ALTERNATIVE MANAGEMENT OF POST-TRAUMATIC STRESS DISORDER IN TREATING MILITARY VETERANS IN THE NEW YORK CITY METROPOLITAN AREA: PERCEPTION OF VETERAN ADMINISTRATION COUNSELORS

MSA 699 Project Report

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by
Marsha S. McLean

Project Instructor
Dr. Calvin A. Lathan III

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Executive Summary
The fundamental purpose of the study was to evaluate the perception of Veteran Administration Counselors in connection with utilizing Alternative Management Strategies to successfully treat military veterans with Post-Traumatic Stress Disorder (PTSD). Four research questions were carefully articulated to collect appropriate responses applicable to the study. From the four research questions, the researcher created 10-survey questions using Survey Monkey as a valid instrument to collect and analyze data.

The survey questions were designed to analyze the perception of the participants regarding the most effective PTSD treatment recommended and utilized. A link was created and made available on Facebook social media to be completed by the Veteran Administration Counselors. Survey participants were allotted a two-week time frame within which to complete the survey. From the anticipated 22 possible participants, 11 responded, indicating a 50% response rate. The survey was anonymous, protecting the confidentiality of the participants, and eliminating any basis for repercussions.

The data collected was further analyzed and compared to a number of literature-reviewed articles, to better understand the most efficacious treatment for PTSD. The results indicated that Veteran Administration Counselors found medication to be the most effective treatment for PTSD, with behavioral therapy recommended as the second line of treatment and predominantly utilized in connection with medication. The literature review contradicted with the survey results, indicating Alternative Management Strategies being more efficacious in comparison to current evidence-based treatment techniques (medication and behavioral therapy). The study indicated the need for additional research and control testing techniques to further substantiate the efficacy of Alternative Management Strategies in successfully treating veterans with PTSD.
# ALTERNATIVE MANAGEMENT OF PTSD IN VETERANS

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Chapter 1

The Problem Definition

Post-Traumatic Stress Disorder (PTSD) is a mental health condition originating from any traumatic experience associated with physical harm or threat. On average, a combined total of half a million military veterans who deployed into combat zones were formally diagnosed with PTSD, as of 2017. The current treatments available through the Veteran Health Administration were recognized as having limited benefits in assisting veterans toward successful recovery. Veterans continued to encounter dramatic challenges as a result of PTSD, significantly impairing their ability to lead normal functional lives after transition from military service to civilian life. The medications prescribed by the Veteran Administration psychiatry were renowned for primarily treating the symptoms of the disorder, and creating growing negative consequences such as medication addiction, substance misuse and abuse. Counseling provided through behavioral therapy approaches reportedly yielded limited benefits in targeting the specific needs of each veteran, and worked as a hindrance to successful recovery. As a result, there is an emergent need to more effectively evaluate the extent of current evidence-based treatment approaches in treating veterans with PTSD. More importantly, it is necessary to examine Alternative Management Strategies and their impact on providing more efficacious benefits to improving the symptoms of PTSD in veterans. Therefore, it was appropriate to conduct this research as a starting point, to investigate the perceptions of randomly selected Veterans Administration Mental Health Providers in conjunction with recommending and providing Alternative Management Strategies in the treatment of PTSD.
Introduction

The risk of exposure to trauma has been in existence since the beginning of creation. With reference to the American Psychiatric Association (AMA), Post-Traumatic Stress Disorder became formally recognized in 1980 as a mental health disorder, and was thereafter added to the third edition of the Diagnostic and Statistical Manual of Mental Disorders, DSM-III (Wilson, 2014). Prior to the addition, the disorder was not properly identified and its addition later created questionable considerations. The addition was motivated by the adjustment disorders arising from Vietnam veterans, upon their discharge from military service into the civilian world (Arnaudova, Aleksandrov, Stoyanov & Ivanova, 2015). As a result, more attention was dedicated to a heightened understanding of the causes and symptoms associated with the disorder, and treatments that would become necessary. PTSD is currently categorized as a serious and growing mental health issue among veterans who served in combat and those exposed to military sexual trauma (MST). The resulting factors of PTSD is commonly identified with diminished quality of life outcomes, increased risks of medication addiction, substance abuse, unemployment, high cost associated with healthcare, homelessness and suicide among military veterans (Reisman, 2016).

Background of Problem

One reference pointed to an estimated 500,000 military veterans with PTSD, since 2005 (McFarlane, 2015). According to the Department of Veteran Affairs (2017), the number of veterans with PTSD was widespread and continued to incline at a dramatic rate, primarily as a result of continued combat operations and military sexual trauma. It was estimated that an estimated 20% of military veterans who served in the Operations
Iraqi Freedom (OIF) and Operations Enduring Freedom (OEF) was screened positive for PTSD in 2017. With reference to the Gulf War (Desert Storm) veterans, approximately 12 out of every 100 (12%) had PTSD, along with an averaged 15 out of every 100 Vietnam War veterans (15%) suffering from PTSD. The National Vietnam Veterans Readjustment study indicated that 63% of recent veterans with PTSD also had an alcohol dependence and drug abuse problem (Hermann, Shiner & Friedman, 2014).

A study conducted in 2016 by the Department of Veterans Affairs discovered that severe PTSD had a direct correlation with unemployment. The study further indicated that veterans who suffered from PTSD were 50% more likely to become unemployed due to symptomatic changes in concentration and focus, anxiety, depression, irritability and anger. In 2017 alone, it was suggested that an averaged 200,000 veterans with PTSD remained unemployed, projected increases in the coming years. Another article emphasized a correlation with PTSD and homelessness. It was estimated, that on a given night, at least 50,000 veterans experienced homelessness nationwide. Substance use disorder was identified in connection with PTSD, which contributed largely to the resulting factor (Hansen & Simonsen, 2017).

Consistent with the National Center for Veterans Analysis and Statistics (2017), it was indicated that 22 veterans committed suicide on a daily basis, primarily linked to PTSD. This number is reported as exceeding soldiers killed in action in combat. According to the Department of Veteran Affairs (2017), the suicide rate was 22% higher for veterans when compared to non-veterans in the United States. The estimated risk was calculated as being 19% higher among adult male veterans in comparison to non-veteran adult men, and 2.5 times higher for female veterans in contrast to non-veteran adult
women within the United States (Psikivatr, 2015). Studies have further suggested that veterans with PTSD were more difficult and costly to treat, resulting in increasingly higher rates of neglect to care, adding to existing challenges. The annual expenditure to providing initial treatment to PTSD veterans by the Department of Veteran Affairs averaged more than $2 billion annually, equating to approximately $8,300 per veteran. The serious impact of PTSD on the overall well being of veterans was alarming, drawing attention to the need for greater improvement and care, in helping to more effectively manage the debilitating and re-occurring symptoms and consequences described above (Talkovsky & Lang, 2017).

**Purpose of the Study**

The purpose of this research was to analyze the perception of Veterans Administration Mental Health Providers on the need for Alternative Management Strategies in direct reference to PTSD, with emphasis on military veterans in the New York City Metropolitan area. According to multiple credible sources, there were reportedly perceived limitations in current evidence based treatment approaches, resulting in minimal success rates (Kar, 2016). In addition, continuation of deployment with the already existence and prevalence of PTSD will continue to dramatically increase, requiring urgent attention and resolve (Loughran & Heaton, 2017). A secondary purpose of this study was to underscore the many problems resulting from un-successfully treating PTSD. Another fundamental objective of the study was to evaluate the usefulness of available Alternative Management Strategies to more concretely rectify the current problem. (Carroll, Kiluk, Nich, Devito, Decker, LaPaglia, Duffey, Bbuscio & Ball, 2017).
Questions to be Answered (or Research Objective)

With a new generation of deployed soldiers returning from deployment with PTSD, and adding to the growing number of veterans with current diagnosis, the Department of Veteran Affairs is presented with the challenge of identifying the most effective methods of treatment to address PTSD. Prevalence estimates of PTSD symptoms based on self-report surveys and statistics among deployed active duty soldiers and transitioned veterans was disturbing, pointing to a significant problem that requires immediate attention. Current evidence-based treatment options utilized by health care professionals and clinicians have reportedly yielded limited success. According to research, it was indicated that Complementary and Alternative Medicine (CAM) therapies were more efficacious at controlling symptoms and promoted a health-related quality of life in contrast to current evidence-based techniques.

This study addressed the following research questions:

1. How effective are Alternative Management Strategies in managing veterans with Post-Traumatic Stress Disorder in the New York City Metropolitan area?
2. To what extent does Post-Traumatic Stress Disorder exist among military veterans in the New York City Metropolitan area?
3. To what extent does Veteran Administration Counselors and Psychiatrists support the use of medication in treating veterans with Post-Traumatic Stress Disorder?
4. To what extent does Veteran Administration Counselors and Psychiatrist support the use of behavioral therapies in treating veterans with Post-Traumatic Stress Disorder?
Assumptions

The researcher assumed that Post-Traumatic Stress Disorder among veterans in the New York City Metropolitan area was a serious and growing concern, requiring immediate response to control the negative consequences and to prevent further escalation. The researcher also assumed that the most effective protocol to mitigate the problem of PTSD was to more frequently recommend veterans to utilizing Alternative Management Strategies. The assumptions were based on substantial evidence that emanated from credible research surrounding the existing problems and recommendations for effective resolve.

The researcher further made the assumption that the participants were mental health professionals employed by the Department of Veteran Affairs. The researcher also assumed that the participants were competent to fully understanding and completing the survey as honestly and accurately as possible. Lastly, the researcher assumed that the survey was constructed sequentially and appropriately, to collect pertinent and relevant data, applicable to the study. Respondents were informed of the anonymity of the survey and the freedom to participate without any repercussions.

