin a new life phase as a product development consultant and adventure trainer. He is positive about treatment experiences. Overall Damon considers himself a strong leader who functions well with people but in the company of others noticeably identifies some post-trauma memory loss surfacing. He welcomes the challenge of leadership again but feels his disabilities have robbed him of the physical and mental gifts he once possessed.

Paramount for him is the battle to recover his former abilities to enable future success. To date, his struggle has been a very difficult emotional process.

Seth, the last participant to arrive at the treatment center on court recommendation, also experienced difficulty with alcohol and with the shifting job market after separation from military service. He remained underemployed until reporting to the treatment center for therapy. He was anxious about leaving the facility and finding work immediately upon program completion. Seth stated that, “It’s hard for me to be here right now. I almost didn’t come here but I came here because that’s what they want. Veterans’ Court told me I have to come here. I was ordered through the state so I’m here” (personal communication, August 2, 2012). Seth was very candid in his conversation and allowed that he continues to experience stressors. He related an incident that occurred while he working in a bar:

I don’t wear my disability on my sleeve. It’s something I’m pretty good at, keeping to myself so that I’m not around anyone, around someone else that I don’t feel comfortable talking with about it. If I start getting angry on the job I keep it under wraps until I clock out. In the last bar job I had I wound up choking somebody out but he also assaulted me. I got fired from that job because of it and that’s why I don’t work in that industry any more. I didn’t feel like I was being backed up by my boss and I don’t want to be in that environment any more. (Seth, personal communication, August 2, 2012)

The participants in this category experienced significantly stressful warzone events under traumatic circumstances that harmed their lives and eventually placed them at the mercy of the court system. Their criminal behaviors affected their futures but through the legal process they were given the alternative of a structured treatment program offering a viable outcome. All three praised the outreach efforts of state Veterans Treatment Court for (a) achievable rehabilitative solutions, (b) the opportunity to avoid a criminal record for their
behaviors, and (c) the value added treatment they received through the treatment center and DVA.

**Family Disruption**

Three participants have experienced a nonexistent or very strained family communication process resulting in less than average social support. Expanding on established relationships is not always effortless in rehabilitation and, over time, may result in the individual reestablishing damaged or estranged relationships. Cultivating relationships anew with family, those they regard as close, or others accompanying them on the journey toward recognizing family goal achievement require time and effort. Two examples are provided by individuals who shared their perceptions of these promising circumstances.

Richard, the first participant discussed in this segment, was confined repeatedly for a variety of petty offenses and sensed being abandoned by his family, none of whom attempted any contact or communication during multiple incarcerations. Richard explained that, “Every time I went to jail my family didn’t call me, they didn’t visit me. They probably didn’t understand how deep the situation was or maybe they were just scared so maybe they just wanted to leave me alone” (personal communication, July 13, 2012). One aspect of Richard’s experience is that because his condition caused tumult within his extended family he fears others will judge him harshly on past behaviors.

I’m scared, people don’t really know about my PTSD. I don’t really mention it too much because I am worried that they’re going to be scared because they don’t really understand it. Maybe they heard about somebody that had it or maybe they watched a movie and somebody flipped out. I’m just scared about them finding out about that or my past, anything that I have done bad catching up to me. I’m scared that I won’t be accepted because some people don’t like people that are in the military. I just don’t want any of the symptoms to come out if someone tries to control and keep down, like my not being in the moment. It scares me sometimes about my memory because with my anxiety I have trouble being in the moment as much as I try too. I’m thinking about the past thinking about the bad stuff from the past, the present based on perceived threat, the future, and of course the future is not promise to me. So it really messes with my memory and I can’t be like I was a kid just going to a playground and being happy and playing in a sand box. (Richard, personal communication, July, 13, 2012)

Richard displays remorse when recalling his multiple incarcerations. He understands that his family cared deeply about him during his frequent detentions but implemented a no contact agreement. When he had money he helped his extended family and was disappointed
there was no reciprocation when he needed help. His wife did nevertheless assist him monetarily when she could while he was at the treatment center.

Participant Robert related that, “My wife stuck with me while I was here at WVTC for a year unemployed” (personal communication, July 26, 2012). Shortly after program completion he lost his sobriety, self-esteem, job, and family. Robert succumbed to chemical dependency, criminal behavior, and again entered the treatment center. He lamented losing his family and reflected on possible explanations:

TBI is going to cause impulsivity. The impulsiveness of being where I’m supposed to be, staying on target, doing what I have to do is a challenge. Next are memory problems which are the same for the PTSD memory problems. Both are going to cause you to be angry because you are not cognitively processing things at a normal level. Sleep, I don’t get sleep from PTSD so I’m always kind of tired and irritable. I’m always continually amped up and have to constantly do intense exercise. It’s kind of like a manic depression, manic all the time with no downer, just being up. (Robert, personal communication, July 26, 2012)

Presently, Robert regularly participates in an on campus therapeutic PTSD therapy program and continues with DVA outpatient psychotherapeutic treatment for warzone trauma. His attitude and behavior improves steadily however, he is estranged from his family and remains uncertain about returning home in the near future.

The participants discussed in this section are diligently participating in their respective treatment programs and meeting the requirements imposed by WVTC. Although most struggle with psychological conditions they all have prevailed over their substance addictions and have strong desires to overcome homelessness.

**Motivation to Change**

Eight participants discussed their perceptions of motivation. Two of them conceded that identifying personal values allowed them to achieve fulfillment in the areas of usefulness, independence, and self-sufficiency.

**Identification and Acknowledgement of Personal Values**

One of the participants, Danny, is the product of a highly charged military background in which motivation equaled productivity. Busying himself daily and seeing the results of his work gave him pride of accomplishment and confidence in not being idle:
If I’m motivated and I have something to do every day I can feel productive and I can see some sort of results of my work at the end of the day then I feel good, I feel accomplished, I feel like I’m something. If I don’t have that I can get distracted very easily. I can go off into thinking that I’m non-productive and didn’t do enough and I end up having a confidence breakdown with the depression and anxiety. It will almost tear me apart sometimes if I feel that things have not been productive or if I feel that I am just not doing enough. I come from a very high paced environment working with the military and you are always doing something and even when you are not doing something, you are doing something because you never want to be that guy that is idle because the idle guy isn’t favored. (Danny, personal communication, July 17, 2012)

Danny sought recognition for his willingness and ability to accomplish many tasks within a narrow timeframe. For him, unsuccessful goal attainment invited depression and feelings that were sometimes very disparaging. After receiving depressive disorder treatment he recognizes cognitive therapy (CT) is efficacious for changing his thoughts. His self-defeating beliefs are now diminished and his depression is regulated.

Damon values a strong desire for independence and aspires to reside in an apartment or condominium surrounded by nice things. When entering his residence he wants everything perfectly clean with nice furniture, a big screen TV, and where buddies can come over on weekends:

That’s what motivates me to get full-time employment and work and work hard, because I’m a very hard worker. To be able to be in the military you have to work hard and be driven. That’s how I was before a lot of things happened. That’s the most motivating factor just to be independent. It really scares me because I’m fearful of failing, of not being able to do the job like I used to be able to do my military job. That’s a huge fear because I was very good at what I did and now going out into the real world and getting something that’s maybe completely different, or if it’s the same thing in a civilian environment, it’s working with all different types. Fear of failure is something that’s been on my mind. I’m so fearful of failing. (Damon, personal communication, August 1, 2012)

Damon went on to say that he is beginning to get back his motivation now but compares it to creating a bad habit and then trying to break that bad habit and starting a new habit. Having nice things, a bank account, and independence are what motivate him to work.

**Modifying Beliefs and Attitudes**

Three participants related that changing their beliefs and attitudes empowered them to take motivation to another level. Each one is committed to move forward and accomplish new goals.
As a result of his severe trauma, Martin had difficulty keeping steady employment, continued withholding emotions, and persisted drinking to relieve the pain. He eventually admitted himself to treatment at WVTC:

I spent a year in sobriety and I really built a relationship with myself in that year and I’m even off the medications because now I’m going through therapy. I need to be honest with myself and know my surroundings and if I know that I’m potentially being put in a situation which could have a negative effect on my condition it may even effect people around me. I need to be honest with myself. Self-awareness and awareness of my environment will definitely help with that. It’s just about building a relationship with me, knowing my limitations. I used to have this attitude that the loser way to think was to set limits for yourself. I don’t think that way anymore. I’m a little older now and I realize that I have strengths and I also have down falls especially now and I need to be very aware at this point. (Martin, personal communication, July 26, 2012)

The therapy Martin received is helping him with life consistency and he feels that his newly established self-relationship is the first time he has found motivation for a changing attitude. One thing he has learned to accept is that some things he can make happen and others he cannot. He says he will not stop the pursuit to become whole until he has his mental condition under control. Martin believes that his attitudes and beliefs are healthier than they have been in years. He plans to keep pursuing a better outlook on life until he reaches his desired comfort level.

Robert has some concerns about beliefs and attitudes he might embrace when confronting work situations because of his condition, to handle problems on a normal business level. He wondered if he will maintain his composure to communicate effectively with different personality types. Also, he questioned his ability to think over his tactics without presenting an inappropriate belief about someone or assuming an attitude when discussing opinions. Robert has experienced many emotions and thoughts during his second stay at the treatment center. His attitude continues to steadily improve and he revealed that:

I would like to be hired on full-time in six months. It would be great. It gives me motivation that I’m moving along in life, that I’m not sitting stagnant. It gives me a feeling that I am growing, working on communication, how to be around other people, how to get along with people, and how to get along socially. I like that it gives me hope. I will have to do some networking at the hospital because it’s who you know to get hired on for a full-time job. It’s going to cause me to come out of my comfortable spot, come out of my space and go to work in around six months. months (Robert, personal communication, July 26, 2012)
Robert attempted to become cooperative during his rehabilitation and does not want to convey the impression that he is belligerent. He learned to address situations with an unbiased thought process and softer response while assimilating a calmer demeanor. He began to settle into his new persona but still anticipates how he will react in a potentially confrontational encounter.

Participant Kim comprehends that maintaining a positive attitude during treatment on a daily basis is challenging. However, she recognizes that having a negative attitude or belief system is counterproductive and serves no purpose. At this time she is enthusiastic about making progress in modification of her personal beliefs:

Being in transitional housing in the family program so that has already boosted up my confidence. Just being in the program I’m hoping that I will be more confident, more motivated to work, and to take care of my kids better. I’m hoping that working or finding a job will give me that motivation that I can work through anything, no matter what, because I’ve always been the type of person that drives on no matter what’s going on and I haven’t been doing that. (Kim, personal communication, August 10, 2012)

Kim has the appropriate attitude to maintain steady momentum toward her end goal. She is working her way out of depression related to her unemployment situation and inability to support her children. Kim has an established belief system and is very positive about completing her program and propelling herself into a job that will suit her personality and provide needed financial support for her children.

