

The Effects of Combat Zones on Mental Health Among Civilian Contractors

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DEDICATION

This thesis is dedicated to my father, Michael Trupiano. You always found a way to bring light into the room with laughter and your bright personality, even when times were tough. Your laugh and humor will always be missed by not just me, but by everyone who knew you. One of your biggest dreams for me was to continue my education, and now that dream is almost fulfilled. I could hear the excitement and pride in your voice when I told you I would begin working on my Master's degree in the fall. Little did I know you would be my inspiration for my coursework and this field of study. Now, your inspiration will continue to fuel my passion as I strive for change and knowledge. Even though I wish you were here physically to see me receive my degree and walk across the stage, I know you are proud and will be watching and guiding me through my journey.

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Abstract

As the number of suicides among the military and veteran population continue to increase each year, concern has generated program and research development. The Department of Defense (2012) discovered 40% of suicides in the military were in the age range of 17 and 24. They also reported that among military members, 42.1% had a mental health diagnosis, 23.0% had a history of substance abuse or addiction, and 13.5% reported a history of self-harm (DoD, 2012), all pieces to the theory of suicide (Van Orden et al., 2010). Another population with similar combat experiences to military members and veterans are civilian contractors. Although they have similar jobs and experiences overseas, civilian contractors do not receive the same quality of healthcare (Kestian, 2007; Miller, 2009). Civilian contractors are entitled to receive care covered by the Defense Base Act (DBA) and War Hazards Compensation Act (WHCA) (U.S. Department of Labor, 1941, 1942). With similar combat experience to the military, it was expected in this study to see reports from civilian contractors of mental health struggles. Results along with other contractors' experience (Kestian, 2007; Miller, 2009) demonstrate these laws are not enough and need to be updated.

Keywords: *civilian contractors, suicide, mental health*

CHAPTER 1

INTRODUCTION

In 2013, 41,149 Americans decided to take their own lives through suicide, which approximates to 113 suicides per day and 1 every 13 minutes. Males accounted for the majority of the reported suicides at 32,055 and females accounted for 9,094 (Drapeau & McIntosh, 2015). Furthermore, the rate of suicide has increased by 11% each year between 2011 and 2013 (Drapeau & McIntosh, 2014, 2015; McIntosh & Drapeau, 2014). As a result, suicide is number ten on the list of leading causes of death (Drapeau & McIntosh, 2015). Additionally in 2012¹, current military members accounted for 318 of the reported suicides (Department of Defense [DoD], 2012). In 2012², Veterans, those identified as having prior military service listed on the death certificates, accounted for 27,062 of the total 40,600 reported suicides (67%), at approximately 23 suicides per day (Drapeau & McIntosh, 2014; Kemp & Bossarte, 2012). With the average deployment time during the wars on terrorism being 12 months in 2004 and extending to 13 to 24 months by 2008 (Baiocchi, 2013), researchers began to have an increased concern about the relationship between the effects of war and mental health of the military members, especially when relating it to suicide.

Suicide Among Military

Sex differences in regard to suicide vary based on stigma surrounding mental health and social support systems, especially in the military. Just as males accounted for 84% of the military in 2012 (Office of the Deputy Assistant Secretary of Defense, 2012), the DoD (2012) and Kemp and Bossarte (2012) also found that males, 90th percentile of total suicides, were more likely to die by suicide compared to females. Historically, males have maintained the belief that

¹ This is the most recent estimate available.

² This is the most recent estimate available.

they do not experience mental health struggles, while females seek support from family and friends when they experience mental health struggles (Buffel, Van de Velde, & Bracke, 2014). Age appears to vary depending on the status of service. Due to the different methods of reporting suicides, reports among official government agencies differ in terms of suicide statistics. People currently in the military between 17 and 24 years old were found to be among the highest age group to suicide at 40% (DoD, 2012), while 69% of veterans were over the age of 50 who suicided (Kemp & Bossarte, 2012). Caucasian individuals were among the highest racial group to suicide (DoD, 2012; Kemp & Bossarte, 2012).

Response to Military Suicide

Since 2008, the DoD publishes annual reports examining the effects of war on the members of the U.S. military. These reports contain information among three aspects in relation to suicide attempts and deaths: health and treatment, psychosocial stressors, and deployment history. When examining health and treatment, researchers discovered the following: 42.1% had a mental health diagnosis, 23.0% had a history of substance abuse or addiction, and 13.5% reported a history of self-harm (DoD, 2012). When veterans and friends or family of veterans are in crisis, the Veterans Crisis Line is available as a coping resource; use of this resource has been gradually rising each year from 2009 to 2012. Although the crisis line is available to friends and/or family of veterans, 19% of repeat callers within a month were identified as veterans (Kemp & Bossarte, 2012). Crisis lines are essential to those experiencing crisis as it can deter them from unhealthy choices such as substance misuse, self-harm, and suicide.

When examining psychosocial stressors, DoD (2012) focused on the frequency of psychosocial stressors occurring 90 days prior to the suicide. They discovered 40% experienced stress among family/relationships, 32.4% experienced administrative/legal stress, and 32.1%

experienced workplace/financial stress. Lastly, 57.2% reported any deployment, 47.5% were deployed for Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF), and/or Operation Noble Dawn (OND), and 7.5% suicides occurred while deployed overseas.

Problem Statement

To better understand suicide, there are contributing factors to consider when examining why a person contemplates suicide. Since the start of the wars in Iraq and Afghanistan, a total of 391,759 veterans are currently being treated for potential post-traumatic stress disorder (PTSD) among the 23 different VA facilities across the nation (Department of Veterans Affairs, 2015) as a result of traumatic experiences during deployment to any of the combat zones. Additionally, the number of veterans will continue to grow with over 1.4 million people currently in the U.S. military across the five branches (Army, Air Force, Marine Corps, Navy, and Coast Guard) (U.S. Bureau of Labor Statistics, n.d.). PTSD is categorized as a trauma and stressor-related disorder triggered by being exposed to or witnessing near death situations through serious injury or sexual violation (American Psychiatric Association, 2013). If almost 400,000 veterans are currently being treated for PTSD, how many civilians who witness or experience similar traumatic events as civilian contractors are going untreated?

The U.S. Armed Forces have been a constant presence in Iraq and Afghanistan since the start of the war in 2001. With a substantial amount of current and prior military members, especially males, taking their lives through suicide, the concern continues regarding the connection between serving in a combat zone and suicide risk. However, one population often overlooked, who works with the military on a daily basis and may also be at increased risk for suicide due to experiences similar to deployed military members, are government-contracted employees, better known as “civilian contractors.” Although the number of deployed military

personnel deployed to Afghanistan decreased from 66,000 to 39,500 by the end of 2013 (Garamone, 2013), no one seems to be tracking how many non-military civilians contractors continue to work with or without the military and how many suffer from mental health issues including suicide risk.

