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Veterans and Their Family Coping with PTSD

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Abstract

Post-Traumatic Stress Disorder (PTSD) has increasingly received attention as one of the "signature wounds" of Iraq and Afghanistan wars, with more than 560,000 veterans diagnosed with PTSD since 2002. The purpose of this study is to assess the impact of PTSD on all family members. The paper examines the history of PTSD, the preventive measures employed by Department of Defense (DoD), treatment methods, cost of treatments, and possible recommendations that could aid in alleviating the dangers facing family members with PTSD patients. Post-traumatic stress disorder (PTSD) is a mental condition common among war veterans. War veterans are susceptible to PTSD condition because of their military experiences in combats. They have either killed, narrowly escaped death, or witnessed someone die hence developing PTSD. Unfortunately, PTSD inhibits their ability to live a meaningful life after retirement. PTSD does not only affect the patient but also has an adverse impact on the health of other family members.

The data in this research was obtained from analyzing DoD documents, health documents in public and private hospitals, online articles on PTSD, scholarly articles on PTSD, and medical journals on PTSD. The results indicate most of the war veterans with PTSD do not receive adequate healthcare to manage their conditions. Moreover, PTSD condition puts strains on available family resources since the victims have to be treated. There is a need for DoD to overhaul current policies regarding PTSD condition and the government to increase funds to ensure war veterans receive quality healthcare.

Keywords: cognitive behavioral therapy, posttraumatic stress disorder, veterans, combat, depression, trauma, exposure therapy, Iraq, Afghanistan, access to care, social relationships, Department of Defense, psychotherapeutic interventions, psychoeducation, cognitive restructuring, and comorbidities disorders.

INTRODUCTION

Statement of the PTSD Problem

Approximately, 30% of war veterans experience PTSD. Research indicates half of Vietnam War veterans experienced “clinically serious stress reaction symptoms” (Runge, Waller, MacKenzie, and McGuire, 2014). Veterans from other wars have also experienced PTSD. According to Runge, Waller, MacKenzie, and McGuire (2014), 10% of Gulf War veterans, 11% of Afghan war veterans, and around 20% of those veterans who participated in Iraq War have experienced PTSD. Veterans have a difficult time adjusting to civilian life after several years of military activities. Failure to assist veterans with PTSD could be disastrous due to the cost of treatment and consequences associated with the condition. Furthermore, the veterans might not understand the severity of their mental health and fail to seek medical assistance. As such, there is a need for the government, community, and family members to join hands in providing amicable solutions that would help the veterans recover from their condition. Importantly, the veterans need to understand their health, assisted in finding medication, enabled to adjust to civilian life, and helped to coordinate family activities all which are vital in the recovery process (Runge et al., 2014).

Spelman, Hunt, Seal, and Burgo-Black (2012) established that, since the 1990s, the number of American troops committing suicide had increased significantly. In 2009, the numbers went even higher as a result of Iraq and Afghanistan war. In fact, the suicide rates among the veterans have gone higher than the general population. This is ironic since military personnel have access to quality health care and counseling services, which millions of ordinary

civilians cannot access. It is clear that the routine screening of military personnel for depression and mental related issues is not bearing any fruits. Statistics indicate that last year more than 1,600 veterans tried to commit suicide but for one reason or another they did not succeed. Spelman et al. (2012) stated that 30% of soldiers who took their own lives did so while on deployment while another 35% did so upon returning from war. Another marine pilot took his own life days before returning to Iraq for combat because he did not want to go back. Probably, the marine was afraid he could come upon the same traumatic event he had previously encountered (Spelman et al., 2012).

The other problem is a rise in domestic violence particularly; fatal child battery, child endangerment, and, domestic homicides. Waliski, Kirchner, Shue, and Bokony (2012) established that gambling, drugs, and alcoholism is common among war veterans with PTSD. Unfortunately, those behaviors affect the work performance, families, and lives of those involved. Multiple sources indicate that, between 2002 and 2008, 92,998 military individuals had been diagnosed with PTSD, 50,569 had neurotic disorders, 63,009 developed depressive diseases, 27,246 were involved in drug abuse, 16,217 were alcoholic, and 35,937 had useful psychoses. The numbers could be more since the research conducted dwelt on a small sample population. Department of Defense is afraid that, if the situation is not addressed adequately, families, children, and veterans will be affected significantly further burdening the justice system, health care, and mental health care systems (Waliski et al., 2012).

Conditions for the PTSD Problem

This section examines causative agents and signs of PTSD in military and veteran populations. The frequency of PTSD in general population is around 10% and is more common in women than is in men. However, among the military personnel, PTSD is predominant in men since most of the military employees are men. Although trauma is the leading precipitating condition encouraging PTSD, psychological and biological risk factors could also promote PTSD condition. Vagharseyyedin (2015) established that PTSD interferes with various natural systems such as neurochemistry, brain circuitry, immune system, and metabolic function. PTSD treatment involves a combination of psychotherapy and medications even though psychotherapy is more efficient. Currently, PTSD diagnosis is facing challenges due to lack of specific approach that can handle the condition efficiently. However, the introduction of modern biological methodologies provides an opportunity for individualized methods that could prove more useful (Vagharseyyedin, 2015).

The veterans experience traumatizing moments resulting from their experiences during various combating activities. The veterans have experienced shocking, traumatizing, and horrific scenes that remain glued in their memories. Such memories interfere with their mental condition leading to PTSD. The subsequent event occurrence minimizes the chances of the veterans leading a healthy life. Worse still, some of them end up developing suicidal tendencies. Perhaps that explains why there is an increase in suicide cases among the veterans. In fact, the Department of Veterans Affairs (VA) established that 20 veterans commit suicide daily since 2014. Moreover, the VA found out that 18% of the total suicide cases in 2014 were committed

by veterans. This calls for combined efforts from the national government, Department of Defense, community, and family members to help the veterans recover from PTSD and live a healthy life (Vagharseyyedin, 2015).

Shale and Atherton (2016) revealed that PTSD is a persistent, severe emotional response to a traumatizing event, which ruins one's life. The author further explained that not all traumatizing events lead to PTSD. Nonetheless, for a condition to be diagnosed as PTSD, the victim must have experienced a life-threatening event that amounts to horror, intense fear, or helplessness. PTSD is often triggered by a traumatizing event that is beyond normal human experience. For instance, deliberate distractive behavior such as murder and rape could initiate PTSD. Additionally, witnessing sexual assault, military combat, accidents, natural disasters, and death of a loved could elicit PTSD. Shale and Atherton further noted that PTSD symptoms are characterized by increased arousal, avoidance, and re-experiencing. In the case of re-experiencing, the victim re-experiences the event in the form of flashbacks, dreams, and recurrent images. In avoidance, the patients tend to evade events and people that may remind them of the traumatizing event. Increased arousal is characterized by anxiety, irritability, sleeplessness, and developing a fear of the unknown. For a patient to fully be diagnosed with PTSD, he/she must exhibit two arousal symptoms, one re-experiencing, and three symptoms in avoidance category (Shale & Atherton, 2016).

PTSD and DSM-5

According to Criterion A of DSM5, stressors result from exposure to death, threatened by death, a serious injury, or threatened by sexual violence in the following ways; witnessing a traumatizing event, direct exposure, or learning a close person was exposed to a traumatizing event. Criterion B provide that the traumatic event must lead to the following event experiences; nightmares, flashback, and emotional distress. Criterion C states that, the traumatized individual will start avoiding the trauma-related stimuli. Such individuals try to forget those events, anyone, or place that remind them if the stressors (Shale & Atherton, 2016).

The negative thoughts and feelings eventually get worse as provided in Criterion D. The patient is unable to remember key features of the stressor, develop negative thought about the world and oneself, blames self or others for any mistake, they isolate themselves from others, lose interests in life, and avoid anything that has positive impact in their lives. According to Criterion E, the patient experience trauma-related arousal in the following ways; irritability, risky behavior, limited sleeps, lack of concentration, and heightened startle reaction. Criterion F further argue that the symptoms ought to last for more than a month while Criterion G argues that the symptom leads to functional impairment in terms of job and social functioning. Those symptoms should not result from substance abuse or medication as provided by Criterion H (Shale & Atherton, 2016).

Purpose and Objectives PTSD Study

The objective of this study is to increase understanding of PTSD. Notably, the study identifies causes of PTSD, symptoms experienced by patients, and prevalence of the condition in the country. The research also purposes to examine the events and issues underlying the PTSD condition. For instance, the study examines activities that encourage the development of the condition and offers an alternative remedy to the situation (Yambo et al., 2016). The study examines the illogical thinking and interpersonal problems that encourage the development of the condition. The last part provides interventions that family members and other stakeholders could use to curb PTSD among the veterans.

Yambo et al. (2016) argued that the primary purpose of a PTSD study should be to create increased understanding of PTSD. That involves identifying causes and symptoms of PTSD before developing short and long-term plans for managing the condition. The authors sum up their objectives by arguing the effective management of anxiety and stress should be the prime purpose of a PTSD study. Promoting enhanced assessment and cure of PTSD is the prime target of this study. Assessment not only improves diagnostic precision but also offers clinicians methods of monitoring the results of their patients. Advancing scientific study of PTSD enhances understanding of psychology, etiology, and pathophysiology of PTSD and eventually, a better treatment of the condition. That explains why this article purposes to examine cognitive changes linked to PTSD and VA-PTSD recovery programs (Yambo et al., 2016).

This article also seeks to provide the genesis of PTSD, background, and historical information about PTSD to enable the stakeholders to understand the history of the condition, the nature of the disease, and cost implication associated with PTSD. By analyzing the prevalence of the term in society, the article seeks to make it easier for the government to distribute resources equally so that all those in need of medical attention would receive quality health care that improves their condition. Importantly, the article identifies barriers that inhibit access to quality health and possible remedies. Such measures enable the stakeholders to assess the obstacles and come up with solutions that will allow all patients to access quality healthcare regardless of their race, age, and economic status (Yambo et al., 2016).