**Personal Development Awareness**

Participant Todd offered understanding into what motivates his actions. He is aware of personal health, well-being, development, and additional factors that give meaning to his life. In Todd’s opinion health and well-being are important to his daily function and at times he struggles to pursue functioning at a peak level. PTSD has taken its toll on his memory which is affected along with physical and mental conditions. He is definitely at a disadvantage as far as health is concerned and stated:

Disability has a part in depression and being depressed is partly because I feel like I’m useless or feel like I’ve been useless for a long time. I feel like I have the same capability as I once had as a result so that kind of puts you in a depressing state of mind, not being able to do the things you used to be able to do, or being limited, or being not able to do what you want to do. And it’s been hard. I think for one, could not survive on the monthly disability payment I am getting. I wouldn’t make it. Two, I have a child coming. And for three, I don’t know what
my life would look like if I didn’t have a job to go to every day. (Todd, personal communication, July 17, 2012)

Todd’s mental acuity is not as sharp with his condition and does not function well. He must focus quickly to perceive things in their proper perspective. He believes he would be bored without some activity and does not think it would be healthy to not work.

**FAMILY SUPPORT AND QUALITY OF LIFE**

All participants commented on the various levels of family support they receive. Four portrayed loving, attentive families that offer constant support, unconditional positive regard, and encouragement throughout the treatment center process. This theme underscores that for some participants, families remained intact and functioned positively.

**Positive Family Support**

In this segment three participants conveyed positive, caring experiences with family support. They also reported that family support facilitates strengthening relationships and encourages psychological and emotional health that are equally valuable and empowering. Participant Danny has a physically and geographically close extended family and said that:

> My family is amazing and they help me in every way possible. They helped very much in my childhood and young adult life but for some reason I chose to do things my own way. I don’t know if that’s a sense of pride or just a needed separation from having such a close family, but I’ve chosen to do things my way and it’s not always been the best decision. They have given me tremendous support in everything. My dad gifted my vehicle back for nothing. It was such a huge gesture, giving me that freedom and ability to travel to a job. (Danny, personal communication, July 17, 2012)

Danny was very emotional when discussing his family involvement. It is very evident that he has significant family support that encourages him in all endeavors and who anticipated his return home. His psychological well-being is constantly challenged by his inability to concentrate for any length of time, possibly aggravated by the TBI he received while on active duty. He is on an irregular treatment schedule with the DVA and is progressing with PTSD treatment and continues to strengthen his psychological resiliency.

Participant Damon related thoughts and feelings he shares with his family about his stay at the treatment center. He has diligently participated in his individual treatment program and has made great strides due to the level of support from his entire family. He
acknowledged the possibility of confronting obstacles while living in the treatment center without the expression of family support and encouragement. He articulated that:

Once I got out of my own shell and actually stepped back and looked at the love, the support, and the pain that they have for me because I’m their son, their brother, their nephew, or their grandchild it’s incredible. My family is very supportive of what I’m doing right now. I’m just seeing that now because I’m coming out of this cloud of selfishness and everything else and support is unbelievable. If I didn’t have that I would be hurting in here (WVTC). They support my vocational goals and they support me having a good life. Everybody loves me out there. I have a great family and I’m lucky to have that. So many veterans don’t have that. (Damon, personal communication, August 1, 2012)

Damon’s family supported his treatment progress and vocational goals thereby providing him the opportunity to react appropriately to family concerns for his welfare. He is succeeding with behavior modification and his initial hesitation to participate in the treatment program subsided. He is now learning to make appropriate choices and functions at a new awareness level of what he can accomplish given the confidence he achieved in the treatment center.

Participant Kim is experienced a blended support system comprised of her previously estranged father, a younger sibling, and a lifelong friend. She is very enthusiastic about the support she now receives because it also extends to her two children. She acknowledged that:

Several years ago I was told my mom was dead and my dad didn’t want me. Just within the past couple years I met my dad and my biological mom. I have just recently started receiving family support. My dad has been absolutely wonderful. Another supporter, not blood family, but she is like my sister, is my children’s Godmother. She encourages me to stay in the treatment program. I also have my little sister but she doesn’t understand a whole lot about it at fifteen. It’s more support than I’ve had in my whole life so it’s really good. They support everything I want to do. (Kim, personal communication, August 10, 2012)

Kim is very satisfied with the level of support she receives and visits with her father regularly when he comes to visit her and his grandchildren. Her close friend lives in another state and communicates with Kim telephonically on a consistent basis. She is very happy with the relationship with her father after being estranged for so many years.

Reestablishing Relationships

Several participants conveyed the efforts made at reestablishing family connections and friendships that had grew increasingly strained or were altogether absent. Participants discussed how these restored relationships were helpful in their PTSD recovery and pursuing
their employment and life goals. Participants reported this was a task requiring considerable time and effort. The following examples explicate the nature of this effort and its positive outcomes.

Following a prolonged period of isolation Martin, whose parents are both deceased, recently established an emotional association with his siblings and adult children with whom he can now communicate as an outcome of his current sobriety. He provided the following:

> I would say that a good fifty percent of my family is very supportive. Not everyone is capable of being emotionally supportive and that is just how it is and I accept that. Since my parents are deceased my siblings and my children offer support. They are very aware of my struggles and my success and are very supportive. I hate to say it but my children were on the front row of my downfall. My children saw me decay to nothing and now I am establishing a relationship with them because it destroyed the relationship that I had with them for a good four years. It was one of the things that I just drank away. They are adults but they are still my kids and they always will be. (Martin, personal communication, July 26, 2012)

Martin clearly understands the social support process since recently reuniting with family members. He seems comfortable with the knowledge that not all family members are capable of support after being affected by PTSD driven behavior, homelessness, and substance abuse. At this point in his life Martin is satisfied that he has a relationship with his children and siblings. This is important to him since being requested to leave the treatment center during his second commitment to the program because of an inability to adhere to behavioral protocols. He shows positive growth from his initial experience at the treatment center, maintains sobriety, relates well with his children, and clearly accepts that his life focus is improving the lives of others less fortunate.

While some participants were successful in reestablishing relationships that provided support, other efforts were not successful. Two additional participants reported their parents are deceased and additional family members are remote or ambivalent about healing relationships. Scott has only a surviving brother who is perceived as showing disinterest in having a family attachment and any interest shown is negligible or non-supportive. He said that he would like to establish dialogue with his brother but because of years of no communication by either party he believes because of his past addictions and homelessness it best not to disturb his brother and extended family.
Participant Jenna has no paternal or maternal family and her only surviving kin is her young daughter, who as a single parent she is raising. Given the absence of family support she acknowledges receiving encouragement and supportive actions from treatment program staff. She stated:

I don’t have any family. My parents have passed away from drugs and alcohol. That’s why I’m working so hard to move forward. As far as moral support I don’t get any from case managers in my program. I don’t get any support or encouragement from anyone in my program. I get support from counselors at WVTC who always encourage me to keep working toward a goal when I see them. (Jenna, personal communication, August 14, 2012)

Jenna continues to accomplish her goal of confronting her disability and not using it as a crutch. For her to succeed she will need patience with the difficult challenge of overcoming her fear.

**Treatment Outcomes**

All participants discussed their concepts concerning the meaning of quality of life. Because substance abuse is the primary diagnosis, and each is diagnosed with a psychiatric disability, participants are assigned to a therapist or group-support counselor and must attend a twelve-step program. However, since entering treatment, two female participants relate their perceptions for positive changes to their quality of life.

Kim relates that sustaining a meaningful quality of life is dependent on continued therapy for improvement:

I’m working with my therapist and I think if I just continue, even when I’m working, I’ll maintain my visits with her. I don’t think I’ll need any additional counseling as long as I keep working the treatment program I’m working now before I start work. If I continue with the therapist I’d like to be there as long as possible because I feel that mentally I really need that. (Kim, personal communication, August 10, 2012)

Recovery for Kim is a hardship while residing in a substance treatment facility that impacts her ability to dedicate significant time to supporting her family. She is willing to forego: (a) skills development enhancement temporarily to participate in further therapy; (b) continued vocational rehabilitation counseling; and (c) job training, all of which will improve her quality of life. Jenna is searching for a better quality of life through job empowerment by seeking a career that will move her forward, provide potential growth, and equip her with skills to find sound employment:
I have moved through my recovery program for about seven months so I can start work as soon as possible to support my family. I prepared for work by attending Job Club at WVTS and learned job seeking skills such as interviewing skills and how to keep an interview short and simple. I also learned about web sites for job research and how to prepare a professional looking resume. I use that resume now to submit to prospective employers. (Jenna, personal communication, August 14, 2012)

Her aspiration at this juncture is to establish a career path in a position with promotional opportunities, allow her to advance, and not get channelled into a dead-end job. Jenna is prepared to use an entry level job as a stepping stone for forward momentum to acquire a vehicle, apartment, and possessions within the next six months to a year, significantly improving her quality of life.

**Transition to Community, Interpersonal Relationships, and Belonging**

Two participants shared thoughts on transitioning to the community, restoration of interpersonal relationships, and developing a sense of integration. In discussing thoughts on assimilating, Todd related that achieving success as a business owner will afford him the ability to return to the community where he can once again belong. He also revealed that he will soon be a father and that he recently began thinking about starting a business while continuing to work as a chauffeur:

I am working on this offer in compromise right now with the IRS and it’s going to take about six months. In that time I plan to do my basic research and determine all the things I need to formulate a business plan then come up with exactly what is needed for starting up and running this business. If it’s something possible then I’ll do it. If it is something that is not reachable right now then I might take something else. So within the next six months I’m going to start a job that would give me long term stability and growth, that I am qualified for, and would give me health and dental benefits. (Todd, personal communication, July 17, 2012)

Todd spoke about everything he hopes to attain and what he wants to accomplish. He is very conscientious about avoiding substance abuse again because of the impending birth of his child, his recent program achievements, and planning to start his own transportation company. He understands the business function well and operates a limousine, performing the duties of an owner/operator. First, Todd said he plans to “assess what is achievable for me based on my condition. What I can do and what I can’t” (personal communication, July 17, 2012). Next, Todd will evaluate his financial position and needs and stated that, “all those
things I take into account as far as what I am looking at for potential ideas but I think I just
don’t know what I want to do yet’” (personal communication, July 17, 2012). Todd has an
expectation of fear not wanting to rush ill-equipped into the unknown and making
inappropriate decisions.

Participant Robert articulated that although he attempted a role as a stay home father
it proved too socially isolating. He believes that it is important to support his family with
full-time employment and has recently considered an administrative career with a federal
government agency to provide them with economic stability:

When I wasn’t working I felt like I was losing a lot of skills. I felt that I had to
start over because eighteen, nineteen year old kids just coming out of high school
and learning by working retail jobs. Working at DoD I would have to relearn just
to keep up basic skills. I have some concerns about how I might confront issues
because of my condition, to handle issues on a routine business level. Will I be
able to keep the composure, be able to communicate with all different types of
personalities? What’s going to happen with that? It makes me a little scared. How
am I going to handle myself in tense situations? How am I going to react? I have
worries about that. What scares me is that I am going to say screw this job, screw
everything and take off, or I’m going to get into some kind of altercation. It is a
federal job and I don’t want to get into trouble. Just keeping my anger in control,
that’s going to be a job in itself. (Robert, personal communication, July 26, 2012)

Robert craves association with others in meaningful interpersonal relationships because, in
his view, people were not meant to sit around, they were meant to be a part of something
bigger than themselves. In his opinion it is a lot better to be a part of that relationship than
just staying home and spinning his wheels. Additionally, he believes that he was losing a lot
of acquired skills when he was not working. Robert will likely need more time before
seeking an employment with DoD.