Two laws that are supposed to provide reparation to civilian contractors are the Defense Base Act (DBA) and War Hazards Compensation Act (WHCA). The purpose of both Acts is to compensate civilian contractors who sustained injuries, are captured, or become missing while working in a combat zone and families of deceased civilian contractors resulting from injury sustained during their overseas employment (U.S. Department of Labor, 1941, 1942). Although physical injuries or death resulting from injury are monetarily covered, the Acts do not discuss coverage for mental health diagnoses sustained while working in a combat zone. Kestian (2007) reviewed the efficacy of these laws for civilian contractors by providing real life examples. However just as the acts neglect to discuss coverage for mental health, the discussed examples are only of physical injuries.

Purpose of the Study

The purpose of the study is to examine risk factors affecting suicide risk among deployed civilian contractors with traumatic experiences. Objectives guiding this study to determine the risk factors include the following:

- Describe the mental health of civilian contractors;
- Describe the experiences of civilian contractors' access to health coverage;
- Assess the relationship between the length of time in a combat zone and mental health issues;

- Assess the relationship between mental health resources used and the self-perception of mental health status following the resources used
- Identify a model of risk factors that predict suicidality among civilian contractors.

Significance of the Study

Civilian contractors working in combat zones may be as much at risk for mental health struggles, such as PTSD and depression, as the military when combat experiences are similar. Yet, outside of newspaper articles and law reviews, there are few records of civilian contractors receiving U.S. government subsidized care or having access to resources, physical or mental health resources, compared to the 1.8 million active service members and veterans. The findings of this study will greatly contribute a wider understanding of mental health struggles after working in a combat zone as a civilian contractor. Furthermore, the findings will raise awareness of mental health struggles specific to civilian contractors in combat zones that will inform practice, policy, and research toward meeting the needs of this overlooked group.

CHAPTER 2

LITERATURE REVIEW

Since the beginning of the global war on terrorism, military service members have been stationed overseas in Iraq or Afghanistan. As the wars progressed, military service members were soon joined in the combat zones by DoD Civilians or other civilian contractors (Garamone, 2013). For any injuries sustained while deployed in a combat zone, military members have health care access to any health care clinic in the combat zone, medical facility on active duty bases worldwide, and Veteran Affairs facilities within the U.S. Although the Veterans' Affairs (VA) stopped reporting the number of veterans being treated for non-fatal physical injuries, the reported number was up to 900,000 as of 2012 (Reno, 2013). Since civilian contractors are not eligible for care through the VA, they are forced to seek care in the community (Noël, Zeber, Pugh, Finley, & Parchman, 2011) through coverage of worker's compensation. Civilian contractors are covered for a maximum of one year under the DBA and WHCA if physical injuries are sustained (U.S. Department of Labor, 1941, 1942). This proves to be a difficult process as several civilian contractors, who have sustained severe physical injuries, have spent years fighting insurance companies for this entitlement (Kestian, 2007; Miller, 2009). Even though civilian contractors are entitled to compensation, this entitlement is only for one year regardless of progress and insurance companies become a hurdle to overcome. Complications from a physical injury can have additional effects lasting longer than one year leading to financial stressors, internal emotional distress, and stressors among psychosocial support.

Impacts of living and working in war environments do not discriminate against military or civilian status. Of 242 civilian contractors, 66% experienced a threat during their time overseas and 33% experienced this threat on a regular basis (Bierman & Kelty, 2014). When

civilian contractors suffer physical injuries during employment in a combat zone, a possibility of mental health struggles also exists. After completing the Trauma History Questionnaire, a group of civilian contractors were found to exceed cutoff scores for depression, psychological distress, and alcohol consumption (Feinstein & Botes, 2009). Similarly, Brenner, et al. (2008) found that veterans diagnosed with PTSD were experiencing a reduced amount of emotional responses post-deployment and an increased sense of disconnection with others. They were able to determine those most at risk for suicidal ideations were those who experienced a sense of burdensomeness and failed belongingness using various methods to cope, such as drugs and alcohol (Brenner et al., 2008).

Mental Health Outcomes

Mental health outcomes can manifest in many ways among the general population and military members, depending on how an individual copes with their traumatic experiences. For example, mental disengagement and wishful thinking for unrealistic fantasies and rumination among ambulance service workers were found to be the most utilized strategies when coping with PTSD (Clohessy & Ehlers, 1999). Both coping strategies could be a way to escape reality momentarily. Would depression occur when reality returns and individuals realize wishful thinking does not equate reality? Among women, in the general population, who experienced physical and psychological trauma through abuse, there was an increased prevalence of suicidal ideations in those with comorbidity of PTSD and depression as compared to those without (Pico-Alfonso et al., 2006). Similarly, there was a strong association between having experienced military sexual trauma (MST) and meeting diagnostic criteria for PTSD, anxiety (Kimerling, Gima, Smith, Street, & Frayne, 2007; Maguen et al., 2012), depression, and alcohol abuse (Hankin et al., 1999; Maguen et al., 2012); of men and women military members who

experienced combat trauma, such as witnessing people being killed or killing people themselves, 22% of 2,797 OIF Soldiers met criteria for PTSD (Maguen et al., 2010), while 12% of deployed Vietnam Soldiers met criteria for PTSD (Boscarino, 1995). PTSD has not only become more prevalent in today's society among civilians experiencing various types of trauma, but also among our current military members as they continue to experience violence while deployed (Pietrzak et al., 2010).

PTSD is often seen as a comorbid diagnosis with other disorders such as depression and anxiety. Recruited from VA outpatient clinics, people diagnosed with comorbid conditions of major depressive disorder (MDD) and PTSD reported significantly more anxiety and panic than those with MDD alone. Depressive symptoms appeared to worsen when joined with PTSD as compared to MDD alone (Campbell et al., 2007). After a 20 year longitudinal study, Ginzburg, Ein-Dor, and Solomon (2010) also found higher rates of triple comorbidities of PTSD, depression, and anxiety as reported by Lebanon War veterans. Understanding how mental health comorbidities affect a person, possibly leading to other issues, is important and can help professionals in identifying them early on. Ginzburg et al. (2010) followed veterans during a 20-year longitudinal study. It was found at each observation period (year 1, year 2, and year 20), the rate of triple comorbidities of PTSD with other mental health disorders increased each time.