Theoretical framework

The theoretical construct used to guide this research was the Change Theory of nursing, developed by Kurt Lewin. This theory was most applicable to developing and implementing changes in perception toward a goal strategy to better manage veterans with PTSD. Lewin theorized a three-step model, which entailed the unfreezing process of change (current process), into the change process (change of practice or perception), and the refreezing stage, as the new standard or expected protocol (Mitchell, 2018). This
theory will guide the study in an effort to generate heightened awareness about the
current challenges encountered by veterans suffering with PTSD. It will be utilized to
address the stated problem in connection with current evidence-based treatment measures
(un-freezing), to assist Psychiatrists and Mental Health Counselors in better recognizing
the need for improved patient care. This will involve awareness and reinforcement
techniques to accentuate the problems, and the urgent need for improved measures. The
second stage entailed the transitioning phase, by way of recommending, implementing
and approving veterans with PTSD to more effectively utilize more efficacious treatment
options. This can be accomplished by conducting further research, pilot studies and
evaluation of treatment options, to facilitate the implementation of change. Provided the
changes were implemented effectively and yielding positive benefits, the process would
continue to be monitored for maintenance and improvement, at the freezing stage (Grol,

**Definition of Terms**

**Alternative Management Strategies:** the utilization of different health care approaches
that are considered non-traditional in place of conventional medicine (Furnham, 2002).

**Deployment:** any military activity involving combat or support to combat missions,
requiring movement from home station to another location, including overseas hazardous
zones (Merriam-Webster Dictionary, 2018).

**Gulf war (1991):** A war between the forces of the United Nations, led by the United
States, and those of Iraq that followed Iraqi dictator Saddam Hussein 's invasion of
Military Sexual Trauma: assault of a sexual nature, involving force or threat, with repeated and threatening attempts to engage in non-consensual sexual activity with some military personnel (Kimberling, Gima, Smith, Street & Frayne, 2007).

Military Veteran: any person, who served honorably on active duty, reserve or national guard in the armed forces of the United States such as the Army, Navy, Air Force, Marines, and the Coast Guard (Department of Veteran Affairs, 2017).

Operation Enduring Freedom (OEF), Afghanistan: the deployment of United States soldiers to Afghanistan, Pakistan, and neighboring countries of the former Soviet Union as a consequence of the terrorism attacks on the world trade center in September 11, 2001 (Merriam-Webster Dictionary, 2018).

Operation Iraqi Freedom (OIF), Iraq: As a result of Iraq’s refusal to comply with United Nations’ mandates, the United States began deploying troops to the Gulf region in the late 2002 and winning a decisive victory against the forces under the regime of Saddam Hussein, during April 2003 (Encyclopedia Britannica, 2004).

Post-Traumatic Stress Disorder (PTSD): A condition of persistent mental and emotional stress occurring as a result of exposure to a traumatic event, and meeting two symptoms from each of three symptom clusters: intrusive recollections, avoidant/numbing symptoms, and hyper-arousal symptoms (Bisson, 2007).

Vietnam war (1955-75): was a cold war conflict between the United States and the French colonial government in South Vietnam against the indigenous but communist Vietnamese independence movement (Oxford Dictionary, 2002).
Scope of the Study

The scope of the study was to investigate the perception of mental health treatment providers in conjunction with recommending and approving Alternative Management Strategies as the first line of treatment to more successfully manage veterans with PTSD. The study also sought to expose the current problems associated with current evidence-based treatment measures and the multiple debilitating impact of untreated or under-treated PTSD (Reisman, 2016). It was also necessary to use this approach to further examine the willingness of the treatment specialists to respond appropriately and in an expeditious manner to address the issue with utmost importance. The research entailed a quantitative approach, utilizing a 10-question survey, created by the researcher, using Survey Monkey. The survey was accessible from Facebook social media and was limited to mental health providers employed within the network of the Department of Veteran Affairs.
Chapter 2

Review of Related Literature

History and General Background

This chapter examined Alternative Management Strategies to more successfully treat veterans with Post-Traumatic Stress Disorder (PTSD). Historically, military veterans who suffered from PTSD would typically undergo treatment consistent with medication and behavioral therapy. Studies have indicated that despite the use of current evidence-based techniques, PTSD remained a serious mental health condition, which progressively disrupted the normal functions of everyday life for veterans. They continued to experience debilitating physical and mental health symptoms, which reportedly resulted in additional negative outcomes such as medication addiction, substance abuse, unemployment, homelessness and more critically suicide (Crocq, 2016).

In this chapter, we discussed the history of PTSD, a formal definition of PTSD, criteria established for diagnosing PTSD, PTSD screen for DSM-V, the prevalence of PTSD, the current impact of PTSD on veterans, the current treatment measures utilized by the Department of Veteran Affairs, the problems resulting from current treatment measures, and the availability and impact of Alternative Management Strategies in treating veterans with PTSD. The literature review included a summary of different peer reviewed articles, books and journals, as well as reputable websites that corresponded to the topics discussed.

History of Post-Traumatic Stress Disorder

Post-Traumatic Stress Disorder is categorized as a psychiatric disorder that may develop after some degree of exposure to a traumatic event. The events that most
frequently caused military veterans to develop PTSD were commonly associated with exposure to combat and military sexual trauma. The initial medical attempt to formally diagnose and treat PTSD occurred in response to adjustment issues experienced by the Vietnam veterans transitioning from military occupation to civilian life (Marmar, Schlenger, Henn, 2015). The prevalence of the adjustment issues classified as Post-Vietnam Adjustment created growing concerns among mental health professionals, which lead to in-depth research and further, appropriate identification of the disease. In the year 1980, the term Post-Traumatic Stress Disorder was used and formally recognized as a mental health disorder with specific symptoms that could be properly diagnosed. It was added thereafter to the American Psychiatric Association and Statistical Manual of Mental Disorders, DSM-III (Krueger, 2016).

**Definition of Post-Traumatic Stress Disorder and Symptoms**

According to the Diagnostic and Statistical Manual of Mental Disorders, the 4th edition, PTSD is a psychiatric condition caused by exposure to an intensely distressing traumatic event and characterized by continuously re-experiencing, avoidance, and hyper-arousal symptoms (Gibbon, Skodol, Spitzer, Williams & First, 2016). Traumas encountered by military veterans were generally associated with actual or threatened death, serious injury, witnessing someone injured or dead, or the act of killing someone. Veterans with PTSD experienced dynamic symptoms not present prior to exposure to a trauma (Avron, Schnurr & Spiro, 2014).

To satisfy the criteria for PTSD diagnosis, specific symptoms must be present. These symptoms must include a minimum of two of the following: intrusion, avoidance, negative alterations in cognitions and mood, or alterations in arousal and reactivity.
PTSD patients unavoidably re-experience the trauma they were exposed to, through recurrent and intrusive distressing recollections of the event, and were susceptible to experiencing severe distress when exposed to something that triggered resemblance of the trauma (Blake, Keane, Wine, Mora, Taylor & Lyons, 2015). It was also common for PTSD patients to avoid thoughts, feelings, peoples, places or activities of the initial event, out of fear of re-experiencing the trauma. Veterans with PTSD were susceptible to experiencing negative alterations in cognition or mood, which may be manifested in their inability to recall significant aspects of the trauma, in connection with persistent negative beliefs and expectations about themselves, as well as reduced interest in recreational activities. Other typical and present symptoms may include arousal and reactivity, present with hyper vigilance, difficulty concentrating, sleeping disorders, irritability, or startled responses (Henning & Frueh, 2017).

**Criteria Established for Diagnosing Post-Traumatic Stress Disorder**

With reference to the DSM-V, a revision of the classification and diagnostic criteria was considered. Prior to the revision, PTSD was classified as an anxiety disorder, until recent adjustments were made. At present, PTSD was more appropriately identified as a stress related disorder caused by trauma (Spitzer, First, & Wakefield, 2017). In addition, the previous diagnostic criterion entailed a three-factor model of symptoms, which included, experiencing, avoidance and hyper arousal. The revision now reflects symptoms correlating to intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. The revision entailed adding a specification for a dissociative sub-type of the disorder, removing the need for classification such as acute or chronic (Pai, Suris & North, 2017).
Further diagnosis entailed re-experiencing the trauma, continual avoidance of memory, altered impact, consistent with unexplainable hyper arousal and changes in reactivity, as well as, significant occupational and social impairment (Brewin, Lanius, Novac, Schnyder, & Galea, 2017). Under the DSM-V, the requirements differed by comparison to previous version, which does not require an immediate display of symptoms such as intense fear, helplessness or hopelessness as symptoms stemming from PTSD. As specified under new directives, the minimum symptom duration to meet diagnostic criteria is one month. However, a diagnostic specification of delayed symptoms is accepted, if the trauma occurred six moths or longer before symptoms began to surface. Furthermore, a diagnostic specification with dissociative symptoms such as depersonalization or derealization, now meets the criteria for a PTSD diagnosis (Watson, 2017).

**Post-Traumatic Stress Disorder Screen for DSM-V**

The PTSD Screen for DSM-V is a 5-item screen created to be utilized in primary care settings. The evaluation begins with an item designed to assess for positive exposure to a traumatic event. If the response is negative, the score is calculated as 0, and the survey is discontinued. In contrast, a positive response will prompt the veteran to complete five additional yes or no questions about the trauma exposure and its impact over the last month. The PC-PTSD-5 is a tool designed to identify the probability of PTSD. A positive screening requires a provider to refer the patient for further assessment, such as a structured interview, using the Clinician-Administered PTSD Scale for DSM-V. In rare instances, the validated self-report measure is utilized, using the PTSD Checklist for DSM-V (Spoont & Arbisi, 2013).
Preliminary results from validation studies confirmed that a 3-point positive response on the PC-PTSD-5 was indicative of probable PTSD. The result were interpreted as being minimally sensitive, and sufficient to rule out false screening. A cut-point score of 4 was considered a sound, efficient basis for PTSD diagnosis. It was suggestive of a balanced result, conclusive enough to eliminate doubts. Lastly, a 5-point score was interpreted as PTSD for a certainty, with recommendations for further evaluation (Breslau, Peterson, Kessler & Schultz, 2017).