BACKGROUND AND HISTORICAL INFORMATION OF PTSD

History of PTSD

The risk of PTSD has been with humans since they evolved as species. Attacks by animals and the 21st Century terrorist attacks have produced similar psychological effects as PTSD effects in the Vietnam and Iraq wars. Interestingly, Shakespeare's Henry IV appears to have all symptoms of PTSD (Wangelin & Tuerk, 2014). The American Psychiatric Association added PTSD in its 3rd edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1980. Since its introduction in DSM-III, PTSD treatment has filled a vital space in psychiatric theories and practice. An important concept introduced by the American Psychiatric Association was that PTSD was caused by factors beyond personal control instead of inherent individual weakness (Wangelin & Tuerk, 2014).

Before classifying of PTSD as a mental health disorder by the American Psychiatric Association (APA), symptoms of PTSD were recorded among civilians involved life-threatening events such as the Civil War and railway collisions. Civil War soldiers developed conditions such as melancholia, excessive emotionality, and withdrawal syndromes. Others developed excessively exhaustion condition commonly called cardiac muscular exhaustion or soldier's heart condition. Medical officials at that time assumed that the conditions resulted from heavy luggage carried, limited time for a recruit to adapt to the military lifestyle, poorly motivated soldiers, and homesickness. During the better part of the 20th century, mental health conditions among the war veterans were not given high medical considerations due to high fatality rates from accidental injuries during the wars (Wangelin & Tuerk, 2014).

During World War I, disordered action of the heart and shell shock condition were commonly diagnosed among war veterans. Shellshock was characterized by symptoms such as fatigue, tics, tremors, memory loss, and poor concentration most of which are associated PTSD. Ghaffarzadegan and Larson (2015) revealed that the current PTSD condition was initially called old-sergeant syndrome during the world wars periods. Resulting from WWI definition of shell shock disease, other symptoms of the condition witnessed in WWII included battle exhaustion, war neurosis, flying syndrome, psychoneurosis, and cardiac neurosis. After the Vietnam War, most research linked the combat fatigue conditions to veterans suffering from prolonged psychological problems that resulted from their occupational hazards. The National Vietnam Veterans Readjustment Survey (NVVRS) was the pioneer body to research to examine PTSD and war-related mental issues among the veterans. The NVVRS played a crucial role in associating PTSD with Vietnam War Veterans and classifying it as a mental health disorder. The

result contributed to the formal recognition of PTSD by APA as a distinct disorder (Ghaffarzadegan & Larson, 2015).

The Nature and Impact of PTSD

PTSD is common among individuals who have experience with wars or have experienced traumatizing events. The effects of PTSD may be chronic or acute depending on the trauma these veterans were exposed to during wars. The PTSD does impact not only the victims but also the government, the community, and immediate family members (Vasterling et al., 2010). Managing PTSD is a costly affair because billions of money are pumped into medication of PTSD patients.

PTSD patients are also a loss to the community because the society ends up losing energetic and strong members of the organization that would have assisted the community. The society also has to spend more funds on health centers that could support people living with PTSD to recover. At a personal level, the victims tend to develop suicidal thoughts and stress among other medical conditions. Such individuals tend to be violent leading to divorce cases. In fact, Vasterling et al. (2010) established that divorce rates is higher among Vietnam Veterans compared to the general populations. The authors further argue the rates are significantly higher among the veterans with PTSD. According to NVVRS, male and female veterans without PTSD experience longer-lasting relationships as opposed to their colleagues with PTSD. Moreover, rates of divorce were two times higher among veterans with PTSD when compared against those without PTSD (Vasterling et al., 2010).

The distressing events are notable stressors among veterans. Vasterling et al., (2010) highlighted that stressors usually involve a life-threatening event and intense fear. The victims

respond with shame, guilt, emotional numbing, and extreme anger. Whether individuals develop PTSD after traumatizing activities depend on the severity of the stressors. Those at risk of developing the condition include victims of the bombing and sexual assaults. Victims of war, terrorism, and torture are also susceptible to PTSD. Symptoms of the disease consist of flashbacks of the vents, nightmares, and reoccurring images of horrifying events. The victims also tend to avoid people and situations that remind them of the horrific events. PTSD patients tend to push away horrible memories as a healing process though the method is not very practical. Hyperarousal symptoms include exaggerated startle responses, threats, and sleep problems. Additionally, victims report symptoms such as emotional numbing, amnesia, lack of feelings, and withdrawal syndromes. Other symptoms include anxiety, reduced sexual libido, and depression that inhibit well-being of the victims (Vasterling et al., 2010).

Symptoms of PTSD occur within a month after exposure to a traumatizing event though in some individuals, symptoms take longer than a month before manifestation. The degree of PTSD that develops from the trauma and symptoms that manifests depend on the resilience of an individual and the level of exposure to the traumatizing event. Some patients might recover from the conditions without necessarily receiving any medication. A third of individuals who developed PTSD within a month might remain symptomatic for more than three years. Such individuals might also end up abusing drugs. As such, it is crucial to start medication at an appropriate time to avoid the condition becoming chronic. An indicator of treatment is the severity of the symptoms within the first five weeks (Wangelin & Tuerk, 2014).

There are numerous disability, impairment, and secondary problems associated with PTSD (Vasterling et al., 2010). The conditions cause distress that eventually interferes with the

educational, social, and occupational functioning of the victims. Individuals with PTSD often lose their jobs because the situation inhibits their functionality. Some of them turn violent at the workstation, abuse clients, or bosses and abuse drugs leading to their laying off. This results in financial problems that increase stress to the victims and their family members (Vasterling et al., 2010).

Prevalence of PTSD JW

Runge et al. (2014) revealed that 3.5% of Americans struggle with PTSD every year. In fact, the risk of developing the condition at one point in life is 8.7% though the percentage is 75% among soldiers. As per 2014, more than 560,000 Iraq and Afghanistan war veterans had developed PTSD. A further study of PTSD prevalence revealed that 9% of soldiers aged above 18 years returning from war develop PTSD within the first year. However, the percentage rises to 30% after one year. Runge et al. (2014) also established that less than 20% of Afghanistan and Iraq war veterans do not seek medical help while 50% seek medical attention. On the other hand, 10% to 30% of Vietnam War veterans develop PTSD (Runge et al., 2014). Unfortunately, 50% of veterans with PTSD do not seek medical assistance. To make matters worse, combining traumatic brain injury (TBI) and PTSD gives a percentage of over 50% for veterans with traumatic related health problems. Research by the authors also revealed 4% of the general public have PTSD condition resulting from car accidents, abuse, or natural disasters (Runge et al., 2014; Ruzek et al., 2014; Vasterling et al., 2010).

Prevalence of PTSD is greater among male veterans than their female counterparts. The explanation for this is that more men are employed in the military than female. Additionally, women are not allowed to serve in a direct ground combat hence reducing their exposure to

stressors. Rauch, Sheila, and Eftekhari (2012) argued that, though fewer women serve in the frontline, nonetheless they are equally exposed to some stressors such as sexual assaults hence developing PTSD. Interestingly, the authors also argued that age equally contributes to the development of PTSD. For instance, veterans below 24 years of age are more likely to be diagnosed with PTSD compared to veterans above 40 years. The explanation for this is that those aged above 40 years are accustomed to combat-related stressors hence low rates of developing the condition (Rauch, Sheila, & Eftekhari, 2012).

Ruzek et al. (2014) revealed that VA data indicates that black veterans are more likely to develop PTSD compared to their white counterparts. Similarly, Hispanics have higher prevalence rates of PTSD than whites. The explanation for this is that blacks are exposed to more combat-related stressors, most of them join the military at a young age, and have lower education standards. Veterans with lower IQ are prone to PTSD compared to those with higher IQ. The explanation for this is that individual with lower IQ tends to abuse drugs and have generalized anxiety disorder thus being susceptible to PTSD. Ruzek et al. (2014) further stated that suspected early childhood abuse/trauma increases the chances of adult PTSD (Ruzek et al., 2014).

Countrywide cost of PTSD

The government spends around \$8,300 to treat troops with PTSD and \$11,700 to treat those with TBI (Hendin, 2014). That is around five times the cost of treating soldiers without

PTSD (\$2,400). The Veterans Health Administration (VHA) spent a half of its budget from 2004 to 2009 to treat post 9/11 soldiers with PTSD. The VHA spent \$3.7 billion on veterans from 2004 to 2009 with 60% of the budget (\$2.2 billion) spent on a patient with PTSD and TBI (Hendin, 2014). Specifically, VHA spent a total of \$6 billion on war veterans between 2002 and 2010. However, the total cost used on all military personnel between 2002 and 2010 amounted to \$48 billion (Hendin, 2014). C. Hoge et al. (2014) believe it is hard to estimate screening and treating costs of PTSD. The author argued that screening a PTSD in a civilian hospital is around \$23 per patient that is similar to the value of testing a patient with depression (Hendin, 2014).

Ghaffarzadegan and Larson (2015) took a different approach when analyzing the total cost of treating PTSD. The author examined health care received depending on hospital and region in which the patient received care. The authors established that the cost of treatment depended on the hospital and region. In their estimation, the costs of treating an inpatient were between \$7,027 to \$12,954, the price for outpatient was between \$1,812 to \$3,514, and cost for pharmacy was between \$125 to \$238. The research also established that cost for treating serving military personnel were similar to those for treating veterans. For instance, the price of managing enlisted inpatient personnel oscillated between \$10,723 to \$12,954 whereas outpatient's cost was between \$684 to \$1,130. For those identified with PTSD, there is a need for the government to provide enough resources to treat them and improve their wellbeing. Early and quality treatment is beneficial because it averts productivity loss linked to PTSD (Ghaffarzadegan & Larson, 2015).