Current Economic Concerns

Participant Seth was out of work for some time before entering treatment and it was
difficult for his family to make ends meet. He related concerns about the recent slow
economic recovery and his current unemployment status. He expressed apprehension about
his ability to find work after leaving WVTC:

I hope I can work. The economy has gotten better but when I got out of the
Marine Corps in 2008 it was good for about six months and then the economy
went down and I couldn’t find any jobs. I looked around and unfortunately it’s
been real tight ever since I’ve been out of the military, economy wise. The only
way I’ve gotten a job is by knowing somebody. Other than that I’ve put together
the best resume that I can and I'm trying to get a job that’s simple but is worth something. Having to start a job from scratch makes me wish I’d never left the military. I thought about staying in but at the time there were a few things going on in the military and I didn’t reenlist. I figured at the time the military is always going to be there, let’s see what else there is to do. Pretty quickly I changed my mind within a year. A lot of things happened in that time period and so I’m still going to try to get into a job and see what transpires after this program. (Seth, personal communication, August 2, 2012)

Seth is none the worse now but without a steady income he worried. Presently, his only concern is that there will be no work on program graduation or that he cannot find a job. For him one of the worst feelings in the world is being unemployed. Also, Seth is not a borrower and refuses to ask others for financial support because he dislikes imposing on others generosity or taking from someone else. Seth now is working in the local construction industry in commercial demolition, a previous occupation

**Societal Contributions**

Two participants shared thoughts on the importance of making significant contributions to society. After separation from military service, Richard, the first participant in this category, left his experience of serving with the Marine Corps behind. Mostly he has concerns about not having enough money to afford nice things or the ability to afford the bare essentials such as clothing, food, gas, ability to pay the car note, and insurance. Although he still struggles with traumatic warzone reminders he is committed to establishing a successful life and starting a family:

I want to be an upstanding citizen in society. I want to be a civilian. I don’t want either the laurels or mistakes of my past to define me anymore. I just want to be who I am right now, that’s all am concerned about. Also, I really want to start a family and I want to take care of things like bills, and I want to have one less thing that I am worried about which is when my anxiety bothers me. I want a chance at treating my PTSD through work. Maybe I can take my mind off of it. Maybe that might help me get more in the moment, to ease some of my anxiety, to relieve stress. But, at the same time maybe it might cause stress. Maybe I might get depressed because something happens at work or I get in an argument with a coworker or I don’t make a goal that I was supposed to make and it just really brings me down and it might bring me to drink. I might consider it. I might have a craving because of the stress at work. (Richard, personal communication, July 13, 2012)

Richard said that who he was in the past and who he will be in the future is unimportant because he just wants to be who he is presently. He has major concerns about
his PTSD-induced anxiety and how it will affect him in the workplace and whether he will relapse under strenuous conditions. By earning, keeping, caring for nice things with a family, and saving a little bit for the future Richard can establish normalcy as an upstanding contributor to society while enjoying a suitable quality of life.

**Rehabilitation Counseling, Education, and Career Preparation Strategies**

This section offers an observation of how participants approach choices associated with preparing to enter civilian life. All participants progressed through rehabilitation counseling to better address mental health concerns. Many chose to receive vocational counseling services to assist them with awareness and preparation to prioritize career readiness or commitment to educational goals. Decision-making is explored to show how the process may change bearing based on participants’ preferences or struggles. Some participants reveal how acquired skills developed into usable knowledge.

**Rehabilitation Support**

All participants shared opinions on how rehabilitation supports their work goals with two of them declaring that they are ready to return to work without any additional rehabilitation counseling. One participant conveyed that he required minimal formal rehabilitation because work facilitated his rehabilitation. Participant Danny verbalized his personal role in accepting rehabilitation efforts:

> I think I could use some more counseling for my mental health. I could definitely benefit from seeing a counselor-therapist at least monthly and I could definitely be taught how to be more focused and gain the confidence back that I used to have before the doubts brought on often because of my PTSD and my disabilities. I think I could definitely use some help. (Danny, personal communication, July 17, 2012)

Danny misses the camaraderie formerly enjoyed in the military and, speaking metaphorically, “believes he has a mountain to overcome” (personal communication, July 17, 2012). The presence of continued PTSD night tremor sleep disturbances and flashbacks continue to plague him with attention troubles, maintaining composure, and he believes behavior modification therapy may provide significant relief. Danny agrees that continued treatment is necessary “before I end up on the floor and have everything torn from me and think maybe it’s me and maybe I’m broken and maybe I’m not doing enough” (personal
communication, July 17, 2012). Although Danny continues to be troubled by self-doubt and the effects of multiple disabilities presently he is advancing steadily in the struggle to set reasonable expectations for himself to become the man he knows he is capable of being. He recently married and accepted a vocational counseling position in the Northwestern U.S.

**Personal Role in Rehabilitation**

At WVTS veterans are eligible to receive readjustment counseling to alleviate specific psychological symptoms and social readjustment problems. This counseling is specifically intended to assist veterans with transition back to civilian life. All of the participants have participated in this treatment as a phase of their recovery process. Some were concerned about participating not knowing how they would respond to treatment.

Participant Damon is eager to return to work with continued rehabilitation. Although reluctant to assign a specific timeline to the rehabilitation process, Damon is comfortable with a longer commitment to become equipped with the tools to achieve a leadership position on return to work. He is confident that treatment he receives will be the appropriate rehabilitation to accomplish his vocational goal:

> At this juncture I would say I need a lot of rehabilitation because nothing is going to get fixed in two weeks. As a military man I start setting goals for myself and with the right amount of rehabilitation, meaning that basically, every day for the next four to six months, yeah, let’s go test this stuff out, let’s see what I have learned, let’s see if I can apply it and I believe that I will be able to do that. It’s weird because it brings up a good thing. This is the biggest thing I’ve ever done in my life as far as really getting my stuff together and finding who I am. Here, I’m rehabilitating myself, I’m in a program now where it’s court ordered but it’s the best thing that’s ever happened to me. (Damon, personal communication, August 1, 2012)

Damon is optimistic that within a reasonably short time he will be equipped with his former military leadership skill sets and lead again or follow until placed in a leadership position. An employment criterion for hiring by a federal contractor is a DVA disability rating which Robert considers a stigma in the workplace resulting in ambivalence to continue with DVA rehabilitation counseling. He still harbors a negative attitude toward vocational rehabilitation based on his perception of being incorrectly evaluated by therapists during PTSD treatment. He estimates:

> I will need quite a bit more therapy. Combat therapy scratched the surface but obviously I need rehabilitation to just carry out a normal job. It’s kind of like
needing a lot of basic things to be rehabilitated like some things I can’t do anymore. My cognition is shot to hell. I wouldn’t be there if I didn’t have these issues and I wouldn’t have this job without a disability. If you want to look at it as some kind of spiritual quest, learn to overcome things, character building, I don’t know. (Robert, personal communication, July, 26, 2012)

Robert was a mortgage broker who within a short time lost everything as a result of PTSD triggers and depression. He acknowledges his symptoms require further rehabilitation for difficulty performing normal day-to-day functions.

All participants voiced their interest in post-secondary schooling utilizing Post 9/11 GI Bill benefits to enroll in academic programs culminating in graduation with a college degree. Coupled with pre- or post-military acquired skill sets or military training each of them plans to accomplish career preparation and development goals as an outcome of their recovery program guidance. The participants recognize that some of their plans are ambitious and to accomplish them will require determination and commitment. The education/career preparation associations among the participants at time of interview were (a) two working and attending college, (b) one working with some college, (c) three not working with some college (d) one working with college aspirations, and (e) three not working with college aspirations. Their plans are ambitious and to accomplish them will require determination and commitment.

**Prioritizing and Focusing on Work and School**

Several participants were able to strike a balance between the demands of work and school. In the first example, Richard entered a vocational training program that recognized his military acquired skills:

There was a time when I first got out of the Navy I was very picky and I told myself I wasn’t going to flip burgers or do anything like that or make sandwiches. I couldn’t get a job at Jack-in-the-Box because of whatever, the background checks and stuff, because of the decisions that I made when I got back from Iraq. I couldn’t find a job making sandwiches until about maybe a year later when I finally got one making sandwiches because they didn’t really care about my past. For the job that I’m doing now I went to school and I still have a couple more certifications to get in the Information Technology field. (Richard, personal communication, July 13, 2012)

Richard continues with course work to obtain additional valuable IT certifications to help advance his career. He believes being hired into his current position was based on his ability to navigate a certain computer program and diagnostic problem solving skills. Richard
is learning more on the job about servers, active directory, configuring machines, security, and other facets of the IT field.

In the next example Martin, who formerly tended to emergency room hospital patients and provided hospice care, found another position that better suits his thorough commitment to the rehabilitation process:

I was a medic that was my set path and that’s what I was determined to pursue. It was in the military that I discovered the satisfaction that I had in health care, but now apparently health care subconsciously has been a trigger to PTSD keeping me in that frame of mind. I switched from health care which I was pursing in nursing school since I got out of the Army to environmental science. I literally felt loss of identity and could not enjoy the things that I’d always loved. It caused a lot of anger in me because I felt like this anxiety, this demon that had taken me over had literally robbed me of my soul, of a lot that I loved, of my goals, my passions, of the lifestyle that I’d always enjoyed. I now have the basic goal of helping people but in this case I’m taking care of people on more of a global level or a mental level rather than such a personal level. (Martin, personal communication, July 26, 2012)

Martin no longer works traumatic emergency cases or hospice care; rather, he seeks less stressful work because of ongoing rehabilitating and job pursuit in environmental science. Also, he attends community college majoring in biology which he admits is enjoyable because of the similarity to previous nursing school studies. Martin redirected his passion for health studies into a career goal of employment in water quality control with a water conservancy. He anticipates an entry level internship position in the water quality field possibly within a year.

**Decision Making Difficulty**

Existing within the participant group are five combinations of individual work/school scenarios indicating that each participant has given thought to linking a college education with a career endeavor. One participant expressed uncertainty about his stalled career planning effort. Because of self-imposed inability to engage in the decision making process he questions the difficulty of choosing a vocation over first attending college while working part-time. In this example, Danny desires to someday complete his college education on a part-time basis while working full-time but struggles with the decision making process:

I have some higher education but not enough to get all of my requirements for a degree. I’ve done some college that I would need to transfer to a four university to even get a bachelor’s degree at this point. I still have the GI bill and I haven’t
used it yet. I only stopped going to school because of the priority of family. I had to go and take care of my family for a while. I had to quit school and return to another state because my grandfather had some health issues. Maybe I’ll go back and get a degree for forestry. I could get a master’s degree in forest management and work making upwards of seventy-five thousand to one hundred thousand a year doing that. (Danny, personal communication, July 17, 2012)

Danny is aware of the commitment required to obtain his educational goal and is willing to plan for that eventuality. He is realistic about his career objectives as well and at the same time has trouble focusing in one area because of his competitive nature. He is at an age where a career is appealing however, and wants to make the right move to not be left behind. At this juncture he plans to start anew, resolve the self-imposed pressure, and postpone enrollment in a college forestry program until attaining an acceptable comfort level with his new job.