The Prevalence of Post-Traumatic Stress Disorder among Military Veterans

Studies have indicated that the prevalence of exposure to traumatic events is common. However, only a small to moderate percentage reported failure to recover from traumatic events and developed PTSD. According to one reference, it was estimated that approximately 50-90 percent of the general population experienced at least one traumatic event throughout their lifetime (Atwoli, Stein, Koenen & McLaughlin, 2015). Research suggested that PTSD could be chronic, with at least one-third of the veteran population continuing to endorse symptoms up to 10 years following the initial trauma (Whitworth & Ciccolo, 2016). Other sources of data emphasized the serious consequences of PTSD in connection with increased risk of suicide, impairments in work and school performance, social isolation, interpersonal problems, and lifetime co-morbidity with other mental disorders (Minnen, Zoellner, Harned & Mills, 2015). According to one article, it was also believed that the prevalence rate of PTSD was underestimated, as those struggling with the disorder were not accurately diagnosed or did not seek treatment (Ehlers, Cos & Perrin, 2016).

According to Richardson, Frueh & Acierno, 2016, it was reported that the
prevalence of PTSD was an estimated 17.1% among military veterans in the United States, with a lifetime prevalence of 31.3%. The prevalence of PTSD among Vietnam veterans reflected an averaged 31%, with 10% representative of Persian Gulf War veterans (Department of Veteran Affairs, 2015). Veterans who served in the Middle East conflict experienced a prevalence rating of 17%. One survey conducted in the United States in 2015, confirmed that out of 103,788 total veterans who participated in the study, 13% of the study population revealed a positive diagnosis of PTSD. The percentage ratings were significantly higher among the younger population of veterans between the ages of 18-24 and comparatively lower in veterans that were 40 years of age and older (Holdeman, 2016).

Another study conducted in 2015, involved the use of the PTSD checklist in surveying a total of 50,184 active duty military service members (Rosen, 2015). The results revealed that 8.7% of deployed soldiers screened positive for PTSD and 3.0% was indicative of a PTSD diagnosis among non-combatant soldiers. The latter survey found that higher rates of PTSD correlated to age, less educated soldiers, enlisted soldiers, current smokers, and soldiers using alcohol. There were no connections identified between race, gender or service component (Bremmer, Southwick, Darnell & Charney, 2015).

According to the Journal of American Medical Association, 2016, PTSD is more widespread among military veterans than previously anticipated, with prolonged symptoms. A 2016 report estimated that a combine total of 500,000 veterans who served in combat over the past 13 years had a diagnosis of PTSD (Reisman, 2016). In 2014, another study discovered that approximately 21, 784 non-deployed military personnel
suffered from PTSD, while an average 66,935 deployed soldiers or a 32% comparative rating, had a PTSD diagnosis (Gates, Holowka, Vasterling, Keane, Marx & Rosen, 2016). Survival analysis indicated that more than one third of veterans with PTSD will not recover even after many years. From 2010 to 2015, the prevalence of PTSD inclined from 0.4% to 22%, as a result of ongoing combat operations and military sexual trauma (Kessler, Sonnega, Bromet, 2015).

**The Current Impact of Post-Traumatic Stress Disorder on Military Veterans**

**Statistics.** PTSD is a psychological condition that is developed as a result of exposure to a traumatic event. Traumas have the capacity to disrupt the normal functioning of an individual’s mental health, creating disconnect between expectation and reality (Foa, Sketekee & Rothbaum, 2014). Research suggested that 10% to 18% of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) soldiers were more likely to have PTSD after return from combat (Xue, Ge, Tang, Liu, Kang, Wnag & Zhang, 2015). OEF and OIF service members were categorized as being at considerable risk to developing other mental health problems, in addition to PTSD. Estimates of depression for example, ranged from 3% to 25% in 2016 among deployed soldiers (Winter, 2017).

The use of alcohol and tobacco between OEF and OIF veterans were identified in connection with veterans suffering from PTSD. It was reported that every 1 in 10 OEF and OIF veterans returning from combat encountered problems associated with alcohol and drug use (Cook, Jakupcak, Rosenback, Fontana, & McFall, 2016). A report by the Department of Veteran Affairs in 2016, suggested that at least 20% of veterans with PTSD had a diagnosis of Substance Use Disorder (SUD). More conclusively, it was
further reported that every 1 out of 12 veterans with PTSD also had SUD, and every 1 out
of 3, sought treatment through the Department of Veterans Affairs. Additionally, the
number of veterans who smoked nicotine doubled for those with PTSD, averaging every
6 out of 10 (Krinsley, Waring, Gallagher & Skidmore, 2018).

Unemployment Rate. Unemployment was reportedly the most crucial indicator of PTSD and its severity according to a study conducted in 2016. An employment study, documented in the Mental Health Services Research, 2016, reported that veterans with PTSD were 50% more prone to becoming unemployed, due to their inability to concentrate, learn new tasks and become flexible and adaptable (Schnurr, & Rosenback, 2016). Another study reported that at least two-thirds of veterans with PTSD remained unemployed. An analysis conducted in 2017, revealed that the number of unemployed veterans exceeded 200,000 in the United States, with the highest rate representing 29.1% of veterans 25 years of age and under (Hansen & Simonsen, 2017).

Homelessness. According to one article, it was indicated that on a given night in the United States, approximately 50,000 veterans were homeless. Male veterans were 1.3 times more susceptible to becoming homeless, and female veterans being 3.6 times more likely of becoming homeless, when compared to the general population (Resnick, & Rosenheck, 2016). Another report conveyed that approximately 70% of homeless veterans suffered from a substance use disorder, with 45% representing those with an existing PTSD diagnosis. Combat veterans were highly susceptible to suicidal ideation, often associated with PTSD and depression (Sher, Braquehais, Casas, 2015).

Suicide. Suicide was reportedly the first leading cause of death in the United States military, surpassing combat fatalities. The wars in Iraq and Afghanistan
comparatively yielded higher percentages of suicides than previous wars. It was estimated that more than 7,400 veterans committed suicide, which represented 22 suicide deaths in a given day, exceeding the number of soldiers killed in combat (Department of Veteran Affairs, 2015). In 2016, it was conveyed that the risk of suicide among veterans was 21% higher among the veteran population in comparison to the general civilian world (Richardson, Frueh & Acierno, 2016). Military veterans with a positive PTSD screening were 4 times more susceptible to reporting suicidal ideation, in conjunction with being 5.7 more likely to having comorbid disorders (Psikivatr, 2015).

**Current Problems Associated with the Treatment of Post-Traumatic Stress Disorder**

Successfully treating PTSD in the military was evidently a challenge, largely due to an environment that was geared towards perceived competence and resilience. Soldiers’ attempt to seek mental health services was often stigmatized and looked upon as a sign of weakness and an inability to overcome obstacles (Hernandez, Morgan, & Parshall, 2016). As a result of this negative connotation, soldiers often desisted from seeking appropriate help when it is most warranted. According to the Department of Veteran Affairs, 2017, 1 out 3 OEF and OIF veterans reported hesitance to mental health treatment, primarily out of fear of being stigmatized, and 1 out of 5 veterans reported that mental health treatment should only be acquired as a last resort (Department of Veterans Affairs, 2016). Further, veterans being exposed to more than one traumatic event for a specified duration of time were reportedly known to create increasing difficulties to coping with PTSD. According to one reference, a significant number of deployed soldiers were exposed to one or more trauma, ranging from 32% being attacked or
ambushed, with 34.5% who witnessed human remains. Still yet, another 23% reported being fired at, while 16% reported knowing someone who was seriously injured or killed in action (Nasveld, Cotea, Pullman & Pietrzak, 2016).

A significant number of veterans refrained from seeking treatment until condition worsened to a more chronic stage. PTSD diagnosis among deployed veterans inclined from 0.4% to 22% from 2004 to 2015 (Hines, Sundin, Rona, Wessely & Fear, 2016). The Department of Veterans Affairs (2017) currently utilized Cognitive Behavioral Therapy (CBT), Cognitive Processing Therapy (CPT), Prolonged Exposure (PE), and more recently Eye Movement Desensitization and Reprocessing Therapy (EMDR), as trauma-focused therapies to treat veterans with PTSD. Behavioral therapy approaches were reportedly used in conjunction with several forms of antidepressant medications called SSRIs (selective serotonin reuptake inhibitors). According to the Journal of the American Medical Association, it was disclosed that current evidence-based treatments for PTSD was not effective as commonly believed and there was a lack of adequate scientific research to further evaluate treatment outcomes (Najavits, 2017).

Research funded by the National Institute on Drug Abuse and the Department of Veteran Affairs, examined the dropout rate for veterans with PTSD undergoing Prolonged Exposure (PE) Therapy (Lancaster, Teeters, Gros & Back, 2016). Evidently, 43% of veterans discontinued treatment after a 12-week session. PTSD patients who exhibited more severe symptoms were reportedly the most likely to dropout of treatment (Gutner, Gallagher, Baker, Sloan & Resick, 2016). There were other reasons for high levels of drop out as indicated in another study that involved a survey of 650 PTSD veterans. It was noted that 6% of veterans who sought treatment for PTSD reported improvement and
did not require continued services, while 11% became actively suicidal. Another 12% indicated utilizing other treatment options, with 27% of that population reported life problems as an interruption to treatment (Goodson, Lefkowitz, Helstrom & Gawrysiak, 2016).