In a study by VA, the cost of treating veterans from Iraq and Afghanistan who had developed PTSD ranged between \$708 million and \$1.2 billion in two years. This translated to around \$5,904–\$10,298 per patient after discharge from the military (Shale & Atherton, 2016). Interestingly, a large portion of the cost resulted from productivity loss that accounted for over 60% of the total costs. The veteran visited health facilities 10.2 times per year. The cost per visit was \$105. Specialized treatment programs for PTSD cost VA around \$42,716,581 in 2010 (Shale & Atherton, 2016). Even though the above data was obtained from reliable sources, nonetheless it is difficult to estimate the real cost of treating PTSD in the country. Moreover, the data obtained from VA has limited in that it was for specific programs that do not include all veterans. Worse still, the DoD has no data on treatment of veterans with PTSD thus making it hard to come up with the exact cost of medication (Shale & Atherton, 2016).

Cost of PTSD to Community

The economic damage to communities, regarding treatment cost, funding for health centers, and loss of productivity averages to over \$320 million a year in most communities. LeBouthillier, McMillan, Thibodeau, and Asmundson (2014) established that community-based mental health care providers are not equipped to attend to individual needs of military veterans and their family members. Notably, most communities do not have enough resources for evidence-based treatment of PTSD. Lack of funds denies communities to provide effective psychotherapies in community-based settings. Communities do not have behavioral health centers, hospital trauma centers, and substance-abuse treatment facilities. Murphy et al. (2014) argued that PTSD veterans become a liability to the community if the condition is not handled correctly. In fact, PTSD can impact the relationship between a victim and the community

because of the way they respond to the situation. There are cases where such veterans end up being homeless because they are unable to clear mortgages for their houses (Murphy et al., 2014).

Stigma is one issue that affects the PTSD in the society. Stigmatization makes the victims feel guilty thus withdrawing from the society. The results are that such victims fail to seek for medication and job opportunities thus unable to live the life they wanted. Because of stigma, some employers turn away the veterans, therefore, minimizing alternative sources of income available for them. Shame might compel those victims to seek solace in drugs thus living a life that is different from the one they had hoped for. There are cases where the veterans engage in violent behavior within the society (Murphy et al., 2014). A number of them are involved in club fights or join gangs that perpetuate criminal activities in the community. As a result, some of them end up in court accused of criminal offenses. The worse part of is that some of the victims might extend this violence to their children or close family members thus breaking up the family. Breaking up families has a dire consequence to the community since the family is the fabric that holds together a given population (Murphy et al., 2014).

The veterans are vital people in the community because of their previous services of protecting the nation. There is a need for the stakeholders to provide the necessary resources to improve their wellbeing. The veterans should be given job training skills to enable them to get work experience outside the military profession. As a result, the veterans become employable thus improving their lives. If possible, the veterans should volunteer to work for free to gain work experience that would increase their chances of getting job opportunities. Employers must

be sensitized on the rights of veterans to employment. Prompt employment, provision of pension benefits, protection against discriminating, and restoration of health insurance by the government and other concerned authorities are sure ways of improving the health condition and general well-being of the veterans (Murphy et al., 2014).

Cost of PTSD to Family

The cost evaluations for treating PTSD per person ranges from \$1,160 to \$4,724 per year (Lincoln & Sweeten, 2011). Unfortunately, some patients require several years before they could fully recover. As such, families end up spending tens of thousands of dollars in treating their loved ones. In fact, cost of treating PTSD could amount to over \$10,000 thus costing both the families and VA. The VA provides claim benefits for veterans with proven PTSD condition. The cost does not involve money alone. The patients might develop violent tendencies in the family leading to divorce cases. They're reduced productivity might compel them to leave their jobs leading to economic woes. Lincoln and Sweeten (2011) revealed PTSD could cause productivity losses of over \$21 billion per year. Apart from medical bills, lost productivity, the cost to the employer, and lost wages is also another issue that impacts the family and community at large. Worse still, those with PTSD develop other medical conditions such as anxiety, substance abuse, and depression forcing them to spend even more money to treat those conditions (Lincoln & Sweeten, 2011).

The cost of treating PTSD is so high such that the whole family gets involved. Though VA and DoD chip in to assist the veterans, the funds provided by the two departments is not enough for quality health care. As such, some family members end up using their resources to help the victims receive quality healthcare. Additionally, some victims are subjected to treatment

therapies that goes on for years to cope up with the condition thus incurring more costs. As such, the families end up spending thousands of dollars in medication (Lincoln & Sweeten, 2011). Data provided by VA indicate that a family might spend over \$10,000 in a span of four years (Lincoln & Sweeten, 2011). The spouses of veterans might also develop depression, which eventually needs therapy similar to their partners thus increasing the cost of medication on the family. The cost of treating a PTSD patient in the family limits the ability of the family to spend on other issues or go into debt. For instance, children of the veterans in private schools might be forced to go to public school. The family might also reduce the money spent on outings and food to accommodate the hospital bills or go into debt to pay for those extra bills (Lincoln & Sweeten, 2011).

The self-isolation tendencies exhibited by PTSD victims are dangerous for a relationship because the victims end up avoiding their partners and children. Such victim ends up neglecting family responsibilities such as caring for the children and attending academic clinics for their children (Lincoln & Sweeten, 2011). Such tendencies are a recipe for divorce cases if not handled properly. While drug abuse does come as an attempt to cope or release anger/frustration of PTSD, the patients are also known for domestic violence, and low libido. All those conditions provide grounds for divorce case leading to separation of families. Some victims with PTSD are also unable to find any meaningful job opportunities. As such, they are unable to provide basic needs for their families leading to divorce cases (Lincoln & Sweeten, 2011).

PREVENTION

Outline of PTSD Prevention

There is a common saying which states an ounce of prevention is worth a pound of cure. Prevention is any measure taken to inhibit the occurrence of a disease. It could also mean intervention taken to curb the spread of illness. Prevention of Post-Traumatic Stress Disorder in active-military personnel is done via programs designed to prepare soldiers for combat-related stressors. Some programs tend to minimize occurrence of stressing events such as sexual violence while others train members to adapt to traumatizing events. Early detection and treatment of PTSD during the initial stage is another prevention strategy used by DoD. Treating acute stress disorder (ASD) before it develops into chronic PTSD is the best strategy for protecting the military personnel at a risk of PTSD. Spelman et al. (2012) demonstrated that prompt intervention for acute stress disorder encourages decrease of ASD symptoms plus deterrent of PTSD onset.

Preventions of PTSD occurs in three levels namely primary, secondary, and tertiary levels. Primary prevention entails avoidance of traumatizing events that cause PTSD. Secondary preventions involves interventions taken to prevent occurrence of PTSD immediately after exposure to stressor while tertiary prevention entails measures taken to minimize the impact of PTSD after it has been diagnosed (Spelman et al., 2012). The first step involves primary interventions applied to the whole troop before a traumatic event. The primary prevention treatment helps to prepare soldiers for the potentially traumatic experience they are likely to face.

The second step is interventions applied to individuals who have experienced traumatic events and are likely to develop PTSD (Waliski et al., 2012). Those secondary responses are implemented to people regardless of whether they show symptoms of PTSD or not but as long as they had experienced traumatic events. The last step involves tertiary intervention carried out on individuals who are showing signs of PTSD. The tertiary interventions are aimed at improving the functioning of the victims and prevent any further complications.

Waliski et al. (2012) noted that interventions do not necessarily require screening, but the most important part is that they reduce stigmatizing the victims. Interventions are always aimed at individuals seen as vulnerable, and so, they are at a risk of being deemed mentally unfit or unforgeable to serve in the military. Prevention of PTSD among the active soldiers plus the veterans is vital to enhance their well-being and health, safeguard military personnel, and improve forces readiness for military activities. An individual with PTSD cannot concentrate fully in combat. Moreover, they are a danger to themselves and their troupes. As such, quick intervention is a must to ensure they are ready for any military deployment (Waliski et al., 2012).

Pre-trauma Prevention Strategies

According to Runge et al. (2014), risk factors need to be identified and individually taught how to withstand such risk factors to prepare them for traumatizing events. Military personnel are often taken to a virtual laboratory that contains all the elements of the horrific event. The troops are then trained on how to increase resilience and prevent activities that increase stress. Protective factors include unity among troop members, trust in leadership, sound training, and motivating. The importance of pre-trauma prevention strategy is that individual

anticipate the probable traumatizing events and adapt to such circumstances. As such, the rates of trauma is minimized when the soldiers face the real situations (Runge et al., 2014).

Sound inter-gender relationship could go a long way in preventing trauma resulting from sexual violence. Taghva, Dabbaghi, Shafighi, Mortazaviha, and Donyavi (2014) established that avoidance of sexual contact during the military operations is one of the primary pre-trauma prevention strategies. According to Runge et al. (2014), risk factors associated with sexual trauma include a unit culture that forbids soldiers from reporting sexual assault, leadership behavior that condones or tolerate sexual assault, and executive use of alcohol. Other risk factors include young age, sexual abuse history, and female sex. Preventive programs focus on minimizing the chances of exposure to sexual trauma as well as resilience under the provocation of sexual assault. Evidence-based research by Runge et al. (2014) indicates that individual-level factors such as positive coping, realism, positive thinking, physical fitness, and behavioral control are necessary for preventing PTSD resulting from sexual violence in the military. Additionally, family level factors such as closeness, nurturing, support, communication, and emotional ties alongside military unit-level factors such as teamwork, collective efficacy, and positive command climate create a good working environment that minimizes sexual assault. Confidence in training and military operations coupled up with social support could also protect military personnel from developing PTSD (Taghva et al., 2014).