**Developing Knowledge Through Skills**

In this area, participants conveyed thoughts on the importance of making an individual contribution to developing knowledge through building on the skills they acquired during their military service and continually developing vocational skills and competencies. Two participants expressed their commitment to attend short-term training courses to improve their likelihood of employment. Participant Kim has a long-term goal of obtaining a bachelor degree in business to work in the human resources field. Kim admits that, “Unfortunately I have no other actual training besides what I did in the military” (personal communication, August, 10, 2012). Kim received military training focused on IT repair and help desk duties on which she aspires to expand with a post-military certificate generating training course. She acknowledges that attending college may be years away and instead proposed a short-term goal to employment by choosing the IT path she began in the military and earning qualifications in that field. Kim was recently approved for supportive funding to attend an on-line Microsoft IT repair certification training course.

Participant Jenna aspires to obtain a four-year college degree and is presently studying at a community college and seeking employment while completing course work. She hopes to find a job in the administrative field and anticipates the possibly of obtaining a position at a local firm. She stated, “I have a background in pre- and post-military acquired administrative skills. I have clerical skills and maybe I can get something office based” (Kim,
personal communication, August 14, 2012). Jenna is goal oriented and also acknowledges that a short-term, certificate bearing professional administrative course is a beneficial alternative for entering employment. To date, Jenna continues to attend community college and conducts job search for an administrative position when time allows. She plans on long-term pursuit of a degree in comparative literature with a concentration in Latin American studies. Ultimately, her career goal is to teach English as a second language and writing course in a foreign country.
CHAPTER 5

DISCUSSION

Several findings from the present study were consistent with outcomes from previous research in the literature on Gulf War-era II veterans with PTSD. Specifically, the study focused on identifying (a) the factors associated with work adjustment and work integration challenges, (b) assimilating into civilian life, and (c) the factors associated with the extent to which the rehabilitation needs of the study participants were met. Additionally, the study concentrated on veterans’ ability to candidly inform on their lived experiences regarding work adjustment, work integration, and career development difficulties confronted when entering or reentering the workforce. Areas discussed in this chapter are (a) adaptation of Hershenson’s work adjustment model to this study, (b) relationship to previous research, (c) findings of the present study, (d) rehabilitation counseling implications, (e) study limitations, and (f) implications for future research.

ADAPTATION OF HERSHENSON’S WORK ADJUSTMENT MODEL TO THIS STUDY

As stated, the present study relied on Hershenson’s (1996, p. 442) model of work adjustment as a theoretical foundation. In their investigation of mid-career onset TBI effects on work adjustment, Power and Hershenson (2003, p. 1021) discerned that rather than a continuous liner process, work adjustment becomes that of a work readjustment and planning process. They also found that this model provides the framework for utilizing a structured study on the specific topics of work adjustment and work integration. The method for investigating the post-traumatic similarities common in Power and Hershenson’s study group was established as an appropriate vehicle for investigating the present study cohort. As described in Chapter 2, Hershenson’s (1996, p. 443) model embraces teamwork among multiple elements in the vocational subsystems. The subsystems include (a) the organizational culture and behavioral expectations, (b) job demands and skill requirements, and (c) rewards and opportunities to the worker. Because of the interrelated components in the work adjustment model it is possible for chance encounters of the domains to interact
with components of the work setting, which can influence any of the work adjustment components. Power and Hershenson (2003, p. 1022) identified the product of the interaction among these domains with the work environment as work adjustment, consisting of work role component, task performance, and work satisfaction elements.

**Relationship to Previous Research**

When the study participants returned home from OEF/OIF warzones with PTSD they were met with myriad existing programs and services to improve communications, mitigate distress, and resolve crises during post-deployment reentry and reintegration into society. For these veterans personal characteristics relating to post-deployment behavioral concerns, interpersonal, family, societal, work adjustment, and integration are viewed in the context of their relationships to previous research. The present study findings are consistent with previous research with regard to (a) post-deployment behavioral adjustment, (b) social and interpersonal functioning, (c) marriage and family relationships, and (d) positive employment outcomes.

**Post-deployment Adjustment Challenges**

Findings in the literature have established that a rising number of veterans reintegrating into society with PTSD are exhibiting unconstructive behaviors. Before entering the WVTC all of the study participants were exposed to extremely dangerous conditions while assigned to warzone duties enduring strong physical and emotional trauma reactions causing questionable behaviors. Some experienced prolonged, repeated stressors during multiple deployments and increasingly adverse behaviors after military separation. This study confirmed that all of the participants were substance abusers prior to entering treatment and these post-deployment behaviors shifted in the civilian community resulting in many experiencing negative adjustment consequences due to their harmful actions. One explanation for their risky behavior advanced in a study by Creamer and Forbes (2004) suggested that during deployment individuals may question underlying beliefs about self, others, and the world. Available therapeutic techniques are designed to assist with cognitive restructuring of PTSD in individuals that are identifying and challenging these dysfunctional thoughts and beliefs strengthened by a traumatic experience. Williams and Poijula (2012, p. 197) conveyed that in this type of trauma it is critical for the individual to construct meaning
from the changes caused in the basic psychological need for trust. Sadly, there may be no strategy to ameliorate this need since the individual may believe in a foreshortened future, a benchmark symptom associated with PTSD. In their review of studies examining post-deployment adjustment challenges for OEF and OIF veterans Bush, Bosmajian, Fairall, McCann, and Ciulla (2011, p. 455) found a growing population of warzone returnees with behavioral health and psychological concerns. These individuals, many of whom are at risk for a variety of behavioral disorders, offer new and unfamiliar challenges to psychologists and health professionals. The foremost concerns of these returnees are with PTSD, homelessness, anxiety, depression, substance abuse, and retrieving an acceptable quality of life.

During the study interviews, participants described how PTSD and environmental factors became the causal attributions of instability and uncertainty in their lives and the lives of loved ones eventually resulting in vocational stagnation. They revealed that years of coping inability led to: (a) problems with transitioning to life after leaving the military; (b) vocational stagnation; (c) substance abuse; (d) homelessness, stressful, and anger laden situations; (e) failure to address unresolved, embedded psychological difficulties intensified by avoidance and emotional numbing symptoms; and (f) vulnerabilities to socioeconomic barriers, and other difficulties. The primary means participants coped with PTSD-related depression and anxiety was an abuse of drugs and alcohol. This behavior disrupted family relationships resulting in law enforcement confrontations and in some instances court convictions leading to confinement. Some of the participants had negative outcomes due to (a) the causal relationships with substance use disorders, (b) settling for a more sedentary lifestyle to a previously active military one, and (c) poorer health. In the present study, participants largely displayed a broad sense of anger, caution, and general annoyance. According to Hruska et al. (2011) researchers theorized that individuals with PTSD abuse substances to relieve or self-medicate psychological distress caused by trauma symptoms.

**Interpersonal Functioning and Social Adjustment**

The present study findings are consistent with prior research on military connected PTSD with regard to interpersonal, physical, social, and financial functioning and social adjustment. (Amaya-Jackson et al. 1999; Marmar 2009). The quality of life for these veterans
is also diminished due to their limitations provoked by multiple medical conditions that lead to risk factors for a significantly worse quality of life (Gates et al. 2012). A DVA study found that Gulf War-era II veterans using the DVA healthcare system from April 2002 to March 2008 for the first time were diagnosed with a minimum of one and sometimes two diagnoses of PTSD, depression, and substance use disorders (Marmar, 2009).

Mental and physical symptom characteristics signify difficulties in the overall adjustment process for many veterans, their partners, families, friends, and employers. The impact on social relationships is difficult to comprehend by those struggling to understand the significance of war on veterans’ mettle and the very distinct conditions it generates for stimulating the progression of posttraumatic psychological difficulties (Finley et al., 2012; Schnurr et al., 2009).

**Relationship and Family Adjustment**

Previous research on post-deployment adjustment is consistent with the present study findings with regard to relationship issues and coping strategies. Khaylis et al. (2011) found that the focus on post-deployment family reintegration is to provide family based intervention approaches for veterans and their families to decrease discord in family relationships, intimacy challenges, and negative parenting styles. For this process to be successful veteran willingness to participate in family-based interventions is a priority and has been known to be more desirable for veteran reintegration than individual therapy. The literature also supported data collected from participants relating to their strained relationship adjustment concerns. Many times couples have anxiety about PTSD significance in the wake of distressful discernible life domain (i.e., interpersonal and family relationship) encounters resulting in therapeutic interventions (Marmar 2009; Meis, Barry, Kehle, Erbes, & Polusny 2010).

Calhoun et al. (2007) declared that a large segment of the U.S. population consists of active and retired military veterans. For this population deployment to an active warzone sometimes adversely affected their lives and the lives of their families upon their return. Also, a number of returning veterans engaged in unsafe or hazardous activities in general, further distancing family members. Findings in the literature by Solomon et al. (2008) confirmed present study results that traumatized veterans often must negotiate their ability to
trust, share, and be close to another and also negatively impacts on spousal support, marital quality, and relationship satisfaction.

Consistent with the present study findings, contemporary research identified relationship adjustment difficulties of OEF/OIF veterans with PTSD and recurring problems in an array of relationship domains. These include relationship challenges due to confidence barriers, positive bonding obstacles, stalled commitment, unstable relationships, poor communication, diminished intimacy, sexual dysfunction, intimate relationship violence, and expressions of anger and aggression toward spouses and children (Cameron et al., 2011; Erbes et al. 2011).

Contrasting with the detrimental reintegration experiences of some veterans and spouses the literature reflects that many relationships and families offer strong, flexible, and supportive roles to returning veterans. As noted in Chapter 4, there were several instances where families of participants made a positive contribution to their well-being and recovery. Positive family support results in (a) better functioning, (b) a more tolerable adjustment and reintegration process with loved ones, and (c) a higher level of functioning. In the role of determining treatment outcomes for veterans, Charuvastra and Cloitre (2008) found that (a) positive family environments help mitigate negative PTSD symptom change during treatment, (b) change during treatment has a positive or negative family influence, and (c) the impact of PTSD symptoms on family functioning levels disrupts the veteran’s ability to benefit from treatment. Benotsch et al. (2000) determined that subsequent PTSD resulted in a negative family relationship suggesting likelihood of subsequent PTSD symptoms when variance within early levels of emotional distress and avoidance was controlled statistically.

Reunification can be joyful or last up to several years and become wearisome for families (Figley, 1993; Matsakis, 2007). Additional research conducted by Erbes et al. (2011) explored couple and family functioning matters grouped with trauma specific PTSD avoidance symptoms and general avoidance symptoms, most importantly identified as emotional numbing, including avoidance of interpersonal relationships, and sense of imminent demise. In the present study, the participants demonstrated symptoms of emotional numbing and avoidance of interpersonal relationships is consistent with reviewed literature. Both male and female participants exhibited behaviors indicative of their psychological trauma, withdrawal, and avoidance during the initial interviews and in their subsequent
individual recovery programs. Research suggests that these maladaptive coping responses negatively influence spouses.

The findings reported by Galovski and Lyons (2004) suggested the primary contributing factor in decreased spousal psychological wellbeing is the veterans’ PTSD untrained coping skills. Their research acknowledged two components of PTSD symptoms most challenging for families are a veteran’s visibly angry demeanor, and emotional numbing and interpersonal withdrawal. Galovski and Lyons also found several studies in the literature review that provided extensive analyses of the direct impact caused by psychological trauma experiences identified as “secondary traumatization.” This term refers to the occurrence of conditions affecting indirect victims (i.e., spouses and children) who might become traumatized living with victims of violent trauma. Secondary traumatization of participants’ family members became very apparent during the interviews and many of the participants behaviors are reflective of the literature reviewed for this study. As noted in Chapter 4, there were several instances that participant responses to PTSD resulted in strained and sometimes fractured relationships due to the negative impacts on participants’ families.