Access to Care

Receiving care in a timely manner can save a person's life. Army Soldiers were found to have an increased amount of mental distress during the post-deployment health reassessment (PDHRA) 6 months after the initial post-deployment health assessment (PDHA) and received mental health referrals as a result (Milliken, Auchterlonie, & Hoge, 2007). The PDHA and PDHRA are tools used by the military to assess the physical and mental health status among

service members after returning home from deployments (DoD, 2006). Utilizing these tools has proven to be useful in assisting professionals to determine if service members are in need of resources, referrals, or other avenues of access to care. Among 222,620 OIF veterans, 68,923 sought mental health care at least once within a year post-deployment. It was also discovered that 346 per 1000 (35%) active service members sought mental health services, which included those with and without a mental health diagnosis (Hoge, Auchterlonie, & Milliken, 2006). Additionally, 27% of veterans who began treatment after receiving their first diagnosis through their nearest VA facility continued treatment one year later attending at least 9 sessions (Seal et al., 2010). Overall, the military and VA facilities have been working to improve the social environment surrounding mental health by encouraging those struggling to seek help. With the amount of access to care provided to current military and veterans who go through traumatic experiences in war, the same access should be made available to civilian contractors who have similar experiences. Having access to financial compensation for maximum of one year under the previously mentioned acts for civilian contractors is not enough when considering mental health and suicide.

Theory of Suicide

As a response to an epidemic of military and veteran suicides, people have analyzed factors leading to the act of suicide. To help understand the reasoning behind such a sudden and traumatic decision, Van Orden et al. (2010) emphasize three concepts in Thomas Joiner's theory of suicide that are necessary for a person to suicide: perceived burdensomeness, thwarted belongingness, and the acquired capability for suicide. Perceived burdensomeness is the perception that the individual has become a burden on friends and family, often due to family conflict, unemployment, and physical health issues. Thwarted belongingness is the perceived or

real unmet need of social connectedness. Lastly, the acquired capability for suicide is achieved through a diminished fear of death and increased tolerance to pain. All three concepts have been observed in those diagnosed with mental health disorders, such as substance abuse, various mood disorders, and PTSD (Brenner et al., 2008; Bryan, Clemans, & Hernandez, 2012; Van Orden et al., 2010). Furthermore, feelings of shame and embarrassment resulting from the stigmatization and pressures in the military among veterans were positively correlated to their reported suicidal ideations (Ganzini et al., 2013). Although these feelings could also lead to a perceived burdensomeness and perceived sense of thwarted belongingness, a sense of thwarted belongingness has not been proven to be a strong predictor for suicidality among military members (Bryan et al., 2012). However, moving from active duty to civilian life, veterans can experience the feelings of burdensomeness and thwarted belongingness as the sense of comradery and brotherhood was left behind.

Individuals who have a history of risky behavior have a reduced sense of concern regarding pain and death, leading to acquiring the capability for suicide (Van Orden et al., 2010). Through training and combat, military members and veterans are taught to not fear death and essentially beginning the foundation for Van Orden et al.'s (2010) third concept: Acquiring the capability for suicide. Veterans with PTSD are more likely than those without to misuse alcohol and other substances (Hankin et al., 1999; McDevitt-Murphy et al., 2010; Seal et al., 2012); these can further reduce inhibitions contributing to the likelihood of additional risky behaviors. Risky behaviors can play a role in the capability for suicide when treatment is not sought.

From personal observation, there are growing numbers of civilian contractors deployed to combat zones and working with military members each year. Civilian contractors often performed similar jobs to the military or worked alongside with them, such as truck drivers and

security. Some civilian contractors have sustained serious injuries during employment in a combat zone (Miller, 2009). With research supporting the relationship between combat trauma and PTSD among OIF Soldiers (Maguen et al., 2010), and others serving in GWOT, there may be a similar trend among civilian contractors, considering the employment experience is also similar. Additionally, with similar mental health outcomes, there may also be a trend leading to suicide risk.

CHAPTER 3

METHOD

As stated before, the purpose of the study was to examine risk factors affecting suicide risk among deployed non-military civilians with traumatic experiences. Objectives guiding this study to determine the risk factors included the following:

- Describe the mental health of civilian contractors
- Describe the experiences of civilian contractors' access to health coverage
- Assess the relationship between the length of time in a combat zone and mental health complications
- Assess the relationship between mental health resources used and the perception of the effectiveness of the resources
- Identify a model of risk factors that predict suicidality among civilian contractors.

Through a cross-sectional design, this quantitative exploratory study examined the effects of traumatic experiences on mental health of civilian contractors and the level of access to care for mental health issues. Two scales were used in one survey. The cross-sectional design of the study allowed the researcher to learn about the behaviors at one point in time.

Human Subject Considerations

Some of the biggest concerns when using human subjects in a study are participation, psychological injury, anonymity, and confidentiality. This study provided assurance to participants of these concerns. Civilian contractors were asked to voluntarily participate in this study. The research did not identify personal information, and all data was anonymous. Additionally, all completed consent forms and questionnaires will be kept locked in a passcode protected case file. After completion of this study, all materials used will be kept in a secured

office for three years to ensure confidentiality. Throughout and after completion of the study, only the researcher and her thesis chair were allowed access to the materials used in this study. Psychological injury was a possibility because answering questions about experiences may trigger negative feelings and reactions. To protect the participants from any psychological injury, online mental health resources for any struggles appeared on the bottom of each page of the survey in the event participants need professional resources.

Participants

With approval from the Institutional Review Board (IRB) (Appendix C), overseas civilian contractors were conveniently sampled for this study. Participants were recruited through the following civilian contractor associations, who agreed to distribute the survey link to their members: Government Contractors Association and International Stability Operations Association, along with AFCEA International, ASIS International and Professional Overseas Contractors who have granted permission to post the link to the survey on their LinkedIn webpage. Surveys for this study were completed through Qualtrics. Links to the survey were provided to the associations through email.

Measurement

Demographic data included (Appendix D) race, sex, age, specifics regarding employment as a civilian contractor and military history if applicable. Instruments used in this study to assess for risk factors among civilian contractors were the Patient Health Questionnaire with somatic, anxiety, and depressive components (PHQ-SADS) and the PTSD Checklist for DSM-5 (PCL-5). The PHQ-SADS is a combination of three self-report questionnaires: Patient Health Questionnaire 15-item (PHQ-15), Generalized Anxiety Disorder 7-item (GAD-7), and the Patient Health Questionnaire 9-item (PHQ-9). Together, the instrument assesses somatic, anxiety, and

depressive symptoms. The PCL-5 is a self-report measure used to assess for PTSD using diagnosing criteria from the DSM-5. The last six questions cover access to care overseas (Appendix D), such as “Have you ever sought any type of mental health resources,” “Did you find the resources helpful,” and “How did you hear about the services?”