While the current treatments offered by the Department of Veteran Affairs indicated minimal relief to PTSD symptoms, about half the population of veterans with PTSD expressed lack of confidence in mental health professionals, deterring continued treatment (Imel, Laska, Jackcupcak, & Simpson, 2016). Another significant challenge hindering successful treatment outcomes was the added risks associated with exposure therapies, which reportedly resulted in worsening PTSD symptoms. In addition, current evidence-based treatment was reportedly limited in capacity, in focusing on the extensive emotional traumas that occurred in combat, including the act of taking someone’s life (Schottenbauer, Glass, Arnkoff & Tendick, 2015). Mental Health Professionals were not required to ask questions relative to a veteran’s participation in causing death in combat, which created added havoc to addressing the underlying issues responsible for disruptive moral and mental consciences in affected veterans. As a consequence, current evidence-based therapy was not idealistic in this setting, as it created setbacks in delving into the actual issues that lead to PTSD, and its ineffectiveness continued to add to the existing dropout rates (Forbes, Meis, Spoont & Polusny, 2016).

Setraline, Paroxetine, and Fluoxetine were the most common antidepressant medications prescribed for treating symptoms of PTSD. At least 12% of veterans reportedly received opioid prescription drug along with antidepressants. It was indicated that the use of medication had minimal impact at reducing symptoms of PTSD, to include
depression, anxiety, sleep disorders and concentration problems (Wu, Hasson & Clark, 2017). It was further discovered that PTSD patients received higher doses of opioid medications and were more likely to receive medications with early refill options. From 2013 to 2017, it was noted that chronic opioid use among young veterans in the Veteran Health Care System increased from 3.0% to 4.5% (Bohnert & Trafton, 2017). Research suggested that an increasing number of veterans with PTSD, developed opioid use disorders, which resulted in adverse clinical outcomes, such as emergency room admissions, opioid-related accidents and overdoses, as well as violent-related injuries (Jeffrey, Luckey, Balison, & Klette, 2016). One study found that at least 30% of completed suicides were preceded by drug overdose (Teeters, Lancaster, Brown, & Back, 2017).

**Alternative Management Strategies in Treating Post-Traumatic Stress Disorder**

For decades, the Department of Veterans Affairs have utilized both medication and behavioral therapy techniques in helping veterans with PTSD control symptoms and lead normal, functional lives. Studies have indicated that veterans with PTSD demonstrated greater improvement in their PTSD symptoms in response to Alternative Management Strategies when compared to current evidence based treatments (Kar, 2016). However, with the dramatic increase in PTSD patients as a result of ongoing combat and military sexual trauma, a greater gap has been created, emphasizing the need for more effective treatment outcome (Sareen, 2016). The continuation of deployments to war zones will not cease and will further add to the already existing prevalence of PTSD. Therefore, there is an urgent need for treatment counselors and psychiatrists to consider utilizing more fully, Alternative Management Strategies to more successfully
treat veterans with PTSD (Shalev, 2017).

Alternative Management Strategies refers to the use of unconventional medicine separate from what is considered current evidence-base treatment measures. The use of Alternative Management Strategies to treat veterans was uncommon as most treatment specialists complemented therapies with traditional medicines. One of the significant reasons for the continuation of standard treatment by the Department of Veteran Affairs was centered on insufficient evidence surrounding the efficacy of Alternative Management techniques (Laboon & Pilver, 2018). Additionally, the majority of mental health professionals employed by the Department of Veteran Affairs were only trained in specific fields of care and lacked professional experience and expertise to provide services outside the scope of what was considered acceptable and approved alternatives. Furthermore, care not provided by the Department of Veterans Affairs, would require referral and compensation to cover insurance costs, which often deterred providers from recommending and approving other services (Wynn, 2015).

One psychiatric expert characterized PTSD as the body’s function of maintaining somatic memories consistent with visual images or physical sensations. He suggested that the ability to overcome such trauma is highly dependent on an individual’s ability to experience feelings without the misery of what occurred (Kolk, 2016). Another professional in the field believed that trauma was less the experience and more the disunity created, resulting in physiological, psychological, and behavioral consequences. The article further specified recovery as entailing the ability to re-learn a sense of one self relative to emotional and physical experiences (Bailey & Brand, 2017).

Research have supported a multi-faceted dimension of Alternative Management
Strategies, such as Eye Movement Desensitization and Reprocessing (EMDR), Virtual Reality Exposure Therapy, Emotional Freedom Technique (EFT), Acupuncture, Trauma-Sensitive Yoga, Medical Marijuana, Mindfulness–Based Cognitive Therapy, Music Therapy, and Cognitive Processing Therapy (CPT), that can be more effectively used to treat veterans with PTSD. There were among other approaches that were believed to be equally beneficial in successfully treating veterans with PTSD not covered in this research (Wahbeh, Senders, Neuendorf & Cayton, 2018). Each listed alternative treatments was described below, relative to its unique purpose and a brief explanation was provided regarding the extent to which the Department of Veteran Affairs utilized the services to treat veterans with PTSD.

**Eye Movement Desensitization and Reprocessing.** Eye Movement Desensitization and Reprocessing (EDMR) was developed over 20 years ago as a cognitive behavioral therapy approach, with the objective of treating anxiety caused from PTSD. It was thought that after trauma, veterans with PTSD encountered challenges with processing trauma in a positive context. EDMR was designed to help the brain unblock traumatic memories and reprocess into more positive patterns. Using rapid eye movements in combination with psychotherapy, EDMR worked at reducing the power of emotional charges of past traumatic events (Raboni, Tufik & Suchecki, 2017). Research indicated that an average 50% of trauma patients recovered from PTSD after an initial 90 minutes’ session. Another article suggested that some patients required a minimum of 1 to 3 months of therapy before any improvement was observed. However, according to the Department of Veteran Affairs, EDMR treatment proved to yield limited success in treating veterans with PTSD, resulting in it being infrequently approved across the Health
Virtual Reality Exposure Therapy. Virtual Reality Exposure Therapy (VRET) is similar to a gaming system, which utilized a joystick to help navigate through the treatment. In contrast to a typical video game, VRET recreated a realistic environment with smell, 35 sights, sounds and body motion tracking functions. It allowed the veteran the option to use head mounted display system and/or enter a computer-automated room where trauma images were presented. VRET assisted patients in reliving the experience in an environment that was safely controlled, facilitating confrontation of fears with a practicing mental health professional present (Botella, Serrano, Banos & Garcia, 2017). The main objective of VRET was to minimize fear and anxiety caused from PTSD. One research confirmed that there was potential efficacy of VRET in treating PTSD or different types of trauma. It was more appropriately applied to patients who were un-responsive to traditional treatment measures. VRET fostered increased engagement by the veteran, allowing for greater activation of the traumatic memory, necessary to overcoming fear. One reference material suggested that VRET was utilized minimally throughout the Veteran Administration System, partly due to limited available studies evaluating its effectiveness (Gonglaves, Pedrozo, Silva, Coutinho, Figueira & Ventura, 2016).

Emotional Freedom Technique. With reference to Emotional Freedom Technique (EFT), research supported that emotional issues and traumas reportedly caused chronic pain and other disease in the body. EFT was designed, using elements of cognitive and exposure therapy with acupressure to heal the body. Clinical trails as well as credible research confirmed that EFT effectively alleviated symptoms associated with
certain phobias, anxiety, PTSD and physical pain (Lake, 2017). According to one reference, a pilot study conducted randomly on selected veterans with PTSD in 2016, indicated that 65 percent of veterans who reported PTSD, were remediated after 10 or fewer EFT sessions. The evaluation supported that veterans with PTSD were subclinical after an average six sessions. EFT reportedly eliminated negative emotions, through the use of acupressure stimulation that communicated direct signals to the brain, thus reducing the threat response within the body. The Department of Veterans Affairs rejected the approach for many years, despite efforts of congress to have it considered. However, after reviewing the extensive evidence for safety and efficacy, it underwent approval in 2017, but still being recommended minimally (Church, Stern, Boath, Stewart, Feinstein & Clond, 2017).

**Acupuncture.** The Department of Veterans Affairs identified acupuncture as a Complementary and Alternative Medicine (CAM) treatment for PTSD. It was reported to be instrumental at improving health and wellness through stimulation techniques, by the insertion and manipulation of needles placed in specific anatomic points in the body (Cukor, Spitalnick, Difede, Rizzo & Rothbau, 2018). A number of studies have supported the safe and cost-effective use of acupuncture in treating symptoms of PTSD. The results indicated substantial evidence supporting its effectiveness to treat PTSD. As an alternative approach to treating veterans with PTSD, the Department of Veterans Affairs will not recommend acupuncture as a first or second line intervention. In addition, most of the hospital facilities does not offer services internally, and required referrals to outside providers, at the discretion of mental health providers (Kim, Heo, Shin, Crawford, Kang & Lim, 2017).
**Trauma-Focused Yoga.** Yoga is an ancient practice originating from India, designed to create balance between the physical and mental facets of an individual, in an effort to rejuvenate the subtle energies of the body. Recent pilot studies conducted, demonstrated dramatic changes in PTSD scores as a result of trauma-focused yoga (Jindani, Turner & Khalsa, 2018). The systematic review assessed the efficacy of yoga successfully alleviating anxiety and depression associated with PTSD (Libby, Reddy, Pilver & Desai, 2018). According to the Department of Veteran Affairs, researchers with the Atlanta Veteran Affairs Medical and Rehabilitation Center concentrated efforts on thoroughly evaluating veterans’ response to trauma-focused yoga treatment, in reducing PTSD symptoms, chronic pain and insomnia. The study was still in progress and projected to be completed by the year 2020, and the response will be used as a deciding factor, whether to implement and recommend veterans to using trauma-focused yoga treatment approach (Cukor, Spitalnick, Difede, Rizzo & Rothbau, 2018).