Apart from sexual assault, Murphy et al. (2016) revealed that stressors such as dismembered bodies, closeness to an explosion, and combat-related injury could cause a PTSD. Murphy et al. (2016) further argue that soldiers who are highly prepared for threats during

combats are less likely to develop PTSD when exposed to stressors as opposed to those that are poorly prepared for combat-related stressors. The authors also revealed, perceived threat and particularly the severity of the danger form a link between battle experience and PTSD. In fact, the higher the threat, the higher chances of developing PTSD. As such, preparing soldiers for traumatizing events reduces the threat posed by any stressor thus minimizing the development of PTSD. Preparing soldiers for combat-related stressors include increasing the levels of unit support. Attaining support during deployment promotes one's resilience to PTSD since it increases one's ability to cope with a traumatizing event (Murphy et al., 2016).

Interventions for Trauma-Exposed People

Interventions for trauma-exposed people aims at minimizing fear impact and speeding up the extinction of fear memory. The responses often involve behavioral or pharmacological therapy that is given to all those individuals exposed to traumatizing events. The first step includes psychologic debriefing conducted within a few days after exposure to a horrific event, followed up by cognitive behavioral therapy (CBT) for ASD and severe PTSD symptoms. The initial interventions involve psychoeducation in which individuals are advised how to manage stress and family interventions that could help reduce the symptoms of PTSD. Vagharseyyedin (2015) holds that use of CBT upon exposure to stressors has proved to be effective in minimizing the symptoms. In fact, CBT coupled up with psychoeducation, relaxation, and cognitive processing can go a long way in curbing stress from becoming full-blown PTSD (Vagharseyyedin, 2015).

Psychological briefings with individuals who have been exposed to traumatizing events could help make them mentally strong and ready to face traumatizing events. Victims are allowed to talk about their experiences as a way of healing. Brief early interventions that involve treatment of PTSD symptoms are vital to prevent the development of chronic PTSD. In fact, Trauma-focused CBT is known to not only reduce but also prevents the onset of PTSD symptoms in sexual violence survivors and those with traumatic brain injuries. Symptoms of PTSD could even be managed using pharmaceuticals that inhibit pain and sleep disturbance. For instance, 20 to 60 mg of Paroxetine (Paxil) taken daily could be used to control anxiety and mood disorder in people living with PTSD. Cognitive processing therapy could also be used to analyze how an individual feels about traumatizing events before prescribing the best intervention for such an individual (Vagharseyyedin, 2015).

Psychologic debriefing sessions according to Shale and Atherton (2016) are vital for healing process since the victims talk about their experiences, the psychotherapists then advise them on best strategies that they could use to heal. Specialized therapists lead the sessions that concentrate reducing the symptoms, provision of psychoeducation, provision of resources for recovery, and group support. One debriefing protocol called Critical incident stress debriefing (CISD) is a group-oriented structured therapy that involves either family members or the whole group. For instance, victims could be given specific interventions depending on their conditions, taken to town meetings, organizational consultation, family crisis intervention, and referrals for further assessment and treatment. Shale and Atherton (2016) sums up the importance of debriefing by arguing that, the process ought to be competent, compassionate, and humane care for the victims. Unfortunately, the existing research on Psychologic debriefing does not paint a good picture. Some scholars argue there is no difference between anyone who had Psychologic

debriefings and those who did not. This begs the question whether the process is helpful or not. All in all, therapists need to revolutionize psychologic debriefings so that they can have positive impacts on victims. Importantly, these psychologic debriefing sessions should be accompanied by other interventions such as CBT, family-therapy intervention, behavioral interventions, and pharmacotherapy just in case the patient does not respond to therapy (Shale & Atherton, 2016).

Pharmacotherapy interventions entail the use of pharmaceuticals to manage severe symptoms of PTSD. The medicines are given to encourage sleep, minimize pain, and hyperarousal. Just like the use of psychologic debriefing in early interventions, VA/DoD guideline argue that there is limited evidence to support the use of medications during early stages of PTSD. As such, drugs, could not be used to prevent the development of PTSD. According to VA and DoD, some of the drugs that can prevent full-blown PTSD include propranolol, benzodiazepines, and hypnotics zolpidem (for sleep disturbance). Research by Canfield (2014) indicates that pain medicines such as the opioid morphine when used on patients after a traumatic injury reduces the rates of developing PTSD. However, those drugs should be used for managing symptoms such as pain but not to treat PTSD. Other drugs such as hydrocortisone can be used for a patient who underwent cardiac surgery or septic shock because they reduce stress and prevent the onset of PTSD. Use of drugs should be under the full supervision of a qualified doctor to minimize side effects (Canfield, 2014).

Prevention of PTSD in the Department of Defense

The Department of Defense (DoD) provides directions and plans on how to manage stress before it develops into PTSD. Some of the Service-wide Prevention Efforts include

programs that deal with combat stress that leads to PTSD (Vasterling et al., 2016). Programs such as Maintenance of Psychological Health in Military Operations and Combat Stress Control helps in early detection and management of operation stress to enhance the effectiveness of a mission, improve fighting capabilities, and mitigate the impacts of physical and psychological exposure to severe stress. Those programs strengthen the unity in each troop and prepare all soldiers to fight as a unit. The soldiers are advised to take care of one another in their operations hence reducing the chances and impacts of traumatizing events (Vasterling et al., 2016).

Service-wide prevention strategies involve programs that deal with combat stress without necessarily focusing on PTSD. For instance, the Maintenance of Psychological Health in Military Operations program is used among all military groups for early detection and prevention of PTSD to preserve mission effectiveness and combat fighting capabilities, as well as mitigate the impact of exposure to severe stressors. The program advocate for monitoring, identification, modification, and reduction of stressors before they could cause dysfunction. At a personal level, the program teaches individuals to be confident and more competent while at group level it encourages cooperation, teamwork, and concern. Additionally, focus on training soldiers for stress resilience before deploying them enhances their psychological fitness and preparedness to face psychological stressors (Foy, 2012).

Prevention mechanism in the army helps to mitigate or prevent PTSD symptoms after exposure to a stressor. Troupes work directly with team members to discuss stress, anger management, and suicide before they are deployed or returned home. Army personnel are also given talks and debriefs to normalize their feelings and minimize the impact of stigmatization

after returning from military operations. The army also undergoes battlemind program that improves their resilience, mental toughness, and self-confidence when being deployed and after operations (Foy, 2012).

Additionally, the army is exposed to a psychologic-educational intervention program that enables them to efficiently respond to operational stress, promote self-awareness to stressors, and identification of problems in their team members. The results of this programs are that they prepare the army for combat-related stressors and minimize mental health problems. Another program called the Penn Resilience Program is founded on cognitive-behavioral theory in that it teaches the army how to be assertive, negotiate, solve the problem, and make wise decisions. The program is effective because it improves spiritual, mental, social, social capabilities, and physical wellness of the army hence preparing them for stressors during deployment (Foy, 2012). Importantly, the programs measure the spiritual, family, emotionally, and social fitness of army officers. Those unfit in either domain are given a further training to make them battle hardened.

Prevention strategies in the Navy involve preventing and managing stress. Though the interventions do not target PTSD specifically, they try to assist marines to deal with nondeployment and deployment stressors. The Navy and Marine Corps COSC program is a model that examines marines' resilience. The program utilizes a color-coded continuum to indicate the level of resilience among the Marines. Red color means the soldier is ill while green color shows the Marines are ready for deployment. Interestingly, the model can tell between combat and operational stress. By focusing on positive emotions, the program then helps the

marines to foster their resilience. Hendin (2014) revealed that the Marines offer training program called bootstrap to promote resilience among the recruits. The recruits are trained how to manage the absence of spouses thus improving their preparedness for operations. The Families Over Coming Under Stress (FOCUS) program incorporates the marines and their families in a preventive-intervention approach for marine families. The program offers some services such as workshops, briefing, consultations, and training for those families to improve their resilience and prevent family dysfunction when their loved ones are out on military duties (Hendin, 2014).

The DoD programs are designed to offer practical training that involves exposure to potential combat stressors in a controlled environment to condition the military personnel to always respond with reduced anxiety and emotional arousal when faced with stressors (Hendin, 2014). The programs also strengthen the ability to cope with stressor by fortifying suitable coping techniques and receiving encouragement from superiors and peers. The creation of supportive working environments that involve team building, peer stress-management consultants, and sound leadership strategies aid in minimizing stress during deployment and afterward (Hendin, 2014).

Prevention of PTSD in the Department of Veterans Affairs

The Veterans Affairs center offers prevention services to retired military personnel that were exposed to traumatizing events. Such programs are available to all veterans and their immediate family members. Such services include family, group, and individual counseling,

sexual counseling, employment counseling, and referrals to advanced medical programs for those with chronic PTSD (Wangelin & Tuerk, 2014). Importantly, the veterans cannot be redeployed to military activities that might jeopardize their mental health condition. Programs such as Life Guard among the veterans help to promote psychological resilience among the victims that have already accepted their condition and ready to move on. Other programs include FOCUS and Moving Forward, which assist the veterans to adapt to civilian life and achieve their life goals (Wangelin & Tuerk, 2014).

The program used by VA include the Life Guard program that fosters psychologic resilience based on commitment therapy and acceptance. The program helps the veterans to accept all that happened during the military operations. The program enables them to admit that they cannot reverse anything that occurred during operations (Yambo et al., 2016). Importantly, the program safeguards against self-piety consequently facilitating the reintegration of the veterans in the society. Moving forward program is a problem-solving approach that trains the veterans to achieve their life goals. The program focuses on early intervention plus prevention of any mental related health issues. Additionally, it teaches the veterans life skills necessary to solve their life problems (Yambo et al., 2016).