Scoring the PHQ-SADS (Appendix A) involved analyzing the questionnaires as separate instruments. Scores of 5, 10, and 15 represent cut points for mild, moderate, and severe for the items being assessed in the PHQ-15 and GAD-7. In the PHQ-9, scores of 5, 10, 15, and 20 represent cut points for mild, moderate, moderately severe, and severe depression (PHQ-SADS Instruction Manual, n.d.). Individuals completing Section A, PHQ-15 which measures somatization, can score anywhere from 0-30. It has a 3-point likert scale, with not bothered to bothered a lot rating the frequency of occurring symptoms. An example question is: “During the last 4 weeks, how much have you been bothered by any of the following problems?” with symptom answers of stomach pain, back pain, fainting spells, chest pain, etc. Section B, the GAD-7, used a severity score of 0-21 on a 4-point likert scale with not at all to nearly everyday rating the frequency of occurring symptoms. Section C involved a panic measure: if all answers to Question C are marked yes, this points to the panic disorder. Section D used a severity score 0-27 for the PHQ-9, on a 4-point likert scale with not at all to nearly everyday rating the frequency of occurring symptoms. An example question is “Over the last 2 weeks, how often have you been bothered by any of the following problems?” with symptom answers of little interest or pleasure in doing things, feeling down, depressed, or hopeless, poor appetite or overeating, etc.

The PHQ-15, of the PHQ-SADS, demonstrated validity and reliability in two different studies. Han et al. (2009) produced a coefficient alpha of 0.87, while Gierk et al. (2015)

produced a similar finding of 0.80. Furthermore, both studies were able to correlate increased symptoms with increased scores (Gierk et al., 2015; Han et al., 2009), demonstrating validity. The GAD-7 in the PHQ-SADS, also demonstrated strong reliability ($\alpha = 0.91$) and construct validity with scores higher among those diagnosed with generalized anxiety disorder (GAD) than those without (Kertz, Bigda-Peyton, & Bjorgvinsson, 2013). Lastly, the PHQ-9 of the PHQ-SADS demonstrated reliability with a coefficient alpha of 0.87 in one study (Milette, Hudson, Baron, & Thombs, 2010), while another study produced a similar coefficient alpha of 0.91 (Chen et al., 2010). Milette et al. (2010) also produced a sensitivity rating of 0.86 and specificity rating of 0.85, suggesting high internal validity.

The PCL-5 (Appendix B) is a 25-item self-reported questionnaire, with 20 of the questions on a 5-point likert scale (not at all to extremely) to rate the frequency of occurrence. Unlike the PCL-C and PCL-M using the DSM-IV for diagnosing criteria, the PCL-5 uses the DSM-5 for the most recent and updated diagnosing criteria assessing the aftereffects of traumatic events and existence of any posttraumatic stressors. Example questions on this questionnaire include “Repeated, disturbing, and unwanted memories of the stressful experience?” “Trouble remembering important parts of a stressful experience?” and “Loss of interest in activities that you used to enjoy?” Preliminary work has shown cut points for the PCL-5 to be 11-14 points lower than previous versions used with the DSM-IV (Weathers et al., 2013). Little research has been completed using the PCL-5 since the release of the DSM-5 in 2013. However, one study demonstrated an identical reliability to the PCL-S (coefficient alpha’s 0.96), with a cutoff score of 33 using the DSM-5 criteria (Hoge, Riviere, Wilk, Herrell, & Weathers, 2014). Additionally, a cut point of 38 has been determined as valid until further research has been done (Weathers et al., 2013).

Data Analysis

The purpose of the study was to examine risk factors affecting suicide risk among deployed civilian contractors with traumatic experiences. Data analysis plan was as follows:

- Objective 1: Establish the mental health of civilian contractors. It will be achieved by calculating the means and standard deviations of the PCL-5 and PHQ-SADS,
- Objective 2: Describe the experiences of civilian contractors' access to health coverage. It will be achieved by examining the frequencies and percentages of the experiences,
- Objective 3: Assess the relationship between the length of time in a combat zone and mental health issues. It will be achieved by employing a Pearson's R correlation between length of time and mental health,
- Objective 4: Assess the relationship between mental health resources used and the self-perception of mental health status following the resources used. It will be achieved by the calculation of Kendall's Tau; and
- Objective 5: Identify a model of risk factors that predict suicidality among civilian contractors. It will be achieved by applying a multiple regression to analyze risk factors.

Delivered Sample

This study produced a small sample totaling 10 participants. However, only four participants completed the survey. With committee approval, this study reports the results as four case studies since the sample was too small for inferential statistics. Due to the anonymity of the surveys, pseudonyms were assigned to each case study.

CHAPTER FOUR

RESULTS

Case Study One

John is a 54-year-old male and identifies as a non-Hispanic Caucasian. He is married with children. However, his family is not deployed with him overseas. He currently works in an information technology position as a civilian contractor in a combat zone. John has been sent to work in a combat zone for a total of two times: 1 year at Bagram Air Force Base in Afghanistan and 8 months at Camp Spann, RC-North Afghanistan. He also identifies as a military veteran and deployed twice while in the military: one year at Camp Liberty in Iraq and seven months at Camp Victory in Iraq. In May 2010 at Bagram Air Force Base in Afghanistan, John reported experiencing the worst or most bothering³ event as an attack by 22 Taliban. John has never thought his loved ones would be better off without him. He did, however, seek mental health resources in person he had heard about through Military One Source. Unfortunately, he found these services to be very unhelpful. When asked what barriers he experienced to accessing mental health care, John identified his shortened military reserve career as the barrier.

John had the following scores for his PHQ-SADS: 2 (PHQ-15), 2 (GAD-7), and 0 (PHQ-9). A score of 2 for the PHQ-15 represents low somatic symptom severity. He was bothered a little from back pain and pain in arms, legs, or joints. A score of 2 for the GAD-7 represents mild anxiety. He reported among several days that he had trouble relaxing and was easily annoyed or irritable. Lastly, a score of 0 for the PHQ-9 represents zero to mild levels of depression. John did not find any of these problems causing difficulty to do his work, take care of things at home, or get along with other people. He had a cutoff score of six for the PCL-5 and

³ As per the PCL-5, this is defined as an event in which actual death, serious injury, or sexual violence was witnessed.

met diagnostic criteria for only three of the four clusters. The scores for the PHQ-SADS do not indicate a need for clinical intervention; however, meeting diagnostic criteria for three (clusters B, C, and E) of the four clusters is of concern.

Case Study Two

Bill is a 56-year-old male and also identifies as a non-Hispanic Caucasian. He is divorced with children. Similar to John, Bill's family is not deployed with him overseas. Currently, he is not working in a combat zone as a civilian contractor. Bill has also been sent to work in a combat zone for a total of two times: three years in Iraq and two years in Afghanistan. He does not have prior military experience. While Bill did identify a severe event⁴ occurring during his time in a combat zone on the PCL-5, he did not provide details. This event happened to him directly. He has never thought his loved ones would be better off without him and, despite this traumatic event, he never felt the need to seek mental health resources.