**Medical Marijuana.** With reference to Medical Marijuana, a growing number of literature provided strong evidence that Cannabidiol (CBD) contained anxiolytic effects, capable of regulating learned fear, by reducing the expression of fear memory and facilitating its extinction. (Jurkus, Day, Guimaraes, Lee, Bertoglio & Stevenson, 2018). A number of States that previously denied the medical use of marijuana were now allowing patients to access as an alternative treatment for PTSD, in consideration of the findings. In November 2017, the New York Governor signed into legislation, allowing war veterans suffering from PTSD to legally access Medical Marijuana. In a study conducted by the Department of Veteran Affairs in 2017, it was claimed that limited evidence was available to substantiate the positive impact of Marijuana in treating PTSD.
As a consequence, the Department of Veteran Affairs refused to prescribe the use of Medical Marijuana to veterans with PTSD. However, it was indicated that further research was contemplated to better understand the patterns of Marijuana and its connection to health, functioning and service utilization, before future approval was contemplated (Earleywine & Bolles, 2018).

**Mindfulness-Based Cognitive Therapy.** A study conducted in 2015 in connection with Mindfulness-Based Cognitive Therapy, discovered that it was comparatively more successful than current evidence-based therapy. Researchers with the Minneapolis Veteran Administration Health Care System administered nine sessions of Mindfulness-Based Stress Reduction therapy to 58 veterans. MBCT was used in conjunction with cognitive therapy with the fundamental objective of increasing awareness of all thoughts and emotions. The fundamental purpose of the combined action was to instruct veterans to remain in the present moment, allowing for a nonjudgmental response (Gallegos, Cross & Pigeon, 2017). In contrast to focusing on negative and disturbing thoughts, MBCT worked at actively diverting attention away from deep contemplation to creating a more positive, lasting changes to the brain processes. Two months following completion of the treatment, a 48.9% reported significant improvement in the severity of PTSD symptoms, such as avoidance and hyper-arousal. The Department of Veterans Affairs currently utilizes this technique minimally, in treating veterans with PTSD (Colgan, Whabe, Pleet, Besler & Christopher, 2017).

**Music Therapy.** Music therapy is reportedly effective at improving functioning and fostering resilience in veterans with PTSD. Studies have established that music with low pitch and low sound, holds the potential to trigger the brain to release chemicals to
distract the body and mind from emotional pain (Miller & Teramoto, 2017). Music therapists utilized pleasurable sounds to create a more comfortable setting for PTSD patients to talk about unpleasant and painful memories (Garrido, Baker, Davidson & Moore, 2018). A study conducted by the Department of Veterans Affairs in Milwaukee, Wisconsin, sought to evaluate the effectiveness of music therapy in relieving PTSD symptoms. The study entailed 40 veterans with severe PTSD symptoms, who were exposed to one hour of individual guitar training for a six-week intervention. The results indicated a positive response in minimizing symptoms commonly associated with PTSD as a result of the intervention. In the last five years, the Department of Veteran Affairs has more progressively increased the number of music therapists at its clinics (Shack, Heinz & Miller, 2017).

**Cognitive Processing Therapy.** Cognitive Processing Therapy (CPT) is focused on changing automatic thoughts and is generally administered in a 12-session interim, for 60 minutes’ duration each session (Sharpless & Barner, 2018). In this setting, veterans were instructed to construct a brief narrative of the traumatic event experienced. The narrative included a brief description of thoughts, feelings and memories, which the veteran was required to verbally articulate to the treating therapists. The focal point of the sessions was centered on helping veterans challenge their beliefs through socratic questioning and the use of daily journalizing. A complete analysis of the trauma was written at the outset and at the conclusion of therapy, to allow the veteran to solidify the changes in their thinking, toward progressive healing (Monson, Schnurr, Resick & Stevens, 2017). One study demonstrated that CPT was moderately efficacious and highly recommended throughout the Department of Veteran Affairs system (Kaysen, Schumm,
Pedersen, Seim, Gillian & Chard, 2017).

Summary of Literature Reviewed

In this chapter, a review of appropriately selected research studies, journals articles, and reputable websites were reviewed to properly evaluate PTSD in a multi-faceted format. The literature reviews was used as a basis for creating a structure to better comprehend the history and definition of PTSD, its prevalence among military veterans, and current problems resulting from PTSD. The definition of PTSD emphasized the seriousness of the disorder and the projection of continued growth among military veterans in the coming years. The literature review also outlined current issues associated with current evidence-based treatment employed through the Department of Veteran Affairs, and identified a number of Alternative treatment measures for recommendation, to more successfully assist veterans in managing and controlling symptoms of PTSD, with the goal toward recovery.

Evidence based therapies such as Eye Movement Desensitization and Reprocessing (EMDR), Virtual Reality Exposure Therapy, Emotional Freedom Technique (EFT), Acupuncture, Trauma-Sensitive Yoga, Medical Marijuana, Mindfulness–Based Cognitive Therapy, Music Therapy, and Cognitive Processing Therapy (CPT) have very strong bodies of evidence supporting their effective use in treating PTSD. Mental health providers bear the responsibility to effectively evaluate each veteran, in an effort to determine the level of severity of PTSD, and to willingly recommend individualized care that is most appropriate to the patients need.
Chapter 3

Methodology/Procedures

Research Methodology

This chapter focused on the methods that were utilized to acquire data in connection with the purpose of the research. It was segmented into different categories to include, the instrument used to collect the data, the field sample, a description of the actual sample, data collection and recording procedures, data processing and analysis procedures, as well as methodological assumptions and limitations.

The fundamental purpose of this study was to emphasize the need for Alternative Management Strategies to successfully treat veterans with PTSD in the New York City Metropolitan area. The study was created to bring awareness to current challenges encountered as a result of utilizing current evidence-based treatment only, and recommend more reliable and effective measures for improvement. The study was focused on a quantitative research approach, utilizing online surveys to collect data from the Veteran Administration Psychiatry and Psychology team in the New York City Metropolitan area. Health research often results from surveys that were generally used to identify deficiencies and need for improvement within organizations (Kelley, Clark, Brown & Sitzia, 2017). The survey was significant in collecting data from a predetermined population and using the data to make some inference about the existence of the problem in the specified geographic location (Krosnick, 2016). Surveys were effective tools used to advantageously test theories, generate reliable and objectionable outcome and examine relationships between variables to determine cause and effect (Hoe & Hoare, 2013).
**Instrumentation**

The data collected for the study was used to appropriately answer the research questions formulated in Chapter 1. An online survey was created using Survey Monkey, which was made available on Facebook social media for participants to respond. Participants were invited to complete a Questionnaire consisting of 10 questions within a two-week time-span, in reference to current treatment and consideration of Alternative Management Strategies for treating PTSD in the New York City Metropolitan area. Formal consent was originally requested to complete in-house, however, consent was not received, prompting the researcher to utilize alternative channel in collecting the required data for the research study. The 10 survey questions consisted of at least five options from which to select, and was created with originality, simplification and applicability to the topic understudy.

**Field Procedures**

The Questionnaire was formulated by the researcher and sent to Central Michigan University for review and approval prior to data collection. An invitation accompanied a cover letter, prompting participants to respond to the 10-question survey, which was distributed online on Facebook. Participants were also informed by email about the survey invitation, with the Survey Monkey link attached in the email. The survey cover letter entailed specific details relative to voluntary participation, the purpose of the survey, the allotted time for completion, the need for honest feedback and anonymity of the responses. The time frame designated for the completion of the survey included two weeks. The participants were inclusive of mental health providers employed by the
Department of Veteran Affairs. Immediately after collection and analysis of the data from Survey Monkey, the researcher ensured data was deleted thereafter.

**Sample**

A sample of current Mental Health Professionals, including Psychologists and Psychiatrists, employed by the Department of Veteran Affairs, were chosen to conduct the study. The participants were of unspecified ages and included both genders, responsible for administering treatment to veterans with PTSD. The survey questions sought to collect data from the treatment specialists in reference to the prevalence of PTSD in the New York City Metropolitan area, the current treatment measures implemented and to assess the participant’s willingness to recommend Alternative Management Strategies in treating veterans with PTSD. A sample size of 22 was the target for the study, with an estimated 80% response rate. Approximately 30 invites were transmitted by email to provide alert about the survey to be completed. From the target population, an averaged 50% participated in the survey, which was less than anticipated.

**Data Collection and Recording Procedures**

The quantitative research method was employed to acquire relevant information to sufficiently answer the proposed 10 questions in the survey. The study utilized an online approach, identified as the most widely used quantitative research methodology. The 10 survey questions created by the researcher closely mirrored the 4 original research questions recorded in Chapter 1. The questions were appropriately structured to collect relevant and valid data to the subject considered. The survey questions were created, using easily understandable language to eliminate misunderstanding and to ensure easy, accurate, and quick responses. The anonymity of the survey provided a basis for trusting
the reliability and validity of the responses. The responses were recorded by Survey Monkey and later analyzed after the timeline had expired.

**Data Processing and Analysis Procedures**

After the designated 14 days’ expiration for completing the survey, it was subsequently downloaded from Survey Monkey and further analyzed using Microsoft Excel. Survey Monkey was significant in assisting the researcher to analyze the data collected. Microsoft Excel was utilized to manipulate the figures of representation to include a diversity of display, depicted as figures. The authenticity of the data remained unchanged, however, the data was manipulated using Microsoft Excel, as Survey Monkey only afforded limited styles for displaying the data. The depictions entailed different pie charts, line graphs and bar charts, recorded in Chapter 4. The data was only exchanged from the researcher to the assigned Professor and Reviewer for grading purposes only. The results of the survey did not impact the participants, as the original data collected was deleted, and the analyzed data remained anonymous.