A review of the literature by Pietrzak et al. (2009) maintained that some social support combined with positive psychological resilience characteristics and hardiness may enable an individual to defend against the development of psychopathology. Schnurr et al. (2009) and Kennedy et al. (2010) concluded that positive characteristics of psychological resilience influence social and mental wellbeing and readjustment to civilian life. In particular several participants demonstrated qualities that were found consistent with the literature with regard to developing characteristics of psychological resilience. As discussed in Chapter 4, through positive social support and interactions with program participants several participants made positive adjustments within their environment.

**Employment Adjustment Challenges**

Many of the participants in the present study were idled after military separation and faced difficulties integrating back into the workforce based on personal attributes and situational factors. Some of them labored in demanding occupations and experienced difficulty with job conditions and employer bias. The participants made a conscious effort to
work toward goal attainment through perseverance and successful integration into society with work adjustment. Although not all of the study participants became employed there is future promise for them through successful training completion, continued rehabilitation, and pharmacotherapy. Discussions in the literature have elevated PTSD to the forefront of public attention as the most prolific silent wound of the wars in Iraq and Afghanistan. In a recent epidemiological study Wald and Taylor (2009) found that PTSD occupies a position in the top 10 physical and mental disorders correlated with work loss days. They also discovered a direct relationship between individuals identified with chronic PTSD with work related measures and difficulty maintaining interpersonal relationships.

Savickas (1994) posited that irrespective of their socioeconomic status, potential workers can exploit occasions in their work for both self-expression and being meaningful to their community. Yet, some individuals ignore the more prestigious work options and settle for the only available job that is sometimes beyond the human spirit and humbles them with tasks that are difficult, tedious, and exhausting. Regardless, their work can be significant to them and their community and useful to establish (a) meaning-making of their work, (b) contribute to learning improved means to implement their self-concepts, and (c) advance their newly found work identity to achieve success over painful pasts and social barriers to career adaptation.

Findings that work adjustment is imperative for veterans with PTSD for successful return to work were confirmed by Flinn et al. (2005). Their study was similar to the present study since it utilized a comparable sized participant group and relied on outcomes of work adjustment, work integration, and the notion of living independently through achieving self-sufficiency. Because of the likelihood that most individuals desire to participate in performance-based activities on the strength of individual skills, abilities, and interests they are more apt to enter competitive employment situations. Based on various personal attributes experience obtaining, maintaining, and retaining employment suggests involvement in individual vocational training programs to encourage work participation. Worth as a worker is a primary means of achieving a positive quality of life and can be supported by assisting the individual secure a real work situation. For this reason Flinn, Ventura, and Bonder stated that it appears providing meaningful group and individual activities during
occupational therapy can play a vital role which can (a) provide significant work adjustment, and (b) facilitate prospective worker participation.

Many of the participants related that they experienced diminished memory functions with regularity. During data gathering interviews some participants lost their train of thought or forgot the question mid-sentence, admitting to poor memory function. Consistent with the present study findings, Geuze et al. (2009) noted that current occupational and social functioning is a direct product of objective memory performance. They also found that a deficit in recall may establish impaired performance patterns indicative of frontal lobe dysfunction in PTSD correlating with a disabling condition and substantial loss of quality of life. Ryan and Deci (2000) differentiated self-motivated individuals from those who are externally regulated for a specific action, heightening vitality, self-esteem, and general well-being. This is so even when individuals maintain a similar level of perceived competence or self-efficacy for the activity.

**Work Adjustment Significance, Fulfillment, and Success**

Findings from numerous studies on the importance of vocational adjustment and participation are consistent with the present study results. In many instances, participants conveyed how vocational participation and fulfillment were central to realizing positive vocational identity, work adjustment, and overall positive quality of life. Participants were likewise able to convey how a lack of these qualities resulted in a variety of negative outcomes.

Geuze et al. (2009) and Lunney and Schnurr (2007) reviewed several studies that reported the quality of life in persons with PTSD is significantly impaired and concluded that quality of life after PTSD treatment improves. In their study Flinn et al. (2005) recognized individual differences within skill sets, interests, and motivations that sometimes function as work challenges. They also reported that physical and psychological conditions prevent many veterans from working. These circumstances tend to diminish veterans’ inclusion in the workforce, the community, and ultimately influence their limited participation in society, thereby attaining a suitable quality of life. Furthermore, Geuze et al. (2009) reported that loss of social and occupational functioning are linked to impaired quality of life for veterans with PTSD and are liable for the enormous costs to society for the disorder.
Blustein, (2006) acknowledged that the function of working is to assist people establish an identity and become unified in their social interactions. By establishing worth as a worker the individual creates a vehicle by which to achieve a positive quality of life and is realized when the individual secures a real work situation. Blustein also maintained that working provides society with an enhanced socioeconomic wellbeing through its efforts, activities, and expenditure of human energy in specified tasks. Joiner and Sawyer (1992) observed that individuals with PTSD typically receive work adjustment services while approaching reintegration into life and work in a relearning mode. Work adjustment significance for Gulf War-era II veterans with PTSD must recognize that (a) many young veterans may never have worked outside military service and are initial entrants to the workforce, and (b) older veterans may desire occupational transition as they reenter the workforce.

**Findings of the Present Study**

The decision to use the Hershenson’s (1966) model to undergrid the present study was to explore how this population viewed their ability to accomplish the work adjustment process with the probability of securing employment through work integration. Consistent with the model, the present study found that vocational rehabilitation was vital to reestablishing personal, family and social development, and overall quality of life. During interviews previously reported in Chapter 4, participants disclosed perceptions, thoughts, and beliefs about finding meaningful employment and answered questions on how they resumed their lives through post-military work integration. The notion that meaningful answers to these questions would be forthcoming during the exploratory phase was not immediate and only began to coalesce after the transcriptions were analyzed for content. Relative to the stated study questions, interestingly, many perceptions and experiences of the participants indicated that they all value the same core concepts inherent within their rehabilitative and recovery process with an understanding that (a) education and career preparation are indispensable components of self-worth, (b) work identity is paramount to self-esteem, and (c) the concept defining their independence and work identity is self-determination. The intrapsychic domains of (a) work personality, (b) work competency, and (c) work goals,
along with work identity discussed by Hershenson (1996), were found to apply to participants in the present study following qualitative analysis of their responses.

**Interactive Theme Analysis**

Throughout the coding process 455 codes were assigned to the narratives at which point saturation occurred as all important data was gathered. I investigated each of the saturated categories to determine if any additional information was available to gather, permitting concurrent data collection and analysis to occur as themes informed each other. Thus, emergent findings informed the observable data and evolving theories were not defined by extant literature. This procedure allowed for a trustworthy evaluation of the written data which I assessed and that confirmed my assumptions of transcript interpretations. It also facilitated the need for new data as additional themes emerged offering more thoughtful and explicit information. An important aspect of grounded theory is perfecting the analysis during the process to achieve a more truthful data finding (Glaser & Strauss, 1967). The overall goal to focus the data contained in the themes was to more accurately understand the perceptions, thoughts, and beliefs of the study participants. This analysis lead to the emergent theory that Gulf War-era II veterans with PTSD are fully capable, after appropriate therapeutic intervention and work adjustment, to attain self-sufficiency through integration into the workforce.

The emergent themes addressed in the present study provided an extensive look at many enduring concerns confronting veterans with PTSD. The sub-themes attempted to give deeper meaning to the veterans’ challenges adapting to conventional society after warzone duty. Professional rehabilitation counselors have achieved moderate success treating the veterans’ community. Yet, a positive influence on PTSD counseling and treatment will require a deeper understanding of the importance of veterans’ interpersonal impediments, marital problems, family relationship, and psychosocial challenges as revealed in the previously discussed sub-themes

**Achieving Successful Outcomes**

Currently, there is a heightened awareness of veterans’ issues in this country that demands consideration at every level of government and society as a whole. Attention needs to focus on meaningful interventions and work integration strategies to address the plight of
our nation’s veterans during their lengthy civilian reentry process. After more than 10 continuous years of war, veterans continue to separate from their military obligations and join the ranks of those who came before them in the discouraging struggle to gain self-sufficiency. Correlated with this scenario is the doubt voiced by employers about veterans’ mental stability, determination, and readiness for workforce connectivity. Attempts to employ veterans with PTSD in the civilian work environment continue to achieve sluggish results. Although improved hiring efforts for this population have been developed, placed in motion by experts, and received accolades more meaningful proposals for improvements of veterans’ mental health challenges prior to job acquisition are imperative.

Many of the study participants pursued with great self-awareness and determination their individual vocational goals. They encountered many challenges along their paths to recovery and adjustment with the awareness they would eventually accomplished job-readiness. During their journeys through the work adjustment process they learned about themselves, their values, and their desires to live independently through attainment of self-sufficiency in prospective occupational roles. Many self-starters emerged from WVTS with action plans to obtain jobs in several diverse occupational domains armed with the knowledge and determination to provide family support to loved ones. They participated in counseling and were diligent in learning about the occupational roles that would draw from a combination of their civilian and military acquired skills and experience. Engaging in supportive collaborative relationships proved successful for most resulting in encouraging, developing, and accepting new perspectives on their post-military work role involvement.

The process by which the study participants achieved successful outcomes is portrayed in the themes that emerged following data analysis. The findings suggest that veterans with PTSD are receptive to work adjustment strategies with the proper rehabilitation and support services. They advanced through work adjustment to work integration as a result of their full cooperation and participation in the WVTS residential integrative treatment program. From initial program entry participants received psychological services and therapeutic treatment for various addictions and personal challenges including post-traumatic reactions, homelessness, unemployment, and mental concerns.
During their WVTS treatment and recovery six participants sought and obtained employment and two are not currently working because one needed therapy for physical conditions and the other for and psychosocial reasons. Successful compliance with vocational services combines to equip the individual with the ingredients to achieve successful work integration and restoration of work identity. Completing this process allowed participants to achieve independence through self-sufficiency. The results shown in Table 6 indicated that six of the 10 participants became employed in full-time positions while four participants did not become employed for various reasons, two of which relate to participants significant disabilities that currently prevent them from working, one who withdrew from the program and another who chose to remain in treatment to complete her 12-step program while completing IT employment preparation courses.

Generally, vocational services are not available to individuals until they have pursued therapeutic and rehabilitation services for approximately five months during which time they receive continuing work adjustment. By this period in therapy and rehabilitation participants become motivated to not only leave the treatment center but to become employed during the process. Ryan and Deci (2000) suggested individuals experienced different levels of motivation to engage in productive work behaviors depending on different factors including (a) being deliberately influenced, (b) acting compulsively to attain a permanent interest or inducement, and (c) initiating habitual behavior to excel or from fear of being scrutinized. Contrasts between internal motivations and external demands are not uncommon scenarios. The question of whether one acknowledges specific behavior based on “interests and values, or for reasons external to the self is a matter of significance and represents a basic dimension by which people make sense of their own and others behavior” (Ryan & Deci 2000, p. 69).