The VA recently developed a program designed explicitly for sexual traumas. The program is unique only to VA and is implemented by the Veterans Health Administration. The model utilizes primary, secondary, and tertiary interventions to equip its members with necessary skills for handling stressors resulting from sexual violence. The model addresses sexual assault experiences and potential sexual harassment that are yet to occur but might occur (Yambo et al.,

2016). Through the program, the veterans are shown how to avoid dangerous places, and people that expose them to sexual violence encouraged to take self-defense lessons, also given life skills on how to handle sexually abusive partners. Veterans are also taught how to treat spouses, children, friends, family, emotions, and finances. The teachings also involve ways of coping with trauma and resuming family and work responsibilities (Yambo et al., 2016).

TREATMENT

Psychosocial Treatments of Current and Ex-Military Personnel with Chronic PTSD

Condition

In psychosocial therapies, therapeutic interventions focus on personality traits, psychological symptoms, risky behavior, social isolation, and attitudes towards life. For instance, cognitive-behavioral therapy intervention for trauma among the veterans and current soldiers incorporates behavioral therapy and resiliency modeling to assist military personnel to overcome traumatizing events and gain adaptive skills. Those therapies are useful in minimizing the symptoms of PTSD (Wangelin & Tuerk, 2014). Strongest emphasis is given to cognitive therapy, exposure therapy, and anxiety management programs. Psychosocial intervention programs focus on an important factor for instance worrying, which if not managed properly could result into chronic PTSD. In such a case, behavioral intervention would be handy in minimizing the impact of stress and depression to manageable levels hence speeding up the recovery process. Psychosocial interventions are often used to reduce symptoms of a disease,

improve healing process, and limit the progress of symptom into a chronic condition (Wangelin & Tuerk, 2014).

Exposure therapies applied on PTSD patients are meant to minimize symptoms such as anger, guilt, and depression. Exposure therapy is a behavior therapy technique that treats anxiety disorders. It involves exposing patients to the objects and events they fear to overcome their fear of such conditions. People living with PTSD often try to avoid situations that remind them of the traumatizing events. Such patients believe that avoidance would make them feel better.

However, this is a short-term intervention that has no much help in the long run. As such, exposure therapy enables people to overcome their fear by gradually exposing them to similar conditions until they outgrow their fear of the situation. Imaginal exposure entails asking a patient to visualize the terrifying event in his mind. For instance, a soldier who witnessed his fellow soldiers being killed would be asked to imagine the event in his mind. In Vivo exposure, pilots might be asked to go watch planes landing and taking off. They might also be asked to go and watch marine pilots practice. As such, they end up overcoming their fear of flying. In virtual reality exposure, a person is placed in a controlled lab that has a similar condition as to what he/she experienced in combat. Yambo et al., (2016) established that 90% of those who undergo exposure therapy reduce their fear significantly while 65% eliminates their phobia.

Cognitive therapies (CT) teaches a PTSD patient how to evaluate and modify the upsetting thoughts resulting from the traumatizing event. The treatment holds that one can change how he/she feels by changing his/her views. CT focuses on the relationship between feelings, thoughts, and behaviors, and evaluates how changes in a given domain can foster functioning of other areas. Psychotherapists utilizing CT, encourage patients to re-evaluate their

assumptions about PTSD event in order to isolate thoughts that inhibit positive thinking (Foy, 2012). Promoting positive thinking patterns helps the patients to synthesize their traumatic experiences and in the process cope with the past. Exposure to similar traumatizing events alongside talks on the horrific experience is used to minimize avoidance associated with the trauma. The exposure is done in a controlled manner to reduce escape behavior, foster self-confidence, and self-control of the patient. Planning for crisis and stress management strategies are also given to the patients to enable them to curb stress (Foy, 2012).

Eye Movement Desensitization and Reprocessing (EMDR) help victims process traumatizing memories, feelings, and thoughts related to traumatizing events. After a horrific event, patients with PTSD often find it hard to handle what happened to them. EMDR therapy focuses on past, present, and future. The analysis of the history focuses on traumatizing events, the current events considered are those that remind the patient of what they went through while the focus on future is given to the patient to foster skills and attitudes necessary for positive future actions (Wilson, Friedman & Lindy, 2011). The first phase entails history-taking sessions in which the therapist examines the ability of the client to undergo therapy and develop a treatment plan. The therapist and client target the past traumatizing memories and the present issues that ignite those terrifying moments. Emphasis is given on particular skills that help the victim to confront their fear and overcome it. During the second phase, the therapist teaches client stress reduction technique that minimizes the impact of stress. The third to the sixth stage involves recollecting the memories and identifying their current impacts on the patients. The seventh and eighth stage entails examining the progress made by clients and offering further referrals if need be (Wilson, Friedman & Lindy, 2011).

Imagery Rehearsal Therapy (IRT) addresses the nightmares that are synonymous with PTSD symptom. Those who undergo (IRT) report the reduced impact of PTSD, decreasing nightmares, and improved sleep quality. Other psychosocial treatments for PTSD include psychodynamic psychotherapy that solves intrapsychic conflicts emanating from traumatizing experience (Wilson, Friedman & Lindy, 2011).

Brief eclectic psychotherapy includes imaginal exposure coupled up with writing assignments, relaxation, and a farewell ritual. The primary purpose of brief eclectic psychotherapy is to enable the victims to confront their fear, after which they would be able to chat their way forward (Wilson, Friedman & Lindy, 2011).

On the other hand, Stress Inoculation Training (SIT) was designed to enable victims to manage their anxiety more so, veterans involved in sexual assault. SIT process include breathing, assertiveness, and relaxation training, self-talk, positive thinking, and thought stoppage. Thought stopping is not unique with SIT but also very important because it enables the victims to overcome the trigger event. A study conducted by Wilson, Friedman, and Lindy (2012) indicate that SIT is better than other anger management programs when it comes to reducing anger.

Virtual-Reality Exposure (VRE) utilizes multi-sensory feedback, 3D displays, and computer graphics to create an illusion of the desired effect leading to an imagery environment of powerful feelings of presence and immersion into the desired condition. VRE in simple terms could mean conditioning the mind thus exerting a desired effect. A qualified therapist guides the VRE sessions and regulates the virtual scenarios to attain suitable intensity of arousal for the

victim. Continuous exposure to fear-inducing environment leads to extinction of a given fear and reduction of PTSD symptoms. However, the therapist must ensure the client is able to accommodate the amount of stress VRE relays. Finding by Wangelin and Tuerk (2014) indicate that majority of PTSD undergoing VRE end up with reduced severity of PTSD symptoms.

Pharmacotherapy

Pharmacological treatment for PTSD is prescribed for patients who meet DSM criteria and have PTSD symptoms as provided in the DSM5 criterions (Yambo et al., 2016). Before receiving medication, the traumatized victims need to be examined thoroughly by a psychiatrist and a clinician. However, great focus should be placed on screening for mental health conditions. Use of medications should be encouraged if the patient is psychotic, dangerous, or extremely agitated. Some of the drugs used are prazosin, benzodiazepines, and clonidine for treatment of irritable aggression, insomnia, and nightmares. Antidepressants can be used for treating Acute Stress Disorder, while the antipsychotic medication is applied on patients that do not respond to psychotherapy and antidepressants (Yambo et al., 2016).

The PTSD symptoms targeted by drugs include intrusions such as nightmares and flashbacks. Avoidance, negative moods and self-pity, and high level of arousal are also targeted by drugs. Medications for treating PTSD act upon neurotransmitters linked to the anxiety and fear part of the brain such as the gamma-aminobutyric acid, excitatory amino acids, and serotonin (Wangelin & Tuerk, 2014). Most studies indicate that drugs do not eliminate the symptoms entirely but somewhat minimizes the severity of the symptoms. As such, drugs ought to be used in conjunction with psychotherapy programs for good results. The PTSD checklist

and Clinician-Administered PTSD Scale are used to monitor the effects of drugs on a client. The information provided by the scales form the basis for further medical engagement between the clinicians and the patient (Wangelin & Tuerk, 2014).

Selective Serotonin Reuptake Inhibitors (SSRIs) are used for moderating mood and anxiety disorders. Wangelin and Tuerk (2014) reported that SSRIs are commonly used as an antidepressant because of their effectiveness. SSRIs minimize depression by increasing serotonin levels in the brain. Serotonin is a neurotransmitter that transmits signals between cells and brain. SSRIs inhibit reabsorption (reuptake) of serotonin from the brain hence increasing the concentration of serotonin in the brain. In simple words, mental health conditions such as depression are caused by low levels of serotonin. Increased levels of serotonin in the brain fosters good mood, sleep, and emotions. Apart from depression, serotonin can also treat conditions such as anxiety disorders. Some of SSRIs approved by Food and Drug Administration (FDA) for treating PTSD include Sertraline (Zoloft), Fluoxetine (Prozac), Citalopram (Celexa), and Vilazodone (Viibryd). All the SSRIs work almost in a similar way. Their notable side effects include nausea, insomnia, diarrhea, and dizziness (Wangelin & Tuerk, 2014).

Mood stabilizers for PTSD prevent and treat depression and mania tendencies. Mood stabilizers are vital because they enable patients to maintain a constant mood thus managing their work and social work effectively. Hendin (2014) argued that mood stabilizers might be used in the event antidepressants are ineffective. Nonetheless, mood stabilizers for PTSD are used if the patient's primary symptoms are irritability and anger. Mood stabilizers calm down the body so that the brain can process emotions resulting from a horrific event. Mood stabilizers just like

SSRIs, are more effective if used alongside Cognitive Behavior Therapy. Some of the mood stabilizer drugs include Topiramate used for managing seizures and migraine headaches. Divalproex is used to treat manic symptoms and migraine headaches while Lamotrigine to control extreme mood swings (Hendin, 2014).