**Methodological Assumptions**

The researcher made the assumption that the survey would attain at least 80% participation and completed within the allotted time prescribed. The researcher also anticipated that the survey questions were completed truthfully, since the identity of the participants were anonymous and remained confidential. It was further assumed that the inclusion criterion of the sample was appropriate relative to the nature of the study. In addition, the researcher expected that the participants were competent readers, capable of understanding the questions in the survey and having the capacity to complete.
Methodological Limitations

There were limitations identified in the research study approach. The population sample was limited to mental health providers employed by the Department of Veteran Affairs. The sample responses originated from a small group, which may not be a true representation of the larger population of mental health providers. As a result, it was difficult to determine whether the responses would remain unchanged, taking into account a larger population nationwide. Therefore, the findings were only applicable to the specific geographic location under study and could not be generalized beyond that scope. The online survey method further resulted in a lower response rate as opposed to a direct participation format. Bias responses may have also affected the reliability of the responses collected, since the mental health providers were directly responsible for administering treatment to veterans with PTSD. Lastly, only military veterans with PTSD in the New York City metropolitan area were supported with the recommendations of the study.

Ethical Consideration

The survey was created online utilizing Survey Monkey and made accessible through Facebook social media. An electronic consent form preceded the survey online, which the participants read prior to completing the study. The confidentiality and anonymity of the survey was expressed in the cover letter and applied by way of non-identification of participants, followed by permanent deletion of survey results after documentation and analysis of the results. Further, the results were only divulged to the Professor for grading purposes. Additionally, voluntary participation was ensured with no repercussions for responding or failure to respond to the survey.
Chapter 4

Findings

Data Analysis Introduction

The findings presented in this chapter were analyzed from the data collected from the survey conducted from May 25, 2018 to June 07, 2018. The fundamental purpose of the survey was to determine if Veteran Administration counselors were willing to recommend Alternative Management Strategies in treating veterans with Post-Traumatic Stress Disorder (PTSD), to more effectively manage the symptoms and consequences that resulted from current evidence-based therapy. The survey was also used to better understand the significance placed on current evidence-based treatment techniques in comparison to Alternative Management Strategies. The researcher created a 10-question survey, focused on gathering pertinent data relevant to the scope of the study.

The survey was retrievable online on Facebook social media and made available to 30 mental health professions, which included psychiatrist and psychologist, employed by the Department of Veterans Affairs. The targeted population was 22, with 11 responses yielded. The 11 candidates or 50% of the response rate indicated complete responses to all 10 questions in the survey. The fundamental purpose of the study was to answer the following questions:

1. How effective are Alternative Management Strategies in treating veterans with Post-Traumatic Stress Disorder in the New York City Metropolitan area?
2. To what extent does Post-Traumatic Stress Disorder exist among military veterans in the New York City Metropolitan area?
3. To what extent does Veteran Administration counselors and psychiatrists support
the use of medication in treating veterans with Post-Traumatic Stress Disorder?

4. To what extent does Veteran Administration Counselors and Psychiatrists support the use of behavioral therapies in treating veterans with Post-Traumatic Stress Disorder?

**Data Presentation and Analysis**

The research questions provided in Chapter 1 were analyzed in this chapter. The four questions presented in Chapter 1 were re-created to include 10 survey questions. Questions 1 and 2 was used to evaluate the extent of Alternative Management Strategies to treat veterans with PTSD and whether veteran administration considered these treatments to be the effective. Questions 3 and 4 sought to identify the prevalence of PTSD in the New York City Metropolitan area. Questions 5 and 6 were constructed to acquire feedback from the respondents to determine the priority given to using medication therapy in treating veterans with PTSD. Questions 7 and 8 were designed to analyze the importance assigned to using behavioral therapy in helping veterans cope with PTSD. Question 9 was instrumental in determining how veterans in the specific demographic area responded to current evidence-based treatment (medication and behavioral therapy). Lastly, question 10 was used to better comprehend how respondents viewed all treatment strategies in response to what they recommended to be the most important in treating veterans with PTSD. The data in this chapter was depicted using visual and text formats to illustrate and explain what was represented. In addition, validation, conflicts, and other relationships between and among variables was discussed and analyzed.
Research Questions

Question 1: How effective are Alternative Management Strategies in managing veterans with Post-Traumatic Stress Disorder in the New York City Metropolitan area?

In reference to understanding how respondents viewed alternative treatments, the first question asked in the survey correlated to gathering feedback about the effectiveness that alternative management strategies have had in helping veterans successfully manage PTSD. Figure 1 depicts the question, as well as analyzed the data, and indicated optional responses below.

Figure 1: Effectiveness of Alternative Management Strategies

Out of the 22-targeted candidates surveyed, a 50% response rate was provided, with responses to all questions asked in the questionnaire. In response to the perception of alternative strategies being effective in managing PTSD, 5 of the 11 responses indicated that it was very useful, with an overall 45.45% response rate. The remaining 6 anonymous respondents agreed to strategies being somewhat useful, indicating an overall
54.55% total response rate for this category. No responses were provided for the other four categories, rated at 0%. More than half the responses implied a lack of confidence in Alternative Management Strategies advantageously improving PTSD symptoms. According to Kar, 2016, a number credible research substantiated that greater improvement was assessed from the use of Alternative Management strategies to treat PTSD, in contrast to current evidence-based treatment techniques (Kar, 2016).

To further comprehend the perception of respondents, in response to the importance attached to their willingness, to recommend veterans to utilize Alternative Management Strategies, a secondary question was asked. The data is depicted in Figure 2 below.

Figure 2: Willingness to recommend Alternative Management Strategies

How likely are you to recommend alternative strategies in treating veterans with Post-traumatic Stress Disorder in the New York City metropolitan area?

- Very likely
- Likely
- Neither likely nor unlikely
- Unlikely
- Very unlikely
- Prefer not to answer

From the 11 responses provided, 9 respondents or 81.82% responses were provided for the likeliness of recommending Alternative Management Strategies. The other 2 responses indicated neither likely nor unlikely, which represented an estimated
18.18% response rate. Although a higher percentage indicated a possibility of recommending Alternative treatment to veterans with PTSD, no responses were generated for the very likely category, suggesting that they were not thoroughly convinced or wholeheartedly willing to contemplate as an option. With reference to one article, it was held that ongoing deployments and increase in military sexual trauma would continue to add significantly to the already existing prevalence of PTSD. The response suggests that treatment specialists do not perceive alternative medicine as a priority to addressing and correcting PTSD (Sareen, 2016).

**Question 2:** To what extent does Post-Traumatic Stress Disorder exist among military veterans in the New York City metropolitan area?

To determine the extent to which PTSD existed in the New York City Metropolitan area, the survey asked the respondent to select from a 6-category response. Figure 3 highlights the analyzed data below.

Figure 3: The extent of PTSD in the NYC Metropolitan area
From the 11 respondents, 1 participant selected a lot (9.09% response rate), another respondent selected a moderate amount (9.09% response rate), while the remaining 9 participants selected a little (81.82% response rate). The prevalence of PTSD in the New York City metropolitan area was identified as moderate based on a number of credible studies, adding to the accuracy of the majority data responses (Richardson, et al, 2016).

Additionally, in reference to question 2, participants were asked to provide feedback on the percentage of veterans suffering from PTSD in the New York City Metropolitan area, to account for a more substantial response. The responses were shown below in Figure 4.

Figure 4: Percentage rate of veterans with PTSD in the NYC Metropolitan area

What is the percentage rate of veterans suffering from Post-traumatic Stress Disorder in the New York City metropolitan?

- 81% - 100%
- 61% - 80%
- 41% - 60%
- 21% - 40%
- 0% - 20%
- Prefer not to answer

Among the 11 participants, 10 or 90.91%, indicated that PTSD is in the 0-20% category in the New York City Metropolitan area, while 1 or 9.09% of the respondent indicated that it was between 21-40%. The majority of the responses indicated
consistent and accurate data, in connection with credible statistical data. According to the Department of Veterans Affairs, 2017, an overall 20% rating was assigned nationally to veterans with PTSD, while a 14% rating representing the veteran population in the New York City Metropolitan area.

**Question 3: To what extent does Veteran Administration counselors and Psychiatrists support the use of medication in treating veterans with Post-Traumatic Stress Disorder?**

The question was designed to understand the extent to which treatment specialists were willing to recommend medication as the first line of treatment, in contrast to Alternative Management Strategies. The data responses were displayed in Figure 5.

Figure 5: The extent to which treatment specialists support the use of medication

<table>
<thead>
<tr>
<th>Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>The most important priority</td>
</tr>
<tr>
<td>A top priority, but not the most important</td>
</tr>
<tr>
<td>Not very important</td>
</tr>
<tr>
<td>Not important at all</td>
</tr>
</tbody>
</table>

In reference to the participant’s responses provided, it was indicated that a total of 2 or 18.18% viewed medication therapy as the most important priority in treating veterans with PTSD. The majority responses totaled 9 or 81.82%, selected medication as
being a top priority. No responses were provided for the other categories. Wu, Husson & Clark 2017, highlighted that medication had minimal impact at reducing symptoms of PTSD and long-term use resulted in addition problems, leading to further misuse and abuse of medication. The continued use of medication as a priority treatment is expected to worsen the already deteriorated problem (Wu, Husson, Clark, 2017).

To further analyze the perception of the participants, the researcher attempted to gather responses regarding the effective use of medication in treating veterans with PTSD. The data is summarized below in Figure 6.