When individuals entered WVTS they acknowledged making sense of their current behaviors that have transformed during treatment. During this time participants began understanding the consequences military separation had on their job loss and the devastating circumstances that followed without the prospect of work. They continued to experience what Power and Hershenson (2003, p. 1022) identified as “significant deficits in numerous work-related skills…. [and] reduced powers of concentration and emotional problems due to stress reactions” (2003, p. 1022). Even though participants pursued behavioral modification
Table 6. Participant Employment Outcomes

<table>
<thead>
<tr>
<th>Participant</th>
<th>Employment Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Kim</td>
<td>Continuing in treatment; enrolled in online IT course</td>
</tr>
<tr>
<td>2. Jenna</td>
<td>Withdrew from treatment; part-time student</td>
</tr>
<tr>
<td>3. Richard</td>
<td>Full-time IT associate; part-time IT student</td>
</tr>
<tr>
<td>4. Todd</td>
<td>Full-time chauffer</td>
</tr>
<tr>
<td>5. Danny</td>
<td>Full-time Veteran Outreach Coordinator</td>
</tr>
<tr>
<td>6. Scott</td>
<td>Physical disabilities prevent employment</td>
</tr>
<tr>
<td>7. Martin</td>
<td>Full-time care giver; part-time water treatment student</td>
</tr>
<tr>
<td>8. Robert</td>
<td>Psychosocial barriers prevent employment</td>
</tr>
<tr>
<td>9. Damon</td>
<td>Full-time military materiel consultant</td>
</tr>
<tr>
<td>10. Seth</td>
<td>Full-time construction demolition specialist</td>
</tr>
</tbody>
</table>

and adapted to work adjustment with an additional month of immersion they completed assignments designed to provide information gathering skills and readiness training to learn job application formatting, resume development, and job interviewing skills. By this time participants were established in a mixture including environment and subsystems or domain stages previously labeled as: (a) work personality, where individuals self-concept as a worker, initiative toward motivation, and associated work needs and values develop; (b) work competency, involving “work habits, physical and mental skills applicable in work, and interpersonal skills applicable in the work setting;” and (c) work goals, where the process of development lies with peer or reference group influences (Hershenson, 1996, p. 1022).

Rehabilitation Counseling Implications

Today, veterans of all eras continue to struggle with psychological and vocational rehabilitation counseling challenges. With the war in Iraq terminated and the Afghanistan war drawing to a close, increasing numbers of veterans are being separated from the military and seeking supportive services for civilian employment. Additionally, critical demand exists
for knowledgeable, competent, rehabilitation counselors to assist these veterans with job placement and return to work prior to occurrence of substantial social, emotional, and vocational maladjustment. Offering support and assistance to recently separated veterans facing employment dilemmas, rehabilitation counselors need to be a primary source of education and information for employment guidance.

The significance of this study to rehabilitation counseling is relevant because it provides (a) beneficial information on the acute need for early assessment intervention for determining the potential among veterans with PTSD, (b) a stronger PTSD awareness commitment, (c) assistance with achieving meaningful career adjustment and development, and (d) providing efficacious return to work strategies. Rehabilitation counselors may also find a variety of methods to develop and implement innovative and effective post-deployment therapeutic counseling interventions for veterans to attain a positive quality of life after traumatic and stressful warzone deployment. Within their environment this may be accomplished by referral to emergency service providers, hospitals, private and public counseling agencies, and veteran outreach or assistance organizations. Often times, with their collective knowledge of employment dilemmas facing the recently separated veteran these counselors should be recognized as leading sources of guidance for veterans to achieve successful reintegration to civilian life.

In all practicality it is incumbent on rehabilitation counselors to know how to recognize an individual in stress and when, where, and how to recognize veterans experiencing cognitive interruptions that require a referral to accomplish an intervention. One method is involvement in professional continuing education courses to obtain in-depth understanding and appreciation for various treatment programs available for Gulf War-era II veterans with PTSD in crisis. Jackley suggested, for example “cognitive-behavioral techniques can be used to supplement self-awareness and interpersonal work in therapy” (2001, p. 180).

Marmar noted that many advances in evidenced-based trauma-focused psychotherapies are now supported empirically as effective treatments for military and civilian PTSD (2009, p. 496). Cognitive behavior therapy (CBT) has been found to be the most recognized evidence-based trauma treatment offered through the DVA. The DVA provides two types of CBT, both noted for early treatment success in veterans with PTSD. 
These therapies include (a) the manualized Cognitive Processing Therapy (CPT) intervention version found by Monson et al. (2006) to support reliable change in PTSD symptoms during continued use of the CPT treatment, and (b) Prolonged Exposure (PE), a therapy found by Nacasch et al., (2007, p. 691) as a viable treatment for veterans with combat-related chronic PTSD. In addition to these treatments group therapy is also available for veterans with PTSD to discuss their traumas and process painful memories.

Although these treatment modalities take time and sometimes require more than one treatment cycle each has its own benefits for assisting veterans with PTSD discover a variety of coping skills and return to work outcomes. Immediate steps needed to effectively support Gulf War-era II veterans with PTSD are (a) hiring trained rehabilitation counselors with knowledge of effective PTSD treatment and vocational rehabilitation approaches, and (b) to further motivate rehabilitation counselors to engage in continuing education. Gaining this type of skill and knowledge will enhance rehabilitation counselors’ abilities to facilitate the type of adjustment conceptualized in the Hershenson model. A critical demand exists for knowledgeable, competent rehabilitation counselors to assist these veterans with job placement and back to work programs prior to occurrence of substantial social maladjustment. The proactive rehabilitation counselor will recognize that to make a difference in the quality of life for a veteran with PTSD the commitment requires (a) time for these veterans to equip themselves with tools to surmount certain job-related challenges, (b) special emphasis on counseling in job related and academic skills, and (c) preparation to enter the competitive workforce. Although, as Hershenson and Langbauer (1973) explained, discernible patterns of emotional maturity are found in persons at different levels of vocational development which influences their ability to respond similarly when participating in planned guidance and individual counseling (p. 519).

Barrett and Tinsley argued that career counseling assumes the role of fostering the clients’ self-awareness in relation to the possibilities of various occupational roles (1977, p. 306). To accomplish this goal they suggest that counseling professionals encourage clients toward introspection and an awareness of one’s self-concept in vocational decision making. The counselor therefore allows clients to discover individual vocational interests, abilities, values, and needs in the pursuit of understanding characteristics of different occupational roles. Additionally, Hershenson recommended that counseling professionals focus on the
connection involving the person and the environment of their work setting (1996, p. 443).
The counselor/client partnership also must withstand the effects of (a) prevailing approaches

to living, (b) learning, (c) socialization within this association, and (d) the effects of the
cultural and economic context on all the constituent elements.

The following recommendations for the field of rehabilitation counseling, though not

a complete inventory, are considered essential for achieving successful PTSD treatment for

veterans, career counseling, and entry level employment outcomes: (a) seek support from the

DVA, the recognized agency leader in research, evaluation, diagnosis, and treatment

available to determine PTSD symptom identification approaches; (b) provide a holistic

treatment plan to understanding veterans and their families needs, interests, and personalities
to create treatments to connect them to real-life environments; (c) specialize in cognitive
disabilities counseling to gain a focus on discernible PTSD behaviors; (d) prepare veterans’
for the effects of PTSD symptom diagnosis on employability; (e) become familiar with

military culture, self-stigma, and shame based conduct; (f) develop sensitivity to veterans’

emotional excess and the knowledge to assist them channel their emotions (i.e., anger
management, conflict resolution, communication and relationship issues); and (g) provide

supportive services within employment programs based on needs (i.e., job accommodations,
specialized training programs, and supported employment. This commitment by

rehabilitation counselors will help to enable veterans build confidence and instill a deeper

sense of community belonging not just for those who withhold feelings of rejection and
disdain for their actions while serving in uniform, but also for the veterans who are living

with undiagnosed PTSD.

LIMITATIONS

The study has several important limitations. The focus illustrates the specific context

of a small non-randomized convenience sample comprised of veterans with PTSD residing in

a substance abuse rehabilitation facility in a limited geographical area. Participants were also

mostly male and White. To provide a more representative examination, future studies should
reflect gender, ethnic, and other demographic characteristics reflective of the population of

post-combat PTSD. Also, because the sample is fairly circumscribed it is not assumed to
generalize to a broader veteran population with PTSD in rehabilitation facilities throughout
the southwestern states specifically, or the U.S. in general. This study also generalizes to the narrowly delineated category of Gulf War-era II veterans’ that: (a) functioned in a combat, combat support, or combat service support role in Afghanistan or Iraq; (b) separated from military service a minimum of one year prior this study; and (c) sustained PTSD as the result of warzone trauma stressors. Hence, findings do not generalize to veterans with disabilities other than PTSD who served in other theaters of operation, separated from military service less than one year ago.

Another limitation was my presence during data gathering. Some of the participants were reserved with their answers and gave abrupt or brief answers to the questions. Even after giving them an opportunity to explain or reword an answer or coaxing several of them with prompts of, “What was that like for you?,” “Do you have anything else to add?,” and “Can you tell me more about that?,” some of the participants answered with “No,” to several of the question prompts. Also, during the interviews a barrier to in-depth answers was the presence of the voice recording device positioned on the interview table. To some of the participants the recording device evoked an uncomfortable atmosphere in the interview room and may have been a disadvantage to the quality and quantity of answers. Relative to gender responses I noted that the two female participants spoke at length about the status of their children and the importance of providing for shelter, clothing, and an acceptable quality of life for them. This was in contrast to the male participants who overall offered little insight on their family relationships and for those with children very guarded information was revealed.

The most challenging aspect of conducting research for the present study centered on staying focused on the participants’ behaviors during the interview process. Many were very casual about keeping interview appointments and rescheduled appointments were sometimes completed only after scheduling a second or third interview. Some of the interviews were conducted at times when other meetings were taking place in adjoining rooms and, although private, the noise levels in those rooms became overwhelming at times making it difficult for participants to follow their train of thought. Mostly I felt disappointed when some participants offered very sparse, short, repetitive, and not well thought out data and chose not to fully expand on their answers.
IMPLICATIONS FOR FURTHER RESEARCH

In a description of early work adjustment development Sawyer (1992, p. 102) explained that during the 1960s adjustment services transitioned to the status of an identifiable service or service product. The status of adjustment services developed rapidly after state vocational rehabilitation agencies recognized work adjustment as a legitimate service in the rehabilitation process. From the modest beginning of work adjustment services rehabilitation professionals have undergone distinct challenges providing adjustment information and education to help seekers. With increasing numbers of veterans separating from military service, many with PTSD symptoms pursuing community integration will elect to enroll in vocational and educational training through a variety of federal, state, and local social services providers. The unintended consequence of military downsizing will place an inordinate financial burden on health care professionals, supportive service providers, community resources, families, and employers.

A central understanding of funding streams, training, and educational options are needed to address work adjustment. This material can serve as a guide for veterans’ with PTSD to navigate both the veteran and civilian social service systems to develop an understanding of complex occupational therapy, skills, and training information. It also provides an opportunity for family involvement in gaining a greater understanding of PTSD symptoms, stressors and coping behaviors.

Ottomanelli and Lind (2009, p. 503) maintained that empirical evidence for the veteran population with PTSD is deficient as to the most effective methods of vocational rehabilitation. Relative to research conducted by Hershenson (1996) and Power and Hershenson (2003) further comprehensive examination of correlates with employment after PTSD is encouraged. Topics including significant obstacles of self-concept, psychosocial concerns, degree of cognitive disability, emotional investment, coping means, and employment history should be studied. Ottomanelli and Lind (2009, p. 503) suggested that conducting employment studies utilizing “common outcome measures such as competitive employment rates, duration of employment, and job tenure” are needed.