Atypical antipsychotics for PTSD are used in the event SSRIs, and antidepressant is unsuccessful. Though there is limited data on atypical antipsychotics, nonetheless, they are used in chronic PTSD for treating psychotic disorders (C. Hoge et al., 2014). One example is Olanzapine used for treating psychotic symptoms such as delusions, bizarre behaviors, and hallucinations. C. Hoge et al. (2014) argued that atypical antipsychotics drugs should be used for treating mood disorders and co-occurring psychotic symptoms in PTSD.

Other drugs for PTSD include Monoamine Oxidase Inhibitors (MAOIs), Prazosin, and Tricyclic Antidepressants. MAOIs and Tricyclic Antidepressants act on neurotransmitters such as norepinephrine and serotonin. MAOIs increase the concentration of norepinephrine and serotonin by inhibiting the functionality of enzyme monoamine oxidase (MAO) that degrades norepinephrine and serotonin. Tricyclic Antidepressants minimizes aggression, social anxiety disorder, and hyperarousal behavior among the PTSD patients. Prazosin, on the other hand, is used for decreasing nightmares. Additionally, prazosin is known to reduce alcohol cravings in individuals addicted to alcohol (C. Hoge et al., 2014).

Collaborated Pharmacotherapy and Psychotherapy Approaches

Psychological intervention was initially used for management of PTSD after its formal recognition (Yambo et al., 2016). Clinicians argued that psychological interventions coupled up with pharmacological interventions could curb resolution of trauma to acute PTSD. On the other hand, pharmacological interventions such as monoamine oxidase inhibitors and tricyclic antidepressants are used as a long-term intervention for PTSD condition (Yambo et al., 2016). Pharmacotherapy corrects the imbalances in neurotransmitters that cause PTSD symptoms. Combination of Pharmacotherapy and Psychotherapy enhance treatment outcomes and more so among the patients with comorbid conditions because pharmacotherapy makes exposure therapy tolerable (Yambo et al., 2016).

Yambo et al. (2016) conducted research in which combining pharmacotherapy and psychotherapy methods were examined and revealed that cognitive-behavior therapy (CBT) and interpersonal psychotherapy used alongside drugs such as SSRIs have a positive impact on a patient as opposed to only when either pharmacotherapy or psychotherapy is used. In fact, a combination of SSRIs and CBT helps patients troubleshoot most of PTSD symptoms such as avoidance and hyperarousal. Yambo et al. (2016) further revealed patients who undergo combined pharmacotherapy and psychotherapy interventions have a higher recovery chance of 72.6% compared to 62.5% for those who opt for medication alone. Moreover, patients who receive a combined treatment develop fewer if any side effects (Yambo et al., 2016).

Integrative Care

Collaborative care according to E. Hoge et al. (2012) is a disease-management approach that incorporates mental health care and general medical providers in treating PTSD. Studies indicate positive results for an integrative, collaborative healthcare that include care management, CBT, and pharmacotherapy for treating PTSD. Integrative, collaborative health care for PTSD is a gentle yet powerful technique that deals with negative emotions and stress. The modalities used include breathing techniques, guided imagery, progressive relaxation, and bio-energy techniques. Collaborative care is a PTSD management program that integrates mental health providers and general medical providers in the treatment of patients with PTSD and comorbid medical conditions. Collaborative care incorporates care management and evidence-based psychotherapy, for instance, CBT, and pharmacotherapy targeting PTSD patients. Mainly, collaborative health care is more valuable in the integration of new technology of treatment that combines aspects of established evidence-based practices. Institute of Medicine (2012) provides that collaborative healthcare has been effective in reducing symptoms of PTSD among patients in acute care medical setting or at primary care. For example, integrative, collaborative healthcare decreases stigma and improve continuity of care among the veterans. Collaborative care provides for behavioral activation, lifestyle advice, and management of drug treatment (Institute of Medicine, 2012).

Developing Therapies for PTSD

The Department of Defense is utilizing alternative methods such as Tai Chi and yoga therapy to improve the lives of PTSD patients. Yoga and Tai Chi are traditional physical exercises that enhance the flow of energy in the body. The physical activities also enable the

patients to improve body and mind control through breathing, meditation, and physical positions. The methods reduce anxiety, stress, and depression among the patients who often exercises using those techniques. Virtual Reality therapy is a new method that could be used to help patients recover from trauma and fear. Virtual reality therapy helps individuals recover from trauma and stroke (Institute of Medicine, 2012). Virtual Reality (VR) technology transports a victim to another world or a pleasant state of mind hence enabling him/her to overcome a specific fear associated with PTSD. VR technology is an exposure therapy that exposes victims to simulated traumatizing scenarios before introducing them to cognitive behavioral therapy that teaches patients how to handle real life traumatizing events (Institute of Medicine, 2012).

Couples therapy for individuals with PTSD could utilize Cognitive-Behavioral Conjoint Therapy (CBCT) to enhance their intimate relationship. CBCT for PTSD fosters the interpersonal environment in which patients exist and utilizes supports from partners to improve sexual arousal and eventually to the healing process. CBCT enable affected couples to understand the effects of PTSD, improve communication, make sense of the traumatic event, solve their problems, and confront challenges as a team. CBCT for PTSD is divided into three phases. The first step entails receiving psychoeducation on PTSD (Institute of Medicine, 2012). During phase one, the couple is taught symptoms of PTSD and how those symptoms affect the relationship. The couple is also shown how to adapt and improve their resilience. The second phase involves learning how to confront fear, feelings, and negative thoughts. The last phase addresses cognitive appraisals such as dysfunctional (Institute of Medicine, 2012).

Family therapy provides an opportunity for a family to learn how to cope up with a distressing event. Horrific nightmares, hyperarousal, hypervigilance, flashbacks, depression, and anger are not only problematic to the victims but also family members. Research indicates that PTSD patients tend to ignore family gatherings, tend to sleep alone, and avoid their children because they fear they might hurt them (Institute of Medicine, 2012). As such, family therapy becomes helpful because it teaches the family how to manage stress, improve resilience, and help the family understand each other. According to Institute of Medicine (2012), most soldiers prefer family therapy over individual therapy because it addresses PTSD symptoms and resulting impacts on the family.

Contemplative methods such as meditation, mind-body skills, and mindfulness showed more significant improvements among patients. Another technique called acupuncture seeks to improve mental health by stimulating mind and body by inserting needles into specific body parts. Though acupuncture produces positive results, the results can be better if acupuncture is combined with CBT. Though field therapy used acupuncture methods to enable patients to focus on traumatizing events after which they learn to overcome their fear. Though field therapy treats some mental disorders such as fatigue, depression, phobia, anger, anxiety, and physical pain (Institute of Medicine, 2012).

Dog-Assisted Therapy is equally useful managing PTSD symptoms. Having a dog can help when the uplift mood and minimize stress. Dogs bring out love feelings, are good companions, and are fun. Service dogs can help physically challenged veterans to move, guide them when walking, and pick up objects for them. Dogs can also provide emotional support for

individual with mental problems because they comfort, support, and give friendship (Institute of Medicine, 2012).

Guidelines for Treatment of PTSD

Anyone who suspects he/she has PTSD needs to see a psychiatrist or a psychotherapist to analyze the symptoms and level of PTSD. The therapist would place the patient on a Post-Traumatic Stress Disorder Symptom Scale to determine the incidence and strength of PTSD symptoms. The scale would also determine how negatively the event has impacted the patient (Wilson, Friedman & Lindy, 2011). The clinician ought to assess how PTSD symptoms affect the functioning ability of a patient regarding relationships and working. The second step would require the victim to seek professional help if he/she has PTSD. Early treatment of PTSD is vital to minimize the chances of it growing into a chronic PTSD. Depending on the psychiatrist's advice, the patient would seek the best treatment that would mitigate the risk of the condition and possibly cure the condition. Choosing a therapy is as important as the recovery process. One has to determine the education level and experience of clinician before being treated. Having a good fit between the patient and the therapist can make a whole difference in guaranteeing the recovery of the patient (Wilson, Friedman & Lindy, 2011).

VA/DoD guidelines for managing PTSD advocates for evidence-based psychotherapeutic interventions. Those interventions are categorized as stress inoculation training or trauma-focused psychotherapy. Trauma oriented psychotherapies involve cognitive restructuring such as CPT and are combined with stress reduction skills, psychoeducation, and anxiety management. Benzodiazepines and propranolol are some of the drugs that VA and DoD mention as being

useful in managing stress and anxiety. VA and DoD further argue against the use of pharmacology as preventive for PTSD (E. Hoge et al., 2012).

According to American Psychiatric Association (APA) procedure for managing PTSD, the three approaches for treating PTSD include pharmacotherapy, education and support, and psychotherapy. The methods can be used in solitude or as a combination. APA recommends for the use of a treatment that is backed with evidence as being the most effective before resorting to other interventions (E. Hoge et al., 2012). APA believes that treatment could be affected by the severity of the traumatic events and timing of treatment. According to the guideline, CBT is effective for treating core symptoms and chronic PTSD. SSRI and SNRI are the antidepressants drugs advocated by APA as long as they reduce symptoms associated with the condition (E. Hoge et al., 2012).