Figure 6: The effective use of medication in treating veterans with PTSD

A 27.27% response rate or 3 respondents indicated that medication was extremely effective at treating PTSD, while 63.64% indicated that it was very effective. In addition, one response or 9.09% of the responses provided, thought that medication was somewhat effective. From the responses evaluated, most of the respondents believed in the efficacy of medication to successfully treat veterans with PTSD. Studies have however, contradicted this perception, indicating more problems resulting from the use of
medication in comparison to benefits. Anti-depressant medication and opioids used to
treat PTSD have reportedly caused addiction issues, overdoses, violent-related injuries,
hospitalization as well as suicide (Teeters, Lancaster, Brown & Back, 2017).

**Question 4: To what extent does Veteran Administration Counselors and Psychi atrists support the use of behavioral therapies in treating veterans with Post-Traumatic Stress Disorder?**

As part of the questionnaire, it was important for the researcher to gain perspective on the perception of the mental health providers in response to the extent to which behavioral therapy was utilized in treating veterans with PTSD in the New York City Metropolitan area. A graphic representation of the data is presented below in Figure 7.

**Figure 7: The extent to which treatment specialists utilized behavioral therapy**

From the 11 responses provided, 2 (18.18%) of the participants agreed to always recommending behavioral therapy, with the majority response of 9 (81.82%) indicated
that it was a formality to refer veterans for behavioral health treatment. Research has suggested that some forms of behavioral therapy approaches can be used to improve PTSD. The Department of Veterans Affairs currently utilized Cognitive Behavioral Therapy (CBT), Cognitive Processing Therapy (CPT), with limited use of Prolonged Exposure (PE) and Eye Movement Desensitization and Reprocessing (EMDR). CBT and CPT were utilized more pervasively with short-term success. However, newer studies have suggested that PE and EMDR were more effective by comparison, but not utilized fully throughout the VA system (Reisman, 2016).

In an effort to better understand the perception of the mental health professionals, the participants further asked for additional responses relative to the importance of using behavioral therapy to effectively treat veterans with PTSD. Figure 8 depicted the data in an understandable format below.

Figure 8: Importance of Behavioral Therapy in managing veterans with PTSD

At least 36.36% (4 responses) indicated that behavioral therapy was extremely valuable in the treatment of veterans with PTSD in the New York City Metropolitan area.
More than half the responses indicated a positive response of behavioral therapy being very valuable (54.54% or 6 respondents). One participant responded that behavioral therapy was somewhat necessary, which reflected 9.09% of the response rate. While behavioral therapies have had attributable success, the rate is reportable minimal, due to the limited options promoted by Department of Veteran Affairs. The introduction of a multi-faceted approach to behavioral therapy indicated substantial improvement in addressing the problem of PTSD (Reis, 2016).

The researcher wanted further feedback on the impact of current evidence-based treatment (medication and behavioral therapy) measures in helping veterans successfully cope with PTSD. Figure 9 below is used to depict the data described.

Figure 9: Impact of standard treatment in helping veterans cope with PTSD

What is the impact of standard treatment (medication and behavioral therapy) in helping veterans with Post-traumatic Stress Disorder in the New York City Metropolitan area to

![Circle chart showing impact of standard treatment]

From the 11 responses provided, one (9.09% response rate) of the participants indicated that standard treatment only, had a very positive impact on treating veterans with PTSD. Approximately 81.82% (9 respondents) selected a positive response to standard treatment, with the remaining one (9.09% response rate) respondent, indicating a
neutral response. While the majority of responses collected, suggested that standard
treatment had a positive impact, a number of credible research reviewed arguably
differed. It was held that Alternative Management Strategies were more efficacious in
treating veterans with PTSD, when compared to the outcome of current evidence-based
techniques. The rate of veterans enrolled in current treatment plans, receiving standard
treatment, derived minimal positive results (Teeters, Lancaster, Brown & Back, 2017).

With reference to the final question on the survey, the respondents were required
to list treatments in the order of importance in response to their perceived benefits, in
successfully treating veterans with PTSD. The responses generated in order of
importance were firstly, the use of medication, followed by behavioral therapy, and
thirdly, Alternative Management Strategies. The data is analyzed below in Figure 10.

Figure 10: Rank of treatment according to importance

Please rank the following items in
order of importance to you, with
number 1 being the most important,
and number 4 being the least
important, in the treatment of veterans
with Post-traumatic Stress Disorder in

From the 11 responses collected, 10 of the respondents (90.09% rate) agreed that
medication would be recommended as the first line of treatment, with 1 respondent
(9.09% rate) indicating differently, agreeing to behavioral therapy. From the data provided, the analysis suggested that mental health providers strongly believe that medication and behavioral therapy were more instrumental in helping veterans successfully cope with PTSD in contrast to Alternative Management Strategies. Alternative Management Strategies have proven to yield comparatively higher success rate in improving PTSD in veterans. The newly adopted approaches to behavioral therapy treatment also proved to be more efficacious in comparison to traditional measures. With respect to medication, studies have indicated that medication minimally reduced symptoms of PTSD (Wahbeh, Senders, Neuendorf & Cayton, 2018).
Chapter 5
Summary, Conclusion, Recommendations

Summary

The purpose of this study was focused on Alternative Management Strategies efficacy in treating veterans with Post-Traumatic Stress Disorder (PTSD) in the New York City Metropolitan area. Treating PTSD in a veteran population has been reportedly difficult due to the complexities entailed in the different types of trauma. In addition, selective veterans with PTSD refrained from continuous treatment often as a result of dissatisfaction with current evidence-based therapy techniques (Wahbeh, Senders, Neuendorf & Cayton, 2018). Four major questions were designed to collect data, analyze and draw conclusion in connection with the current perception of treatment techniques being utilized. The questions were thereafter segmented into 10-survey questions used to collect data from Veteran Administration Counselors and Psychiatrists employed by the Department of Veteran Affairs. The study emphasized the potential for moderate to severe physiological, psychological and behavioral consequences of PTSD and secondary risk factors if left untreated, or under-treated (Sareen, 2016).

With reference to survey question one, more than half of the respondents indicated that Alternative Management Strategies were somewhat useful in improving symptoms of PTSD, which contracted to evidence supported from current research articles. In response to question 2, on the likeliness of recommending veterans to utilize Alternative Management techniques, 81.82% gave a positive response. In addition, question 3 and 4, yielded a majority response rate, identifying the current prevalence of PTSD ranging from 0-20% in the New York City Metropolitan area, which proved to be
consistent with credible statistical research. With reference to question 5, 6, and 10, it was indicated that veteran administration treatment counselors perceived medication as being most instrumental in treating veterans with PTSD, and as a result recommended as the first line of therapy. Questions 7, 8 and 9 indicated majority responses, supporting the extreme usefulness of behavioral therapy as a second line of treatment, often recommended in conjunction with medication therapy.

The result of the data was compared to multiple credible research articles on the issue of effective treatment strategies and outcome. The documented data in Chapter 4 indicated that veteran mental health providers were adamant about current evidence-based treatment techniques and found that medication therapy was a top priority in yielding improved outcomes for veterans with PTSD. In opposition, research from multiple, reliable sources, supported that Alternative Management Strategies provided greater improvement by comparison. Studies have confirmed that medication therapy resulted in minimal benefits by mildly treating the symptoms of PTSD, such as anxiety, depressive mood and sleep disorders (Shaley, 2017). It was further substantiated that medication usage was more detrimental to a veteran’s health, especially when used in combination with opioids. Veterans reportedly developed a tolerance to PTSD medication quickly, requiring increased dosage, and as a consequence created dependence issues. Additionally, veterans reportedly abused and misused different types of PTSD medication, due to inadequate benefits and the high potential for addiction. This has lead to further dramatic consequences such as hospitalization due to overdose, unemployment, and homelessness and in extreme cases suicide (Bennett, Pouget & Golub, 2016).
Veteran mental health providers, also generally contemplated behavioral therapy usage in conjunction with medication therapy. Across the Department of Veteran Affairs health system, the techniques frequently utilized entailed Cognitive Behavior Therapy (CBT), Cognitive Processing Therapy (CPT), Prolonged Exposure (PE), and recent additions of Eye Movement Desensitization and Reprocessing (EMDR), and Music Therapy, with the latter two recommended on a limited scale. Research has indicated that CBT used alone have yielded limited results (Kar, 2016). However, when combined with Alternative Management Strategy such as Virtual Reality Exposure therapy (VRET), it was perceived to be comparatively more beneficial, especially with war veterans. Studies have also supported that the use of CPT alone does not promote substantial efficacy, unless supported with another alternative treatment technique. CPT and EMDR reportedly promoted improved results in both war and MST veterans (Reisman, 2016). Research further dedicated to studying other approaches to more effectively treat veteran with PTSD, have uncovered significant benefits, utilizing Emotional Freedom Therapy (EFT), Acupuncture, Trauma-Focused Yoga, Medical Marijuana, and Mindfulness-based Cognitive Therapy. The success rate of these approaches was conclusive and extensive.

The Department of Veteran Affairs hesitated to utilize the treatment options discussed for a number of reasons. One included, lack of education and training on the part of the mental health professionals to provide care in specific areas mentioned. As a result, those alternatives were not offered directly at the different health care facility. Another reason included the high cost associated with referrals to outside providers. Further, there was an established need for confirmative analysis and testing of Alternative Management Strategies, due to perceived limited empirical evidence by the Department
of Veteran Affairs. Lastly, some of the services already approved, such as EMDR, VRET and Music therapy were not widely utilized in treating veterans with PTSD (Shalev, 2017).