Bill had the following scores for his PHQ-SADS: 4 (PHQ-15), 1 (GAD-7), and 4 (PHQ-9). A score of 4 for the PHQ-15 represents low somatic symptom severity. He was bothered a little from pain in arms, legs, or joints and feeling tired or having little energy. He was also bothered a lot by feeling his heart race or pound. A score of 1 for the GAD-7 represents mild anxiety. He reported among several days that he worried too much about different things. Lastly, a score of 4 for the PHQ-9 represents mild levels of depression. He reported in the PHQ-9 among several days that he had little interest in doing things, felt depressed, had little energy, and felt bad about himself. Despite a score on the PHQ-9 that does not indicate clinical intervention, it is important to note that Bill found these problems somewhat causing difficulty to

⁴ As per the PCL-5, this is defined as an event in which actual death, serious injury, or sexual violence was witnessed.

do his work, take care of things at home, or get along with other people. He had a cutoff score of four for the PCL-5 but met diagnostic criteria for two (clusters B and E) of the four clusters.

Case Study Three

Paul is a 47-year-old male and also identifies as a non-Hispanic Caucasian. He is married with children. However, his family is not deployed with him overseas. He currently works in a law enforcement advisor position as a civilian contractor in a combat zone. Paul has been sent to work in a combat zone for a total of three times: nine months in Kandahar, Afghanistan; 16 months in Ghazni, Afghanistan; and six months in Logar, Afghanistan. He does not have prior military experience. In June 2012, Paul reported experiencing the worst or most bothering event⁵ as being seriously injured in an improvised explosive device (IED) blast. Paul reported he sometimes felt those he loved would be better off without him and has sought in-person mental health resources he heard about through a referral. Even though he sought these resources, he felt they were neither helpful nor unhelpful. However, he noted he found the in-person resources the most helpful of all the available resources. He also reported insurance approval and payment to be a barrier he experienced when seeking mental health care.

Paul had the following scores for his PHQ-SADS: 14 (PHQ-15), 13 (GAD-7), and 17 (PHQ-9). A score of 14 for the PHQ-15 represents medium somatic symptom severity. He was bothered a little from constipation, bowel movements, nausea, gas, or indigestion. He was also bothered a lot from back pain, pain in arms, legs, or joints, feeling tired or having little energy, trouble falling or staying asleep, feeling his heart race or pound, and shortness of breath. A score of 13 for the GAD-7 represents moderate anxiety. He reported among several days that he had difficulty stopping or controlling being worried, worried too much about different things, was

⁵ As per the PCL-5, this is defined as an event in which actual death, serious injury, or sexual violence was witnessed.

easily annoyed or irritable, and felt afraid as if something awful might happen. He also reported nearly everyday that he felt nervous anxiety or was on edge, had trouble relaxing, and had difficulty sitting still from being restless. In addition these symptoms, he reported in the last four weeks he had an anxiety attack that has happened previously, come suddenly out of the blue, causes worry about having another, and had physical symptoms such as sweating, shortness of breath, and heart racing. Lastly, a score of 17 for the PHQ-9 represents moderately severe levels of depression. He reported in the PHQ-9 among more than half of the days he felt depressed, had little energy, and felt bad about himself. He had little interest in doing things nearly everyday. He also experienced the following items more than half of the days: feeling down, depressed, or hopeless; trouble falling asleep, staying asleep, or sleeping too much; feeling tired or having little energy; poor appetite or overeating; feeling bad about yourself; trouble concentrating on things; and moving or speaking slowly or fidgety. Paul has found it to be very difficult to do his work, take care of things at home, or get along with other people as a result of these problems. He had a cutoff score of 45 for the PCL-5 and met diagnostic criteria for all four clusters. Paul's scores indicate a need for clinical intervention and his identification of suicidal ideation need to be addressed.

Case Study Four

Frank is a 35-year-old male and also identifies as a non-Hispanic Caucasian. He is divorced with children. Similar to the other participants, his family is not deployed with him overseas. He currently works in a communications position as a civilian contractor in a combat zone. Frank has been sent to work in a combat zone for a total of 10 times; he spent six to nine months in each location: Afghanistan, Iraq, Pakistan, Lebanon, Libya, Nigeria, and Egypt. He also identifies as a military veteran and deployed 10 times while in the military. He deployed to

combat zones in Afghanistan, Sierra Leone, and Northern Ireland, along with several other peacekeeping areas overseas. Frank reported experiencing the worst or most bothering events that happened directly to him in 2007: “Being in a building that was hit by a rocket; having an enemy round strike the sandbag I was firing from and narrowly miss my head; and being heavily outgunned in a position that was literally collapsing around me as the enemy drew closer.”

Frank has never thought his loved ones would be better off without him and never felt the need to seek mental health resources.

Frank scored 0 on all pieces of the PHQ-SADS. Likewise, he did not find any of these problems causing difficulty to do his work, take care of things at home, or get along with other people. He had a cutoff score of 2 for the PCL-5 and did not meet diagnostic criteria for any of the four clusters.

CHAPTER FIVE

DISCUSSION

There were a few concerns identified when reporting the results for each case study. John reported to experience a frightening situation involving the Taliban and sought mental health care as a result. Yet, his low cutoff scores for the PHQ-SADS and PCL-5, while meeting three of the four clusters on the PCL-5 for diagnostic criteria, causes concern. Although individuals can report successful recovery after seeking mental health care, John reported his services were very unhelpful, which increases the concern for this participant. Bill also reported a frightening situation, but did not provide details about the event. The unwillingness to provide any detail points the concern toward the possibility of suppressing emotions and memories regarding the event. His lack of detail for this troubling event is also concerning when compared to his low cutoff scores for the PHQ-SADS and PCL-5. Similar to John and Bill, Frank also reported two frightening situations while having low cutoff scores for the PHQ-SADS and PCL-5. Another concerning factor for Frank was the amount of deployments he reported during his military service and as civilian contractor. Being in a combat zone as often as Frank reported could lead to him being desensitized to such threatening situations. Desensitization would give explanation to low cutoff scores on the instruments used. These participants may need clinical intervention regardless of their low cutoff scores. Paul, however, differs from the other participants in that it is clear he needs clinical intervention. Even though Paul does not have prior military experience, his traumatic experience generated just as much concern with his high cutoff scores.

Even though policies have been in place for several decades providing coverage for civilian contractors, they continue to be an emerging population to the public knowledge. Successfully practicing with this population involves removing barriers so they are no longer the forgotten heroes. Such barriers include changes to current insurance practices and policies in place. The DBA and WHCA are the only current policies in place, which were put in place in 1942 (U.S. Department of Labor, 1941, 1942). Since policies guide insurance practices, this population is unable to receive proper mental healthcare, let alone physical healthcare. With the experiences this population endures, they deserve current policies in order to provide them the clinical interventions they desperately need. Without updated policies and proper healthcare, these individuals begin to take matters in their own hands. In the movie *13 Hours: The Secret Soldiers of Benghazi* based on true events, a civilian contractor is severely injured after the area is hit with a mortar round. Upon returning home, this individual enlisted into the military in order to receive care for his injuries (Bay, 2016). The situation experienced by this contractor demonstrates the lack of healthcare needed despite the policies in place. This is the exact reason why policies need to be updated so contractors do not feel the need to make similar or worse decisions to relieve their pain.