Australian National Health and Medical Research Council Procedures advocates for the use of most effective intervention as per the provided evidence. The expert opinion could be sort in the event there is no sufficient evidence to support a particular response. Just like other APA, the Australian group advocated for psychotherapeutic interventions before resorting to pharmacologic interventions. The guidelines also argued against the provision of psychologic debriefing alongside structured psychosocial interventions immediately after the traumatic event. Although the guidelines advocates for psychotherapy as the first alternative, nevertheless, it recommends for antidepressant if approved by a clinician (E. Hoge et al., 2012). Lastly, International Society for Traumatic Stress Studies does not advocate for specific treatment

methods but argues for the use of psychotherapeutic interventions before embarking on other alternatives (E. Hoge et al., 2012).

ACCESS TO CARE

Obstacles to Healthcare for PTSD Patients

Public, self and structural stigma limit the ability of soldiers to seek medical help. For instance, some veterans find it hard to seek help due to their PTSD condition because they would appear weak, blamed for their misfortune, or treated differently. Some of the victims might feel ashamed or embarrassed to seek help (Wilson, Friedman & Lindy, 2011). Moreover, some veterans believe finding medical advice would be short careers in the military. Sometimes, the veterans have no access to quality care within a specific time hence losing the window of opportunity that would have enhanced their health. Culturally diverse populations also find it hard to seek help. For instance, Black American and Latinos claim racial barriers limits their ability to seek quality health care (Wilson, Friedman & Lindy, 2011).

Waliski et al. (2012) established that barriers exist at institutional, provider, and patient levels. Patient barriers could include the effect of seeking medication on your job, assumption that mental health care treatment is not adequate, lack of information on PTSD treatment, financial challenges, and logistical challenges such as distance to be covered when going for medication. Providers face challenges such as inadequate time, minimal training, and transportation challenges to the point of the war. At the organizational level, the barriers include

lengthy procedure and requirements for screening, limited resources, and extended period of treatment. Stigmatization associated with mental disorders could pose an obstacle at all levels (Waliski et al., 2012).

Some of the barriers in DoD include using of drugs that have side effects. Drugs such Lithium and Serotonin reuptake inhibitors though are prescribed for PTSD, have long-term effects on the career of a soldier thus limiting their usage. In fact, the navy does not allow its members who are using Serotonin reuptake inhibitors to carry weapons since the drug inhibits their functionality. Moreover, job categories such as piloting prohibit officers under medication to fly. During the fighting, the barriers that exist include accessibility, lack of information, and stigmatization. Waliski et al. (2012) revealed that soldiers in the theater of war might be unreachable during war thus limiting their chances of receiving medical care. The war could be so intense such that the caregivers might fear to reach the patients. Some of those places could be inaccessible due to poor roads and landing places. Some of the soldiers might refuse to seek help during the war for fear of stigmatization. In fact, some of those under psychiatric care might be prohibited from going to war hence complicating the matter further. Lastly, some of the soldiers in war might lack the necessary information on how to seek medical help during combats (Waliski et al., 2012).

Barriers to Provision of Evidence-Based Healthcare

The requirement that one needs to have an honorable discharge from the military, the long wait list for care and social barriers play a role in denying an individual access to quality care. The DoD requires one to have an honorable discharge from the military before accessing

government-sponsored care (Wilson, Friedman & Lindy, 2011). As such, some veterans end up not receiving quality care. The long wait list at healthcare facilities that is facilitated by poor scheduling practices and limited health care providers also limit access to quality care.

Psychological treatment is the best solution for PTSD patients. Unfortunately, the medical profession lacks adequate psychologists that could handle trauma-based therapy (Wilson, Friedman & Lindy, 2011).

Research conducted by Wilson, Friedman, and Lindy (2011) indicate that barriers to the provision of Evidence-Based Healthcare include limited education, lack of research knowledge, and skills. The study suggests that the psychiatrist level of education determines their service delivery, competence, and attitudes towards clients. The authors also revealed there is an association between a therapists' knowledge and awareness of demographics such as work setting, educational level, and previous experience in evidence-based healthcare. Some patients also do not like opening up and sharing their problems thus posing a barrier to evidence-based healthcare. Clients with communication problems and stigma find it hard to open up undoubtedly about their issues. As such, clinicians end up prescribing wrong medication or fail to prescribe medication that was recommended earlier for that patient (Wilson, Friedman & Lindy, 2011).

Some subpopulation in the military experienced further barriers to evidence-based care. For instance, American Latinos, Blacks, and Indian veterans could use VA mental healthcare facilities because VA neglects them, distrust of VA, and inability to access VA. Similarly, sexually assaulted women, minority groups, a veteran living in rural areas, and severely wounded veterans could encounter further barriers when trying to access evidence-based care

(Wilson, Friedman & Lindy, 2011). There is a need for early intervention to ensure patients receive evidence-based care that incorporates CBT, couple therapy, and pharmacotherapy.

PTSD Healthcare Facilitators

The healthcare facilitators help the veterans and their family members to comprehend and obtain full benefits from DoD on issues related to PTSD. The consultation offered by the facilitators is often private and confidential. They also adhere to insurance laws and DoD terms when providing their services (Wilson, Friedman & Lindy, 2011). Most importantly, they help the patient to understand insurance coverage, define health care issues, and resolve issues between the patient and their doctors. In short, healthcare facilitators are an experienced counselor who provides confidential services for those with PTSD and need medical help.

VA and DoD are currently utilizing information technology in healthcare provision to curb stigma and logistical barriers that hinder veterans with PTSD from accessing quality healthcare. Use of technology allows the client to access healthcare regardless of their location thus enabling most of the veterans in rural areas to access healthcare. For instance, the use of telemental health (TMH technologies) or telemedicine allows the client to interact with clinicians from the comfort of their homes as long as they have internet connectivity. Telemedicine will enable patients and clinicians to communicate via Skype or other online videos apps. The methods allow the clinician to provide clinical information after screening assessment (Vasterling et al., 2010). Additionally, clinicians use TMH technologies such as telephone and video conferencing to carry out therapy sessions with clients thus breaking distance barrier.

TMH infrastructure is helpful because it is cost effective and allows clients to receive health care without jeopardizing their time with family members or work (Vasterling et al., 2010).

Internet-Based Interventions include internet-based cognitive and behavioral therapies (I-C/BT) using online media delivery methods. I-C/BT programs were formed to expand the delivery of PTSD medical care and reduce the cost of treatment. Most of the I-C/BT approaches focus on CBT model that depends on cognitive and behavioral techniques that modifies the behavior of a PTSD patients. The internet intervention incorporates four components of CBT; anxiety management, cognitive restructuring, psychoeducation, and exposure. Vasterling et al. (2010) established that I-C/BT allows therapists to identify triggers, classify the triggers according to severity, teach stress management, carry out vivo exposure, take the clients through a writing session in which the clients write down their horrific experiences, and recommend some interventions. In one of Vasterling et al., (2010) analysis, the authors observed that I-C/BT led to 30% in symptoms level of PTSD patients.

Shale and Atherton (2016) described an alternative internet-based treatment approach in which a client undergoes ten writing sessions of 45 minutes each that take place twice a week for five weeks. During the online courses, the patients describe their ordeal, evaluate recovery process, and describe the impact of the ordeal in their lives. The purpose of these meetings to examine the effects of the initial intervention and recommend further interventions if need be. Additional responses that might be included are psychoeducation, muscle relaxation, relaxation training, exposure, and cognitive restructuring. Participants in this model report reduced

withdrawal behavior, the decline in symptoms of PTSD, anxiety, and depression as well as improved resilience and functionality of patients (Shale & Atherton, 2016).

RECOMMENDATIONS

Analyze

The Department of Defense and the VA ought to gather information on delivery, implementation, and success of all rehabilitative, treatment, prevention, diagnosis, and screening programs currently in use to determine their effectiveness. Reoccurrence of PTSD symptoms in military patients that have been treated is an indication that treatment, prevention, and screening programs utilized by DoD and VA are not effective. The departments need to analyze that data and interview all individuals presently under medication and those who have received therapy to determine if the agencies are making any gains in the fight against PTSD (Lincoln & Sweeten, 2011). Improving the mitigation available for PTSD would need the authorities to enter the collected information on patient's medical record after which it would be availed to researchers who would investigate methods of improving service delivery for PTSD patients. Analysis of data obtained from DoD and VA on service men and veterans indicates that there is inadequate tracking of those individuals who have been diagnosed with PTSD. As such, the current data on the prevalence of PTSD is not accurate. There is need of using electronic medical records to ensure all data on PTSD is stored safely for future reference and analysis (Lincoln & Sweeten, 2011).

To analyze the impact of PTSD and implement quality evidence-based healthcare for the patients, DoD and VA need to assess data collected before, during, and after treatment. The data should be entered into electronic medical records for patients. The data should then be available to researchers for analysis. Nevertheless, measures should be put in place to guarantee the confidentiality of the patients. The RESPECT-Mil program is an effective strategy that ensures Marines are screened for PTSD. Unfortunately, limited data exist on the progress of the program (Institute of Medicine, 2012). There is a need for a proper recording to ensure all those diagnosed with PTSD are followed up so that they comply with full treatment. Irrespective of poor data collection, screening, diagnosis, and treatment of PTSD exists in VA and DoD though with some barriers. Despite those obstacles, the departments have made strides in improving the scope and quality of healthcare extended to people living with PTSD (Institute of Medicine, 2012).

The increase in the prevalence of PTSD due to increased conflict zones such as Afghanistan, Iraq, and Syria, DoD and VA has implemented some programs to screen, diagnose and treat those with PTSD as well as rehabilitate them. The military is busy establishing Comprehensive Soldier Fitness and stress prevention program to inhibit and minimize the prevalence of PTSD in current soldiers (Institute of Medicine, 2012). However, the programs are still in initial stages, and their impacts cannot be verified. The problems facing the programs include lack of clinicians, caseloads, and lack of resources. These issues make it hard for PTSD to receive quality healthcare. The VA and DoD need to establish research programs that would evaluate the effectiveness of all programs designed to cure PTSD. The DoD alongside VA

should continuously coordinate, review, and evaluate those programs on a regular basis to ensure they are effective (Institute of Medicine, 2012).