**Conclusions**

Post-Traumatic Stress Disorder (PTSD) was the most urgent problem encountered by the United States military and the veteran population. According to the *National Institute of Medicine* (NIH), 2017, PTSD has become an expanding epidemic. Both pharmacological and psychological interventions proved to yield limited efficacy. The study revealed that Veteran Administration Counselors and Psychiatrists failed to consider Alternative Management Strategies as being more efficacious in comparison to current evidence-based treatments (Lake, 2017). Evidence-based practice remained the gold standard for treating PTSD. Although not objecting to Alternative Management Strategies, it was indicated as the third in consideration, following medication use and behavioral therapy. The study disclosed a prevalence rate of chronic to severe PTSD averaging 20%. With the anticipated inclination in the rates of PTSD from continued deployments due to combat operations, increasing challenges will likely amount, using current evidence-based therapy only. The data collected confirmed that medication therapy remained the first line of therapy, pointing to continuous increasing risks to antidepressants and opioids addiction and substance abuse on a larger scale. Additionally, failure to utilize appropriate behavioral therapy techniques, in collaboration with more reliable and efficacious Alternative Management Strategies, will seemingly result in under-treating PTSD, hindering successful recovery (Kar, 2016).
According to the Department of Veteran Affairs, limited evidence existed in support of the effective use of Alternative Management Strategies in the treatment of PTSD. With reference to current, validated research, current modalities undergoing tests in controlled studies have substantiated the incomparable efficacy of Alternative Management Strategies in contrast to current evidence-based treatment outcomes. In addition, Alternative Management Strategies proved to be more cost-effective with low-risk to worsening symptoms of veterans with PTSD. Controlled costs were expressed as well, through long-term symptom improvements, with decreased potential of relapsing into PTSD after recovery (Reisman, 2016). The widespread use of Alternative Management Strategies was indentified as being integral to improving the symptoms of PTSD among military veterans. Continuous research was necessary to further assess current methods to tailor specific treatments to meet the individual needs of veterans (Cukor, Spitalnick, Difede, Rizzo & Rothbau, 2018).

**Recommendations**

In connection with the literature review and the evaluated data from the survey, the researcher recommended Alternative Management Strategies as the future solution to effectively treat veterans with PTSD. The theoretical framework used to provide guidance on this research was the Change Theory, according to Kurt Lewin. The model involved a three-stage process that can be used to furnish recommended changes to better manage veterans with PTSD. Firstly, at the un-freezing stage, the researcher highly recommended addressing the extensive pitfalls resulting from current evidence-based treatment (growing prevalence, medication addiction, unemployment, homelessness, suicide), to bring full awareness to the problems and reinforce the need for improved
measures in an expeditious manner. Secondly, the change or implementation process, will involve approving veterans to more extensively utilize Alternative Management Strategies offered by the Department of Veterans Affairs and outside entities, when not available. In an effort to influence change and transform the perception of veteran treatment specialists, further research, pilot studies and evaluation of the use of alternative measures were necessary to facilitate change. For Alternative Management Strategies to become the standard operating procedure, the process will require extensive monitoring, and continuous evaluation and improvement for maintenance to occur (Grol, Bosch, Hulscher, Eccles, Wensing, 2017).

Post-Traumatic Stress Disorder was reportedly a debilitating mental disorder significantly impacting the veteran population with prospects of increasing prevalence in the near future. Research confirmed on several accounts that the use of varied approaches to alternative treatment techniques proved to be more efficacious when compared to current evidence-based treatment measures. To further substantiate its impact, it was necessary to conduct additional qualitative and quantitative research, in an effort to better comprehend the impact of Alternative Management Strategies in the treatment of veterans with PTSD. Future research should direct attention on examining the clinical effects of using varied alternative approaches through-randomized-control trials involving experimental group, and making comparison with another group receiving current evidence-based treatment, within a 30 day specified time frame for trial and evaluation. Measure of PTSD symptoms must be quantified using the Clinician-Administered PTSD Scale and the PTSD Checklist prior to treatment and after expiration of treatment. In addition, a longitudinal study measuring symptoms for one year would
be practical, to further analyze the outcome of treatment administered and to enable a more conclusive evaluation of current evidence-based treatment when compared to Alternative Management Strategies.
References


outpatient clinic. *Journal of Psychological Trauma, 8*(1), 107-14.


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Lake, J. (2017). The integrative management of PTSD: A review of conventional and CAM approaches used to prevent and treat PTSD with emphasis on military personnel. *Advances in Integrative Medicine, 2*(1), 13-23.


ALTERNATIVE MANAGEMENT OF PTSD IN VETERANS


Appendix A

Survey Questions

1. How effective are alternative strategies in managing veterans with Post Traumatic Stress Disorder in the New York City metropolitan area?

- Extremely useful
- Very useful
- Somewhat useful
- Not so useful
- Not at all useful
- Prefer not to answer

2. How likely are you to recommend alternative strategies in treating veterans with Post-Traumatic Stress Disorder in the New York City metropolitan area?

- Very likely
- Likely
- Neither likely nor unlikely
- Unlikely
- Very unlikely
- Prefer not to answer

3. To what extent does Post-Traumatic Stress Disorder exist among military veterans in the New York City metropolitan area?

- A great deal
- A lot
- A moderate amount
- Not at all
- Prefer not to answer

4. What is the percentage rate of veterans suffering from Post-Traumatic Stress Disorder in the New York City metropolitan?

- 81% - 100%
- 61% - 80%
- 41% - 60%
- 21% - 40%
- 0% - 20%
5. To what extent does Veteran Administration counselors support the use of medication as a priority in treating veterans with Post-Traumatic Stress Disorder in the New York City metropolitan area?

- The most important priority
- A top priority
- Not very important
- Not important at all
- Prefer not to answer

6. How effective is the use of medication in treating veterans with Post-Traumatic Stress Disorder in the New York City metropolitan area?

- Extremely effective
- Very effective
- Somewhat effective
- Not so effective
- Not at all effective
- Prefer not to answer

7. To what extent does Veteran Administration Counselors support the use of behavioral therapy in treating veterans with Post-Traumatic Stress Disorder in the New York City metropolitan area?

- Always
- Usually
- Sometimes
- Rarely
- Never
- Prefer not to answer

8. How valuable is behavioral therapy in the management of veterans with Post-Traumatic Stress Disorder in the New York City Metropolitan area?

- Extremely valuable
- Very valuable
- Somewhat valuable
- Not so valuable
9. What is the impact of standard treatment (medication and behavioral therapy) in helping veterans in the New York City Metropolitan area to successfully manage Post-Traumatic Stress Disorder?

- Very positive
- Positive
- Negative
- Very negative
- Prefer not to answer

10. **Please rank the following items** in order of importance to you, with number 1 being the most important, and number 4 being the least important, in the treatment of veterans with Post-Traumatic Stress Disorder in the New York City metropolitan area?

- Alternative strategies
- Medication
- Behavioral therapy
- Other (please explain): ________________________________________
Appendix B

Survey Online Cover Letter

SOCIAL MEDIA SURVEY

Marsha McLean, a graduate student in the Master of Science in Administration program invites you to take a survey about Alternative management strategies in treating veterans with Post Traumatic Stress Disorder. Interested participants can access the survey at https://www.surveymonkey.com/r/P58BYRB. Please note that you must be age 18 or older to participate in this study. Thanks for your help with my project. (Submitted by Marsha McLean, MSA program, phone (410) 903-8318, mclea1ms@cmich.edu).
Appendix C

Request to Conduct Research Letter

Date: 05/16/2018

Dear Participant:

My name is Marsha McLean and I am a graduate student at Central Michigan University. For my final project, I am examining Alternative Management of Post Traumatic Stress Disorder (PTSD) among military veterans in the New York City Metropolitan area. Because you are an employee, I am inviting you to participate in this research study by completing the attached survey.

The following questionnaire will require approximately 15-20 minutes to complete. There is no compensation for responding nor is there any known risk. In order to ensure that all information will remain confidential, please do not include your name. Copies of the project will be provided to my Central Michigan University instructor. If you choose to participate in this project, please answer all questions as honestly as possible and return the completed questionnaires promptly by clicking on the survey link found at the end of this letter. Participation is strictly voluntary and you may refuse to participate at any time.

Thank you for taking the time to assist me in my educational endeavors. The data collected will provide useful information regarding Alternative management of Post Traumatic Stress Disorder (PTSD) among military veterans in the New York City Metropolitan area. Completion and return of the questionnaire will indicate your willingness to participate in this study. If you require additional information or have questions, please contact me at the number listed below. Please feel free to e-mail me if you would like a summary copy of the study.

Please note that if you are not satisfied with the manner in which this study is being conducted, you may report (anonymously if you so choose) any complaints to the MSA Program by calling 989-774-6525 or addressing a letter to the MSA Program, Rowe 222, Central Michigan University, Mt. Pleasant, MI 48859.

Sincerely,

Marsha McLean, (410) 903-8318 or mclea1ms@cmich.edu
Faculty instructor: Dr. Calvin Lathan III, lathan1ca@cmich.edu

CLICK THIS LINK TO BEGIN THE SURVEY: https://www.surveymonkey.com/r/P58BYRB

Thanks for your participation.
Appendix D

Permission Letter

From: Prout, Christina Leigh
Sent: Thursday, May 19, 2018
To: McLean, Marsha Schinne
Cc: Lathan III, Calvin A; Fort Hamilton - CEL
Subject: Research Review Application approval/M. McLean

Dear Marsha,

Your Research Review Application has been reviewed and approved. You may start your data collection. This approval will not expire as long as your topic and methodology remain unchanged. If your topic or methodology changes, please submit a new Research Review Application and supporting documents to your instructor by e-mail.

Please contact your instructor if you have any questions. Also, be sure to check with your instructor concerning the due dates for your project.

Good luck with your project. This is the only notification you will receive. Please keep a copy for your records.

Kim Gribben

Assistant Director, MSA Program

WARNING: This message (including any attachment) may contain confidential information and is intended only for the individual(s) named. Please do not distribute, copy, or forward this e-mail without the permission of the sender. Please notify sender if you have received this e-mail by mistake and delete it from your system. Thank you.