As a recognized leader in research and training individuals in various professional clinical disciplines the DVA has advanced several efficacious therapies and techniques for providing services to veterans with PTSD. In this regard further research may find that
interdisciplinary collaborations comprised of clinical psychologists and rehabilitation counselors can offer innovative therapeutic PTSD treatment approaches. By emulating other partnered disciplines the notion of treating veterans as a team using cognitive behavioral therapy (CBT), cognitive processing therapy (CPT), and other treatments can prove invaluable. Configuring highly trained, specialized integrative partnerships is deterred only by time, acknowledgement of their dedication to professional and ethical standards, and their willingness to work together to provide veterans with successful and efficacious treatment protocols. The team approach to mental health can: (a) present non-threatening, relaxed, and personalized treatment surroundings outside of the traditional DVA atmosphere; (b) ensure a consistent flow of information between the patient, family members, and the interdisciplinary team of clinical experts; and (c) greatly improve veterans’ rehabilitation outcomes and help restore them to pre-PTSD mental health status.

To build on future research of a large group of veterans with PTSD past research must be first examined for its relevance. Previous national research, including two noted epidemiological studies, has focused on veterans concerns. Based on a 1983 congressional mandate the first study, the *National Vietnam Veterans Readjustment Survey* (NVVRS), was administered between November 1986 and February 1988. During this study a representative sample of 3,016 American military veterans who served during the Vietnam War era were interviewed. The purpose of the study was to obtain the most accurate prevalence rates of veterans’ postwar psychological challenges to better serve their needs (Kulka et al., 1990). The second study, the *National Comorbidity Survey* (NCS), conducted between September 1990 and February 1992, was the first extensive subject matter survey of mental health in the U.S. In this study a representative sample of 8,098 Americans in the age group of 15 to 54 were assessed based on the diagnostic criteria of the *DSM-III-R* (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Pursuant to recommendations from the Agency for Healthcare and Research in 2011 project VALOR (Veterans After-discharge Longitudinal Registry) was the first national longitudinal study to investigate the natural history of PTSD. With a representative sample of 1600 Gulf War-era II male and female veterans the purpose was to assess the course of combat-related PTSD and discover patterns and predictors of progression or remission of PTSD and treatment utilization (Rosen et al., 2012).
Future research of a representative veteran sample for a large scale survey, possibly on the national level, would ideally consist of active duty, National Guard, and reserve Gulf War-era II veterans with PTSD. To replicate the present study on a larger scale the survey participants should be (a) male and female of ethnic diversity, (b) residents of substance addiction treatment facilities, (c) experiencing occupational challenges, and (d) in need of appropriate work adjustment prior to entering or reentering the workforce. Two earlier studies relied on Vietnam War veterans and the civilian population to gather data on personal mental health struggles and other challenges. The third, and to date, most timely and unique registry study, Project VALOR, evaluated the clinical course of PTSD, psychosocial correlates, and health outcomes of Gulf War-era II veterans. This particular study is the closest in time and topic to the present study. A scaled down version of Project VALOR aims, utilizing the present study criteria, coupled with the above requirements, could provide additional research data for smaller scale veteran service provides and can better inform interdisciplinary treatment teams.

**CONCLUSION**

This study addressed several purposes. First, it was intended to provide a better understanding of the barriers to employment Gulf War-era II veterans with PTSD encounter without significant work adjustment after military separation and before workforce integration. Second, it was designed to investigate the following three questions (1) How do veterans with PTSD view their work competencies?, (2) What significant work adjustment and work integration challenges do veterans with PTSD experience?, and (3) To what extent have veterans’ work goals changed from pre- to post-military service? And third, it was intended to memorialize the perceptions, thoughts, and beliefs of the participants through their narrative statements. The ability of each participant to display a level of introspection and self-awareness during the interviews was paramount to completion of this study.

I learned from the study that the participants were very attentive to nuances of the interview and data gathering processes. The pre-interview discussions with each of them was non-threatening and allowed them to address open topics, share their military histories, and derive a level of comfort with the information exchange process. They tended to be watchful of my demeanor, body language, and tone during the initial meeting and overall openly
discussed their current situations. Possibly because of the time lapse between our initial meetings and the formal interviews some participants did not meet my expectations when answering the study questions. Some of the participants gauged their answers to the study questions with well crafted answers while others withheld information and declined to expand on their answers. From this experience I have adjusted my counseling procedure with clients to: (a) allow appropriate time for clients to fully communicate problems, needs, and concerns, (b) present in a less formal and more candid, probing style, and (c) provide counseling and supportive services to clients at their own pace.

The wealth of personal information obtained during interviews however, was honest, straightforward, compelling, and provided rich data from which to draw significant correlations to previous studies. The most significant findings from this study are the sense of purpose and achievement the participants gained through meaningful work adjustment and restoration of work identity. They view themselves as having transferable skill sets to compete in the civilian economy, are proud of their work competencies, and are able to distinguish between their mental capacity and work habits for positive or negative work integration. Many participants encountered almost insurmountable circumstances with interpersonal, social, and substance use barriers before entering the WVTC program. The participants’ demonstrated resiliency during their treatment and recovery process. They offered inspiration to those who witnessed their undeniable achievement and successful work adjustment and work integration outcomes. It also established an example for other veterans with PTSD at WVTC to endeavor to work and live independently through self-sufficiency.

This study contributes to the larger knowledge base of veterans with post-combat PTSD based of the scope of the investigation. The study was narrowly defined with the specific intent of (a) examining a group of Gulf War-era II veterans with PTSD in a residential treatment setting, and (b) avoiding external influences of veterans from disparate eras with dissimilar physical or mental health conditions. The limitations placed on the study design are broad enough to capture a significant amount of data for comparisons to extant literature on PTSD and narrow enough to be easily replicated within any comparable population with a specific set of like circumstances. The completed study provided a template for the application of Hershenson’s (1996) work adjustment model to comprehensively examine populations with a variety of conditions and that have intentions of
entering or reentering the workforce. It also presented data that supported the position that (a) Gulf War-era II veterans with PTSD willingly accepted work adjustment supportive services, (b) were viable candidates for full-time employment consideration, (c) successfully competed with their non-military counterparts, and (d) were prepared to take lower paying employment to support their families.
REFERENCES


Ruzek (Eds.), *Cognitive behavioral therapies for trauma* (pp. 1-13). New York: Guilford Press.


APPENDIX A

INFORMED CONSENT
Informed Consent

Vocational Adjustment Following Separation From Military Service: A Qualitative Investigation of Work Integration Challenges for Gulf War-era II Veterans with PTSD

Principal Investigator
Paul J. Hayes
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San Diego State University
Interwork Institute
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619-808-3965

Co-Investigator
Charles Degeneffe, Ph.D., CRC
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San Diego, CA 92108
619-594-6921
Vocational Adjustment Following Separation From Military Service: A Qualitative Investigation of Work Integration Challenges for Gulf War-era II Veterans with PTSD

Participation in the Research Study

You are being asked to participate in this research study because you are a Gulf War-era II veteran with PTSD served by [redacted]. Please read this consent form and ask Paul J. Hayes any questions you may have about the study. You can also contact Dr. Degeneffe, thesis supervisor for Mr. Hayes.

Investigators

Paul J. Hayes, (619) 808-3965
Charles Degeneffe, Ph.D., CRC, (619) 594-6921

Why is This Study Being Done?

This study asks about your well-being, your employment needs, and your employment challenges with PTSD, as you are getting ready to enter the work force. This study aims to know how the needs veterans with PTSD are being assimilated into the work force and how veterans with PTSD utilize supportive services provided by [redacted].

How Many People Will Take Part in the Study?

About 10 people will take part in this study.

What is Involved in the Study?

There will be a one-time interview where data will be collected from you. You will provide written answers to a socio-demographic survey and verbally answer a series of 10 work related questions in a private setting with the primary investigator, Paul J. Hayes.

There are no right or wrong answers to the survey. You will complete the survey in a private office at [redacted].

Your own feelings and thoughts are most important in this research study. First, we will ask you to answer some demographic questions about yourself. Next, you will be asked 10 work related questions about your experience seeking employment after separation from military service.

How Long Will I Be in the Study?
You will be involved in the study for a one time interview lasting from one to two hours

What are the Risks of the Study?

The risks involved in the study are minimal. It is possible that answering the questions on the surveys might evoke discomfort and negative feelings. If at any time during the study you do not feel comfortable, you may discontinue your participation, either temporarily or permanently.

What about Confidentiality?

All complete surveys will be kept under lock and key in the principal investigator’s office. The only persons who will have access to the surveys are the principal investigator. Each survey will be given a code number so that no identifying information will be recorded on any of the completed surveys.

Efforts will be made to keep your personal information confidential. We cannot guarantee absolute confidentiality. The results of this study may be published in academic journals or presented at rehabilitation and psychology professional conferences as long as you are not identified and cannot reasonably be identified from it.

However, it is possible that under certain circumstances data could be subpoenaed by a court order. It is also not guaranteed that efforts to disguise identifying information with regard to case studies will keep your identity anonymous. Organizations that may inspect and/or copy your research records for quality assurance and data analysis include the following groups: the United States Food and Drug Administration, San Diego State University Institutional Review Board, the Contract Research Organization, the Site Management Organization, and the Office for Human Research Protections.

Psychological Treatment and/or Questions About the Research

While enrolled in this study, you should not participate in any other research project. This is for your protection against any possible adverse effects caused by the interaction of multiple study interventions.

Are you currently involved in any research projects at this time? Yes ___ No ___

Previous Research Participation

I have participated in the following research studies within the last three months.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Mandatory Reporting of Child and Elder Abuse

California law mandates that filing and reporting of reasonable suspicions of child or elder abuse. Participation in this research could result in the principle investigator being required to report child or elder abuse.

What are the Costs?

There is no cost to you or your insurance carrier for your participation in this study.

This research is funded through the University Grants Program at San Diego State University.

What is the Compensation?

There is no financial compensation for participation in this study. There are no other discernable benefits to participate in the study. There are potential benefits for improved services for family caregivers of persons with brain injury and for research on this population. Concerning services, support professionals such as rehabilitation counselors, social workers, psychologists, and nurses will better understand the unique needs of family caregivers of persons with brain injury. Second, brain injury rehabilitation facilities, such as Sharp Rehabilitation Services, can better understand how to support the needs of family members of persons with brain injury at acute-care discharge and when the family member returns home.

Regarding research, this study will advance the understanding of how work adjustment support needs of veterans with PTSD over time. This research will also help to better understand how effective utilization of community support services for persons with PTSD relates to short and long term employment outcomes.

What are My Rights as a Participant?

Taking part in this study is voluntary. You may choose not to take part or may leave the study at any time. Leaving the study will not result in any penalty or loss of benefits to which you are entitled. Your choice of whether or not to participate will not influence your future relations with Sharp Rehabilitation Services, San Diego State University, or the San Diego State University Foundation.

Whom Do I Call If I Have Questions or Problems?