Innovate

Stakeholders need to initiate research to provide modern methods necessary for prevention, treatment, and rehabilitative services to PTSD patients. Innovating specialized PTSD programs to deliver PTSD care that combines different treatment models such as traditional methods and alternative medication is vital in the management of PTSD (LeBouthillier et al., 2014). Mitigation such as family therapy must be evaluated to determine their cost and effectiveness. A thorough assessment of functional and symptoms improvements is needed, and the result of these evaluations made public. Additionally, the VA and DoD need to encourage neurobiology research that would enable the clinician to use neurobiology knowledge for PTSD screening and treatment. There is various complementary and alternative medicine (CAM) for treatment of PTSD though there is not enough evidence to ascertain their effectiveness. Nonetheless, CAM treatment and particularly yoga have had benefits for the clients. Some of the programs are intended to foster hardiness and resilience in veterans and current soldiers before, during, and after deployment to a war zone (LeBouthillier et al., 2014).

Notably, the Marine Corps' Operational Stress Control and Readiness program alongside the U.S. Army's Comprehensive Soldier Fitness program established in the forces helps service members to deal with stress when deployed. It is worth noting that, the DoD and VA are willing to use emerging treatment methods as well as technology in the management of PTSD (LeBouthillier et al., 2014). The only problem with these programs is that there is no empirical

evidence to ascertain their effectiveness. Moreover, both the VA and DoD have varying approaches to the provision of these services with VA concentrating on veterans and families while the DoD focuses on current service members. Specialized programs for regulation of PTSD healthcare, which combines emerging treatments, alternative medicine alongside couple and family therapy, must be evaluated thoroughly by DoD and VA for cost, effectiveness, and efficiency. The programs should not address recovery process but also return to work formulae (LeBouthillier et al., 2014).

There is a need for neurobiological mechanism research to understand stress responses about PTSD. Research on neurobiological mechanisms would lead to the development of effective pharmaceuticals. This kind of research has the potential of determining those with the likelihood of developing PTSD, diagnose it, and establish the most effective management of PTSD (LeBouthillier et al., 2014). A further study on genetics is equally important. Genetics can be used to determine those with PTSD and those at risk of PTSD thus help prevent PTSD, efficiently treat PTSD, enhance the quality of life, and minimize costs of treatment.

Integrate

Integration should be characterized by screening for PTSD, assess its implications, and treat PTSD comorbidities. There are three areas of integration that must be considered. The first one is integrating treatment, diagnosis, and screening of PTSD with clinical setting such as primary care to treat those with symptoms as soon as possible (Hendin, 2014). Secondly, PTSD treatment ought to be integrated with a cure for psychological, physical, and psychosocial conditions that accompany PTSD. Thirdly, treatment models such as psychotherapy need to be

combined with pharmacotherapy, and CAM therapies to address all elements of PTSD condition. Hendin (2014) argued that there are instances when PTSD is accompanied with other conditions such as physical and mental disorders thus complicating treatment of PTSD. Such situations call for integration and collaboration of all interventions to achieve better results. However, treating PTSD alongside other condition is hard because there are no guidelines that healthcare providers could use to address PTSD simultaneously with other conditions (Hendin, 2014).

Individuals with comorbid psychiatric disorders such as drug abuse, concussion, and severe depressive disorder ought to seek services of a specialized clinician. DoD and VA advocates for collaborative healthcare approach that is infused at primary care stage so that patients with comorbidities disorders are treated starting with the most severe condition before progressing to other conditions. In the event the patients with comorbidities disorders do not respond to interventions at primary levels, then the patient should be referred to a specialist. Analysis of data from DoD and VA reveal that the departments do not or rarely integrate their interventions. As such, VA and DoD ought to carry out research to identify guidelines for treating individuals that have comorbidities disorders besides PTSD (Lincoln & Sweeten 2011). PTSD screening process ought to include an examination of comorbid disorders and subsequent treatment of such conditions in the event they exist. In fact, providing an integrated healthcare leads to positive health results. An integrated healthcare approach factors in the prevalence of the condition, the impact it has on society and the necessary paths to recovery. Integrated care leads to the identification of symptoms, in patients and their families, and utilization of trauma policies, practices, and procedures that alleviate the disorder (Lincoln & Sweeten 2011).

Implement

There is a need for supporting and encouraging the utilization of evidence-based methods for PTSD rehabilitation, treatment, and screening. The stakeholders need to use practical tools that determine and measure the level of PTSD in veterans to provide effective medication (Canfield, 2014). As such, DoD needs to implement and validate screening, diagnosing, and assessing tools for PTSD to ensure only useful tools and methods are used. Importantly, selection of veterans suspected of or having PTSD should be carried out yearly to evaluate their progress and implement new therapies if the initial ones have failed. Numerous evidence-based models could be used to screen, diagnose, treat, and restore soldiers with PTSD. PTSD is characterized by multiple symptoms such as depression, anger, and anxiety. This calls for useful tools for assessing, screening and diagnosing to differentiate between PTSD and other mental health conditions (Canfield, 2014).

Canfield (2014) established that screening is done on members before after deployment to determine their mental condition. Members who turn out positive for PTSD are not treated immediately. It is unclear whether such members seek medical help later on or foregoes it. Screening of service members is a critical step in the fight against PTSD. Civilian clinicians who screen service rarely screen for PTSD. This is very risky because some service members could continue serving in the military with PTSD thus endangering their lives and those of troupe members. This calls for utilization of electronic health records to improve screening of PTSD among the forces. PTSD screening ought to be carried out yearly when members of the troops go for primary care services at the DoD. The VA should be commended for its excellent job since PTSD screening is encouraged each time a veteran goes for primary care (Canfield, 2014).

According to Canfield (2014) a good number of clinicians at the DoD and VA are not knowledgeable in the management of PTSD. Those trained in handling PTSD ignore the guidelines set for managing PTSD or lack experience to treat such patients. Moreover, some service member chose not to attend PTSD sessions due to their military duties. There is a need to hire more knowledgeable and experienced clinicians to handle PTSD cases. If possible degree causes for clinicians should include management of PTSD to improve service delivery among the forces (Canfield, 2014).

Overcome

Overcoming entails removing all barriers that inhibit delivery of screening, rehabilitation, and diagnosis services. Race, lack of resources, and dismissal from the military are some of the obstacles hindering access to quality care for PTSD patients. For PTSD treatment to be effective, all those barriers must be overcome so that every veteran receive quality and affordable healthcare to speed up his/her recovery. Similarly, DoD ought to encourage research that supports modern methods of treating PTSD. For instance, the department needs to invest more in telemedicine, virtual reality, and internet-based care for treatment of PTSD (Foy, 2012).

Foy (2012) like most of the authors, observed that some barriers limit provision of quality healthcare. Those barriers exist at either personal, provider, or organizational level. Some veterans eligible for health care at VA do not seek for healthcare at the facilities due to logistics reasons. There is a need to implement strategies that would enable service members, and

veterans overcome those barriers. To overcome those obstacles, telemedicine ought to be encouraged since it would eliminate the need for transport, reduce medication cost, and reduce the severity of stigma. The only problem with telemedicine is that users must be computer literate and have access to the internet. However, these are minor issues that could be handled easily considering the benefits that come along with telemedicine. There is a need to carry out further research on modern ways of preventing, treating, and rehabilitating the PTSD, and implementing the findings of those research to improve service delivery (Foy, 2012).

CONCLUSION

In conclusion, PTSD is a significant threat to the well-being of veterans. PTSD patients face numerous challenges in life that inhibit their healthy lives. For instance, some turn violent leading to divorce cases. The high cost of treating PTSD is also expensive for some family. Worse still, the veterans find it hard to search for other jobs since they are not mentally capable of handling those responsibilities (Foy, 2012). Most members of troops and veterans have PTSD due to physical injuries, brain injury, and depression. Tracking of the rehabilitation process is not done correctly thus making it hard to ascertain if those with PTSD have recovered or not. Lack of data on those treated with PTSD also makes it hard to determine if the interventions used are effective or not. Such information is required to refine the current service delivery and improve future interventions of PTSD hence dealing with the condition effectively. Even though data gathering on veterans who seek medication from private hospitals could be awkward, use of

electronic medical records could prove handy in gathering data for veterans who visit private hospitals though the veteran has to agree before his/her data is collected and stored.

Research has proved that integrating pharmacology and psychotherapy is the better way of managing PTSD condition. However, the numerous therapies used have yielded mixed results hence the need for further research to establish better alternatives for managing the requirements. The current international cases of civil unrest, wars, and terrorism suggest there is a need for better treatment of PTSD because those cases are likely to increase more in the future. Nonetheless, the future looks bright for those with PTSD. There is a likelihood of a breakthrough for effective medication than would handle PTSD effectively (Hoge et al., 2014).

Recent studies on PTSD have the potential to expand and improve service to patients. Moreover, the passage of the National Defense Authorization Act of 2012 removed restrictions against PTSD consultations across all states. The Act also allowed the mental healthcare providers to provide services irrespective of their original state. Initially, PTSD veterans could only be treated with a clinician from the same state. However, the Act amended this clause thus increasing accessibility of mental health care. Incorporation of PTSD treatment, diagnosis, and screening in military treatment facilities would also improve care for PTSD patients. Use of healthcare facilitators and elimination of all barriers could increase accessibility significantly to mental health care by veterans of PTSD thus reducing the prevalence of PTSD among the servicemen. Lastly, it is high time rehabilitation of veterans with PTSD received the attention it deserves lest the condition becomes a menace and scare away young people who aspire to serve their country as military personnel (Canfield, 2014).

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