Current policies affect more contractors than people realize. ASIS International has over 90,000 members (ASIS International, n.d.); AFCEA International has over 4,000 members (AFCEA International, n.d.); and Professional Overseas Contractors have over 34,000 members (Professional Overseas Contractors, n.d.) on their LinkedIn pages. There are a few speculations as to why this study recruited a small sample despite the large amount of members for each organization. One possibility points to members not logging into their LinkedIn account on a regular basis and reading through the feed of the agency. For example, ASIS International has

approximately eight new posts each day causing the visibility of the post about this study to decrease. There may also have been contractors who believed they did not have the time to complete such a survey or this study was unimportant to them, essentially contributing to the small sample size and inability for inferential statistics.

Another concern affecting the results of this study is the effectiveness of the measurements with online participants. Although previous research demonstrated strong validity, the measurements used in this study did not capture a full picture of all participants' experiences. This was evident when some participants appeared to be desensitized by not providing details after multiple deployments, reporting not needing mental health care, or having low cut off scores. Completing this study with a qualitative approach gives the ability to capture the full picture of participant's experience this study missed out on since direct contact would be made. It also gives the ability to identify and refer any participants needing immediate help.

Limitations

This study produced a small sample size: a total of 10 participants who began the survey and four of the 10 participants who completed the survey. As a result, this study lacks external validity. There were also limitations when examining the results as four case studies. Additional questions needed to be asked of the participants in order to make it a qualitative study, such as questions surrounding training especially for those without military experience. The last limitation to this study is that it is not a forced survey leading to missing important information pertaining to participant's experiences and coping skills.

Recommendations

Despite the limitations noted, this study has guiding recommendations in order for future research to produce significant results regarding this population. Additional research is needed

to spark updating the DBA and WHCA policies. This additional research should have a bigger sample or more qualitative questions to produce significant results. As mentioned previously, policy changes, to include mental health coverage, are important and will lead to changed practices among insurance companies. Changing insurance practices will allow positive changes in clinical practice to effectively help this population heal from mental health struggles.

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Appendix A

PATIENT HEALTH QUESTIONNAIRE (PHQ-SADS)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability

A. During the last 4 weeks, how much have you been bothered by any of the following problems?

	Not bothered (0)	Bothered a little (1)	Bothered a lot (2)
1. Stomach pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Back pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Pain in your arms, legs, or joints (knees, hips, etc.)...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling tired or having little energy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Menstrual cramps or other problems with your periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Pain or problems during sexual intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Headaches.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Chest pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Dizziness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Fainting spells.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Feeling your heart pound or race....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Shortness of breath.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Constipation, loose bowels, or diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Nausea, gas, or indigestion.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PHQ-15 Score = ____ + ____

B. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1. Feeling nervous anxiety or on edge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Not being able to stop or control worrying.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Worrying too much about different things.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Trouble relaxing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Being so restless that it is hard to sit still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Becoming easily annoyed or irritable.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Feeling afraid as if something awful might happen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

GAD-7 Score = ____ + ____ + ____

C. Questions about anxiety attacks.

a. In the <u>last 4 weeks</u> , have you had an anxiety attack — suddenly feeling fear or panic?	NO	YES
If you checked "NO", go to question D.	<input type="checkbox"/>	<input type="checkbox"/>
b. Has this ever happened before?	<input type="checkbox"/>	<input type="checkbox"/>
c. Do some of these attacks come <u>suddenly out of the blue</u> — that is, in situations where you don't expect to be nervous or uncomfortable?	<input type="checkbox"/>	<input type="checkbox"/>
d. Do these attacks bother you a lot or are you worried about having another attack?	<input type="checkbox"/>	<input type="checkbox"/>
e. During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, or your heart racing, pounding or skipping?	<input type="checkbox"/>	<input type="checkbox"/>

D. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1. Little interest or pleasure in doing things.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed, or hopeless.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Trouble falling or staying asleep, or sleeping too much.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling tired or having little energy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Poor appetite or overeating.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Trouble concentrating on things, such as reading the newspaper or watching television.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Thoughts that you would be better off dead or hurting yourself in some way.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PHQ-9 Score = + +

E. If you checked off any problems on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all <input type="checkbox"/>	Somewhat difficult <input type="checkbox"/>	Very difficult <input type="checkbox"/>	Extremely difficult <input type="checkbox"/>
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Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Appendix B

PCL-5

Instructions: This questionnaire asks about problems you may have had after a very stressful experience involving *actual or threatened death, serious injury, or sexual violence*. It could be something that happened to you directly, something you witnessed, or something you learned happened to a close family member or close friend. Some examples are a *serious accident; fire; disaster such as a hurricane, tornado, or earthquake; physical or sexual attack or abuse; war; homicide; or suicide*.

First, please answer a few questions about your *worst event*, which for this questionnaire means the event that currently bothers you the most. This could be one of the examples above or some other very stressful experience. Also, it could be a single event (for example, a car crash) or multiple similar events (for example, multiple stressful events in a war-zone or repeated sexual abuse).

Briefly identify the worst event (if you feel comfortable doing so): _____

How long ago did it happen? _____ (please estimate if you are not sure)

Did it involve actual or threatened death, serious injury, or sexual violence?

____ Yes

____ No

How did you experience it?

____ It happened to me directly

____ I witnessed it

____ I learned about it happening to a close family member or close friend

____ I was repeatedly exposed to details about it as part of my job (for example, paramedic, police, military, or other first responder)

____ Other, please describe _____

If the event involved the death of a close family member or close friend, was it due to some kind of accident or violence, or was it due to natural causes?

____ Accident or violence

____ Natural causes

____ Not applicable (the event did not involve the death of a close family member or close friend)

Second, keeping this worst event in mind, read each of the problems on the next page and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

<i>In the past month, how much were you bothered by:</i>	<i>Not at all</i>	<i>A little bit</i>	<i>Moderately</i>	<i>Quite a bit</i>	<i>Extremely</i>
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (<i>as if you were actually back there reliving it</i>)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (<i>for example, heart pounding, trouble breathing, sweating</i>)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (<i>for example, people, places, conversations, activities, objects, or situations</i>)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (<i>for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous</i>)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (<i>for example, being unable to feel happiness or have loving feelings for people close to you</i>)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Appendix C



Institutional Review Board Notification of Exemption

September 30, 2015

Vanessa Trupiano
Regina T. Praetorius
School of Social Work
Box 19129

Protocol Number: 2015-0889

Protocol Title: *The Effects of Combat Zones on Mental Health Among Civilian Contractors*

EXEMPTION DETERMINATION

The UT Arlington Institutional Review Board (IRB) Chair, or designee, has reviewed the above referenced study and found that it qualified for exemption under the federal guidelines for the protection of human subjects as referenced at Title 45CFR Part 46.101 (2).