For questions about the study, contact the principle investigator, Paul J. Hayes at 619-808-3965.
For questions about your rights as a research participant or to address complaints about the research, contact the Division of Research Administration (a group of people who review the research to protect your rights) at:

You can direct questions to an IRB representative at San Diego State University at:

Division of Research Administration
San Diego State University
San Diego, CA 92108
Phone: 619-594-6622
Email: irb@mail.sdsu.edu

We have tried to explain the important details about the study to you. If you have any questions that are not answered here, the principal investigator will be happy to give you more information.

The San Diego State University Institutional Review Board has approved this consent form as signified by the Boards’ stamps. The consent form must be reviewed annually and expires on the date indicated on the stamp. Your signature below indicates that you have read the information in this document and have had a chance to ask any questions you have about the study. Your signature also indicates that you agree to be in the study and have been told that you can change your mind and withdraw your consent to participate at any time. You have been given a copy of this consent form. You have also been given a copy of “The California Experimental Subjects Bill of Rights.” You have been told that by signing this consent form you are not giving up any of your legal rights.

<table>
<thead>
<tr>
<th>Signature of Subject</th>
<th>Printed Name</th>
<th>Date</th>
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<table>
<thead>
<tr>
<th>Signature of Witness</th>
<th>Printed Name</th>
<th>Date</th>
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I ___________________________ attest that the requirements for informed consent for the medical research project described in this form have been satisfied—that the participant has been provided with a copy of the Experimental Subject’s Bill of Rights, that I have discussed the research project with the participant and explained to him or her in non-technical terms all of the information contained in this informed consent form, including any risks and adverse reactions that may reasonably be expected to occur. I further certify that I encouraged the participant to ask questions and that all questions were answered.

Signature of Investigator          Printed Name          Date
California Experimental Subjects Bill of Rights

You have been asked to participate as a subject in an experimental procedure. Before you decide whether you want to participate in the experimental procedure, you have a right to:

1. Be informed of the nature and purpose of the experiment;

2. Be given an explanation of the procedures to be followed in the medical experiment; and any drug or device to be utilized;

3. Be given a description of any discomforts and risks reasonably to be expected from your participation in the experiment;

4. Be given an explanation of any benefits reasonably to be expected from your participation in the experiment;

5. Be given a disclosure of any appropriate alternative procedures, drugs or devices that might be advantageous to you, and their relative risks and benefits;

6. Be informed of the avenues of medical treatment, if any, available to you after the experimental procedure if complications arise;

7. Be given an opportunity to ask any questions concerning the medical experiment or the procedures involved;

8. Be instructed that consent to participate in the experimental procedure may be withdrawn at any time and that you may discontinue participation in the medical experiment without prejudice;

9. Be given a copy of this form and the signed and dated written consent form; and

10. Be given the opportunity to decide to consent or not to consent to the medical experiment without the intervention of any element of force, fraud, deceit, duress, coercion, or undue influence on your decision.

I have carefully read the information contained above and I understand fully my rights as a potential subject in a medical experiment involving people as subjects.

Signature of Subject ___________________________ Signature of Witness ___________________________

Date ___________________________ Date ___________________________

Please place your initials here to acknowledge receipt of a copy of this consent form. ___
APPENDIX B

RESEARCH STUDY AGREEMENT
Participation in the Research Study

You are being asked to participate in this research study because you are a Gulf War-era II veteran with PTSD served by Veterans Village of San Diego. Before you give your consent to volunteer, it is important that you read the following information and ask Paul J. Hayes any questions you may have about the study. You can also contact Dr. Degeneffe, thesis supervisor for Mr. Hayes to be sure you understand what you will be asked to do.

Investigators

Paul J. Hayes, (619) 808-3965
Charles Degeneffe, Ph.D., CRC, (619) 594-6921
Administration, Rehabilitation, and Postsecondary Education
San Diego State University

Why is This Study Being Done?

This study asks about your well-being, your employment needs, and your employment challenges with PTSD, as you are getting ready to enter the work force. This study aims to know how the needs of veterans with PTSD are being assimilated into the work force and how veterans with PTSD utilize supportive services provided by Veterans Village of San Diego.

How Many People Will Take Part in the Study?

About 10 people will take part in this study.

What is Involved in the Study?

There will be a one-time interview where data will be collected from you. You will provide written answers to a survey that asks questions about personal information, disability information, military participation information, employment information, and verbally answer a series of 12 work related questions in a private setting with the primary investigator, Paul J. Hayes.

There are no right or wrong answers to the survey. You will complete the survey and the interview in a private office at Veterans Village of San Diego. The interview will be audio recorded. If you choose not to be recorded, handwritten notes will be taken.

Your own feelings and thoughts are most important in this research study. First, we will ask you to answer some demographic questions about yourself. Next, you will be asked 10 work related questions about your experience seeking employment after separation from military service.

How Long Will I Be in the Study?

You will be involved in the study for a survey and one-time interview lasting approximately one-and-
one-half to two hours, depending on length of interview answers.

What are the Risks of the Study?

The risks involved in the study are minimal. It is possible that answering the questions on the surveys might evoke discomfort and negative feelings. If at any time during the study participants do not feel comfortable, they can choose not to answer any question and can skip any particular question that causes discomfort. A participant can also discontinue participation, either temporarily or permanently.

What about Confidentiality?

All complete surveys will be kept under lock and key in the principal investigator’s office. The only persons who will have access to the surveys are the principal investigator. Each survey will be given a code number so that no identifying information will be recorded on any of the completed surveys.

Efforts will be made to keep your personal information confidential. We cannot guarantee absolute confidentiality. The results of this study may be published in academic journals or presented at rehabilitation and psychology professional conferences as long as you are not identified and cannot reasonably be identified from it.

Organizations that may inspect and/or copy your research records for quality assurance and data analysis include the following groups: the United States Food and Drug Administration, San Diego State University Institutional Review Board, the Contract Research Organization, the Site Management Organization, and the Office for Human Research Protections.

Psychological Treatment and/or Questions About the Research

Previous Research Participation

Mandatory Reporting of Child and Elder Abuse

California law mandates that filing and reporting of reasonable suspicions of child or elder abuse. Participation in this research could result in the principle investigator being required to report child or elder abuse in another setting. I am a mandated reporter in the state of California. In the event that there is reasonable cause to suspect or believe any resident of the residential care facility where I work has been abused or neglected by a staff member of a public or private institution or facility that provides care, or whenever the results of an investigation leads to the conclusion that there is reasonable cause to believe that there has been abuse or neglect perpetrated by staff, I am required to file a true, accurate, and correct report, should I have any knowledge of the incident or incidents. I will also provide any records concerning the investigation to the appropriate investigating agency and/or to the agency that licensed the facility. You need to be aware that as a vocational rehabilitation counselor I am a mandated reporter for resident/client abuse in the state of California. This means that if you share with me that a resident/client is being abused or neglected I have to report this statement to law enforcement. If during an in-person, audio recording session I see or hear something that would create “reasonable suspicion” that abuse or neglect is happening I would also have to make a report to law enforcement.

What are the Costs?
There is no cost to you or your insurance carrier for your participation in this study.

This research is funded through the University Grants Program at San Diego State University.

*What is the Compensation?*

There is no financial compensation for participation in this study. There are no other discernable benefits to participate in the study. There are potential benefits for improved services for family caregivers of persons with brain injury and for research on this population. Concerning services, support professionals such as rehabilitation counselors, social workers, psychologists, and nurses will better understand the unique needs of family caregivers of persons with brain injury. Second, brain injury rehabilitation facilities, such as Sharp Rehabilitation Services, can better understand how to support the needs of family members of persons with brain injury at acute-care discharge and when the family member returns home.

Regarding research, this study will advance the understanding of how work adjustment support meets the needs of veterans with PTSD over time. This research will also help to better understand how effective utilization of community support services for persons with PTSD relates to short and long term employment outcomes.

*What are My Rights as a Participant?*

Taking part in this study is voluntary. You may choose not to take part or may leave the study at any time. Leaving the study will not result in any penalty or loss of benefits to which you are entitled. Your choice of whether or not to participate will not influence your future relations with Sharp Rehabilitation Services, San Diego State University, or the San Diego State University Foundation.

*Whom Do I Call If I Have Questions or Problems?*

For questions about the study, contact the principle investigator, Paul J. Hayes at 619-808-3965.

For questions about your rights as a research participant or to address complaints about the research, contact the Division of Research Affairs (a group of people who review the research to protect your rights) at:

You can direct questions to an IRB representative at San Diego State University at:

Division of Research Affairs  
Phone: 619-594-6622  
Email: irb@mail.sdsu.edu

We have tried to explain the important details about the study to you. If you have any questions that are not answered here, the principal investigator will be happy to give you more information.

The San Diego State University Institutional Review Board has approved this consent form as signified by the Boards’ stamp. The consent form must be reviewed annually and expires on the date indicated on the stamp. Your signature below indicates that
you have read the information in this document and have had a chance to ask any questions you have about the study. Your signature also indicates that you agree to be in the study and have been told that you can change your mind and withdraw your consent to participate at any time. You have been given a copy of this consent form. You have been told that by signing this consent form you are not giving up any of your legal rights.

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APPENDIX C

DEMOGRAPHIC QUESTIONNAIRE
Demographic Questionnaire: Integration of Disabled Veterans with PTSD into the Workplace

Please read all the questions carefully before responding.

Section I: Personal Information (Please Circle Responses)

1) Gender: Male         Female
3) Ethnicity: White       Black          Hispanic      Native American         Missing Data
4) Marital status: Married         Single          Separated/Divorced          Widowed
5) Education: High school graduate/GED Some college/professional school
College/professional school graduate Some graduate work Graduate degree
6) Living arrangements: Rehabilitation facility Independent Family member Roommate
7) Military service: Army Navy Marine Corps Air Force Coast Guard
8) Area: Afghanistan (OEF) Iraq (OIF)
9) Engaged in: Combat Combat Support Combat Service Support Other:
10) Years of active service: 1-3 3-5 6-10 11-15 16-20 21-25 26+
11) Years of reserve service: 1-3 3-5 6-10 11-15 16-20 21-25 26+
12) Total combined service years: 1-3 3-5 6-10 11-15 16-20 21-25 26+
13) Medically retired: Yes No Other (specify)

Section II: Disability Information

1) Service connected disability for: PTSD Other
2) VA disability percentage rating for: PTSD_____% Other_____%
3) Coexisting disability (e.g.: amputation-right leg; paraplegia, etc.). Please specify:

4) VA disability percentage rating for coexisting disability: ______%

Section II: Disability Information (Cont’d.)

5) Non-service connected disability for: (explain)

6) Total combined percentage of disability (service- non-service connected; coexisting): %

Section III: Employment Information

1) Employment status: Full-time Part-time Unemployed


3) Last civilian job held: Federal State County Local *Other - see below:

   *Other job (e.g.: private corporation; building contractor, retail clerk, etc.):

4) Job application pending: Yes No

5) Position applied for:

6) Do you require workplace accommodations? Yes No Unknown

7) Which accommodations are required? (e.g.: wheelchair ramp; computer screen magnifier, etc.):

8) What job are you prepared for? (e.g.: semi-skilled, skilled, professional, etc.):

9) What job are you seeking? (e.g.: clerical, warehouse, retail, etc.):

Section IV: Additional space for explanation/clarification of above items

Please identify additional information by section and item number (i.e.: Section III, Item 4, etc.).