- (2) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: (i) information obtained is recorded in such a manner that human subjects can be identified, either directly or through identifiers linked to the subject; and (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

You are therefore authorized to begin the research as of **September 30, 2015**.

Pursuant to Title 45 CFR 46.103(b)(4)(iii), investigators are required to, “promptly report to the IRB ***any*** proposed changes in the research activity, and to ensure that such changes in approved research, during the period for which IRB approval has already been given, are **not initiated without prior IRB review and approval** except when necessary to eliminate apparent immediate hazards to the subject.” Please be advised that as the principal investigator, you are required to report local adverse (unanticipated) events to the Office of Research Administration; Regulatory Services within 24 hours of the occurrence or upon acknowledgement of the occurrence. All investigators and key personnel identified in the protocol must have documented Human Subject Protection (HSP) Training on file with this office. Completion certificates are valid for 2 years from completion date.

The UT Arlington Office of Research Administration; Regulatory Services appreciates your continuing commitment to the protection of human subjects in research. Should you have questions, or need to report completion of study procedures, please contact Alyson Stearns at 817-272-9329 or astearns@uta.edu. You may also contact Regulatory Services at 817-272-3723 or regulatoryservices@uta.edu.

**REGULATORY SERVICES
SERVICES**

The University of Texas at Arlington, Center for Innovation
202 E. Border Street, Ste. 201, Arlington, Texas 76010, Box#19188
(T) 817-272-3723 (F) 817-272-5808 (E) regulatoryservices@uta.edu (W) www.uta.edu/rs

Appendix D

Demographics

Informed consent

PRINCIPAL INVESTIGATOR NAME:

Vanessa R .Trupiano, School of Social Work, vanessa.trupiano@mavs.uta.edu

FACULTY ADVISOR

Regina T. Praetorius, Ph.D. School of Social Work, regtrupr@exchange.uta.edu

TITLE OF PROJECT

The effects of combat zones on mental health among government contracted employees.

INTRODUCTION

You are being asked to participate in a research study about the effects of combat zones on mental health among government contracted employees. Your participation is voluntary. Refusal to participate or discontinuing your participation at any time will involve no penalty or loss of benefits to which you are otherwise entitled. Additionally, you must be 18 and older and a current or former government contracted employee.

Please ask questions if there is anything you do not understand.

OBJECTIVE

The objective of this quantitative research study is to explore the impact of war zones and post-traumatic stress on mental well being among government contracted employees. The design is an online exploratory survey that collects information on trauma, combat exposure, mental health, and service access.

DURATION

This survey will take approximately 20 to 30 minutes to complete depending upon your answers which may increase how many questions you are asked.

NUMBER OF PARTICIPANTS:

We expect 500 participants to enroll in this study.

PROCEDURES

The procedures, involving you as a research participant, include you completing an online anonymous survey. You are being asked to answer questions regarding experiences with trauma, combat exposure, mental health, and access to services. The number of questions you are asked depends on your experiences with trauma, combat exposure, mental health, and service access. For example, if you indicate a particular experience of interest, you may be asked additional questions about that experience that someone who did not have that experience would not be asked.

POSSIBLE BENEFITS

There are no direct benefits for participating in this study; however, you will be contributing to the broader body of knowledge on how civilian contractors are affected by their own personal experiences.

COMPENSATION

No compensation is offered for participation in this study.

POSSIBLE RISKS/DISCOMFORTS

There are no perceived risks for participating in this research study. Certain questions may cause some emotional discomfort. If at any time you experience discomfort you may exit the survey at no consequence to you. If you would like to talk to someone or are in crisis please seek help through this link:
<http://www.suicidepreventionlifeline.org/GetHelp/LifelineChat.aspx>.

ALTERNATIVE PROCEDURES

There are no alternative procedures offered for this study. However, you can elect not to participate in the study or quit at any time with no negative consequences.

VOLUNTARY PARTICIPATION

Participation in this research study is voluntary. You have the right to decline participation in any or all study procedures or quit at any time at no consequence.

CONFIDENTIALITY:

This survey is intended to be anonymous. No identifying information will be collected from you and we will have no way of identifying you unless you contact us. If you contact us, we will have your identity (e.g. email address, phone number, name you provide) BUT we will not be able to link your survey responses to your identity. Every attempt will be made to see that your study results are kept confidential. All data collected from this survey will only be available to Vanessa Trupiano and her supervising professor, Dr. Regina Praetorius. A copy of the data from this study will be stored on the password protected computer of Dr. Praetorius and in a password protected online data backup program administered by the University of Texas at Arlington for at least three (3) years after the end of this research. The results of this study may be published and/or presented at meetings without naming you as a subject. Although your rights and privacy will be maintained, the Secretary of

the Department of Health and Human Services, the UTA Institutional Review Board (IRB), and personnel particular to this research have access to the study records. If you contact the researcher with questions or discomfort, your identity will be kept separate from your answers on the survey. Your records will be kept completely confidential according to current legal requirements. They will not be revealed unless required by law, or as noted above.

If in the unlikely event it becomes necessary for the Institutional Review Board to review your research records, then The University of Texas at Arlington will protect the confidentiality of those records to the extent permitted by law. Your research records will not be released without your consent unless required by law or a court order. The data resulting from your participation may be made available to other researchers in the future for research purposes not detailed within this consent form. In these cases, the data will contain no identifying information that could associate you with it, or with your participation.

CONTACT FOR QUESTIONS

Questions about this research study may be directed to Vanessa Trupiano (vanessa.trupiano@mavs.uta.edu) & Dr. Praetorius (regtrupr@exchange.uta.edu). Any questions you may have about your rights as a research subject or a research-related injury may be directed to the Office of Research Administration; Regulatory Services at 817-272-2105 or regulatoryservices@uta.edu.

CONSENT:

By clicking “ACCEPT” below, you confirm that you are 18 years of age or older and have read or had this document read to you. You have been informed about this study’s purpose, procedures, possible benefits and risks, and you may print a copy of this form using the “Print” function in your browser. You have been given the opportunity to ask questions before you make a decision regarding your participation, and you have been told that you can ask other questions at any time.

You voluntarily agree to participate in this study. By clicking “ACCEPT” below, you are not waiving any of your legal rights. Refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled.

- ACCEPT; I voluntarily agree to participate in this study
- DECLINE; I do not wish to participate in this study

Demographics

What is your sex?

- Male
- Female
- Other

What is your race? (More than one may be selected)

- Asian American
- Black or African American
- Hispanic or Latino
- Native Hawaiian and Other Pacific Islander
- American Indian and Alaska Native
- Caucasian

What is your ethnicity?

- Hispanic
- Non-Hispanic

What is your age?

Please indicate your marital status:

Did your family deploy with you?

- Yes
- No

Are you a government contracted employee working in a combat zone?

- Yes
- No

What industry do you work in?

How many times have you been sent to work in a combat zone?

Please provide the name of locations & length of employment for each location where you have been stationed

Do you have prior military experience?

- Yes
- No

Did you experience combat during your time in the military?

Yes

No

How many times were you deployed while in the military?

Please provide the name of locations & length of deployment for each location where you have been stationed

Block 6

Patient Health Questionnaire (PHQ-SADS)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability

Patient Health Questionnaire (PHQ-SADS)

Patient Health Questionnaire (PHQ-SADS)

During the **last 4 weeks**, how much have you been bothered by any of the following problems?

	Not Bothered (0)	Bothered a little (1)	Bothered a lot (2)
Stomach Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Back Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Pain in your arms, legs, or joints (knees, hips, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling tired or having little energy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble falling or staying asleep, or sleeping too much	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Menstrual cramps or other problems with your periods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pain or problems during sexual intercourse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chest pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dizziness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fainting spells	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling your heart pound or race	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Shortness of breath	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Constipation, loose bowels, or diarrhea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nausea, gas, or indigestion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?

	Not At All (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
Feeling nervous anxiety or on edge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not being able to stop or control worrying	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Worrying too much about different things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble relaxing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being so restless that it is hard to sit still	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Becoming easily annoyed or irritable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling afraid as if something awful might happen	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

In the **last 4 weeks**, have you had an anxiety attack - suddenly feeling fear or panic?

(1) Yes

(0) No

Questions about anxiety attacks in the **last 4 weeks**:

	Yes (1)	No (0)
Has this ever happened before?	<input type="radio"/>	<input type="radio"/>
Do some of these attacks come suddenly out of the blue - that is in situations where you don't expect to be nervous or uncomfortable?	<input type="radio"/>	<input type="radio"/>
Do these attacks bother you a lot or are you worried about having another attack?	<input type="radio"/>	<input type="radio"/>
During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, or your heart racing, pounding, or skipping?	<input type="radio"/>	<input type="radio"/>

Over the **last 2 weeks**, how often have you been bothered by any of the following problems

	Not At All (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
Little interest or pleasure or doing things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling down, depressed, or hopeless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble falling asleep or staying asleep, or sleeping too much	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling tired or having little energy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poor appetite or overeating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling bad about yourself - or that you are a failure or have let yourself or your family down.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble concentrating on things, such as reading the newspaper or watching television	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Moving or speaking so				

slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual

Thoughts that you would be better off dead or hurting yourself in some way

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

No matter what problems you are dealing with, we want to help you find a reason to keep living. If you would like to talk to someone or are in crisis, please seek help through this online chat link:

<http://www.suicidepreventionlifeline.org/GetHelp/LifelineChat.aspx>

You'll be connected to a skilled, trained counselor at a crisis center in your area, anytime 24/7.

If you checked off **any** problems in this section, how **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?

- (0) Not at all difficult
- (1) Somewhat difficult
- (2) Very difficult
- (3) Extremely difficult

Block 5

PCL-5

Instructions: The next questionnaire asks about problems you may have had after a very stressful experience involving actual or threatened death, serious injury, or sexual violence. It could be something that happened to you directly, something you witnessed, or something you learned happened to a close family member or close friend. Some examples

are a serious accident; fire; disaster such as a hurricane, tornado, or earthquake; physical or sexual attack or abuse; war; homicide; or suicide.

First, please answer a few questions about your worst event, which for this questionnaire means the event that currently bothers you the most. This could be one of the examples above or some other very stressful experience. Also, it could be a single event (for example, a car crash) or multiple similar events (for example, multiple stressful events in a war-zone or repeated sexual abuse).

PTSD Checklist

PTSD Checklist

Briefly identify the worst event (if you feel comfortable doing so):

How long ago did it happen? (please estimate if you are not sure)

Did it involve actual or threatened death, serious injury, or sexual violence?

- (1) Yes
- (0) No

How did you experience it?

- (1) It happened to me directly
- (2) I witnessed it
- (3) I learned about it happening to a close family member or close friend
- (4) I was repeatedly exposed to details about it as part of my job (for example, paramedic, police, military, or other first responder)
- (5) Other, please describe:

If the event involved the death of a close family member or close friend, was it due to some kind of accident or violence, or was it due to natural causes?

- (2) Accident or violence
- (1) Natural causes
- (0) Not applicable (the event did not involve the death of a close family member or close friend)

Below is a list of problems and complaints that veterans sometimes have in response to stressful military experiences. Please read each one carefully, then select one of the numbers to the right to indicate how much you have been bothered by that problem **in the past month.**

	Not at all (0)	A little bit (1)	Moderately (2)	Quite a bit (3)	Extremely (4)
Repeated, disturbing memories, thoughts, or images of a stressful military experience?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Repeated, disturbing dreams of a stressful military experience?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Suddenly acting or feeling as if a stressful military experience were happening again (as if you were reliving it)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling very upset when something reminded you of a stressful military experience	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of a stressful military experience?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Avoiding thinking about or talking about a stressful military experience or avoiding having feelings related to it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Avoiding activities or situations because they reminded you of a stressful military experience?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble remembering important parts of a stressful military experience?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Loss of interest in activities that	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Loss of interest in activities that you used to enjoy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling distant or cut off from other people?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling emotionally numb or being unable to have loving feelings for those close to you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling as if your future will somehow be cut short?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble falling or staying asleep?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling irritable or having angry outbursts?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having difficulty concentrating?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being "super-alert" or watchful or on guard?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling jumpy or easily startled?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Weathers, F.W., Litz, B.T., Keane, T.M., Palmieri, P.A., Marx, B.P., & Schnurr, P.P. (2013). *The PTSD Checklist for DSM-5 (PCL-5)*. Scale available from the National Center for PTSD at www.ptsd.va.gov.

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<http://www.suicidepreventionlifeline.org/GetHelp/LifelineChat.aspx>

You'll be connected to a skilled, trained counselor at a crisis center in your area, anytime 24/7.

Block 4

Have you ever felt as if those you loved would be better off without you?

Have you sought any type of mental health resources? (More than one answer can be selected)

- Yes, in person
- Yes, online.
- Yes, self-help books.
- Yes, but a resource not listed.
- Neither, in person or online resources are available to me
- I haven't felt the need to

No matter what problems you are dealing with, we want to help you find a reason to keep living. If you would like to talk to someone or are in crisis, please seek help through this online chat link:

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Did you find the resources helpful?

- Very unhelpful
- Unhelpful
- Neutral
- Helpful
- Very helpful

Which mental health services did you find the most helpful?

⌋

In-person services

Online chat groups

Self-help books

Other

None

How did you hear about the services?

What are some barriers you experienced when seeking mental health care?

No matter what problems you are dealing with, we want to help you find a reason to keep living. If you would like to talk to someone or are in crisis, please seek help through this online chat link:

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You'll be connected to a skilled, trained counselor at a crisis center in your area, anytime 24/7.