Trauma Matters

Fall 2019

A quarterly publication dedicated to the dissemination of information on trauma and best-practices in trauma-informed care.

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www.womensconsortium.org

A Reflection on Migrant & Refugee Trauma

Below are excerpts from a conversation between Bill Rivera and Mary Painter of the Connecticut Department of Children and Families (DCF). The conversation is centered around the experience of migrants and refugees during the border crisis. The information discussed has been categorized into seven topic areas: challenges of DCF involvement, advice for the professional, the experience of unaccompanied minors, countries of origin, how to help, discrimination in America, and resources.

Challenges of DCF Involvement

When migrants and refugees arrive to the United States, there are always cultural and linguistic differences and dynamics. When it comes to DCF involvement, many folks don't understand why a state government agency is in their home directing services or telling parents what they need to do. Not even their own families know what is going on and then we're coming into their home and being intrusive; or that's the perception. It's a very disorienting type of experience and even though our goal is to get ourselves there and hopefully everyone in the same place, many of those families, due to their own lack of knowledge and differences, don't perceive it that way. This is just one of the challenges we face.

Different people have differing voices and perspectives of race, privilege, and power; oftentimes, these conflict with the families we're engaging with. This is one of the many reasons that DCF has a racial justice initiative. It is a priority to try to understand that many of our practices, policies, procedures, and engagements with families are contributing to disparate treatment, resulting in people being treated differently when they don't speak English, are from another country, or have a different immigration status. Data shows us that disparate treatment is taking place and we've decided to take it on; of course, we still hear about it occurring and must ensure we stay on top of it. The role of the Director of Multicultural Affairs is to ensure that the agency understands these dynamics, is educated about them, and then supervised based on a practice guide for understanding how to work with these families to both preserve the family and protect the children.

Advice for the Professional

On the most basic level as an organization, it is important to acknowledge that a lot of work must be done interpersonally to understand and bring different people together as human beings. How we see the world, how we understand different groups, and how we view people of different races has been filtered through stereotypes and media; it is important to get staff to look within themselves and do self-assessments about how their own worldview can distort their engagement with these families.

One of the things we've learned in our work educating people about privilege, power, and racism, is that you don't know what you don't know. It's not that white social workers have any malintent; their bias is often unconscious. The fact of the matter is that they have privilege, having not grown up in circumstances or environments of oppression. Based on the fact alone that they are white means they do not experience many of the things that people of color experience on a daily basis.

Recently, we've been doing a lot of education, awareness, and reporting on how whiteness evokes privilege. The minority of children in Connecticut are children of color, with 60% or more of children across the state identifying as white. In contrast, two-thirds of the open cases at DCF are centered around children of color; this is

called disproportionality and we have the data to prove it.

As a result, much of our education has focused on self-assessments, training, tools, and opportunities for staff to look within themselves and to better understand the dynamics of privilege and how it relates to institutional racism. Recently, some of this has been integrated into the early stages of pre-service training. One question to consider is whether our data indicates that we are moving in a positive direction and there are several ways that we can assess this. With safety concerns considered as the number one marker for success, we analyze our numbers to determine if there is a difference, where that difference is, and then adjust our policies and procedures accordingly.

With many agencies being impacted, we have done a lot of training on immigration and have very clear and explicit policies about reporting or not to Homeland Security. When conducting training with contracted providers, we ask how many folks are aware of policies that explicitly state that they will not report anyone to Homeland Security; we have found there are no agencies that explicitly state this. Within our own statewide initiatives, we must think about how to protect our data and how, or even if, you report an individual's status or not. There are real, personal, agency, and policy implications around reporting vs. non-reporting to Homeland Security and it is important for us to take this into consideration as we provide guidance and implement procedures.

The Experience of Unaccompanied Minors

***Familial Impact*:** The trauma experience for unaccompanied minors and their families is like that of any family going through disruption, loss, and separation and it can be exacerbated by a variety of factors. The migratory experience alone is traumatic and can result in a variety of biological and physiological issues, including post-traumatic stress disorder. For adults migrating to the United States, making the decision to do so alone is a traumatic experience as you actively decide to leave your country and everything you know behind to adopt a new culture and way of life. For children, the trauma of leaving their parents behind is incredibly traumatic.

Connecticut has received about 2,300 unaccompanied minors from the border. When they arrive, they are being placed with sponsors who may be one parent who set up ahead of the child's arrival or another relative from their country of origin. It is easy to predict the challenges that arise when the children get here. Although the parent has done everything in their power to take the child out of harm's way, there is no parent-child relationship. After years of viewing their parent as missing from their lives, a child is unable to developmentally understand the sacrifices their parents have made.

As this is unfolding, trauma begins to manifest through isolation, conflict, and family violence. At the same time, they see the freedoms and material things their American peers have. Because their parents can't give these things to them, they opt to treat their parent as "buddies" and established boundaries begin to break. When the parent tries to discipline the child, conflict ensues; this is when a call to DCF is typically placed sending them into our care. Often, the biggest challenge with unaccompanied minors is the conflict between tradition and American culture; parents/sponsors are trying to preserve their cultural values, but their children are imitating American values. When the parents try to impose rules it results in conflict, separation, referrals to DCF, and family mediation which is difficult to do for many DCF staff who come from a Eurocentric framework.

Many of our Careline referrals consist of family violence: parents try to exercise control as they feel they are losing it and wind up resorting to physical discipline or punishment to which the kids don't respond. In school, the children are hearing about DCF's role in protecting them so if they feel they are being abused or neglected so they disclose to a faculty member or teacher, who is a mandated reporter and must pass the case along to DCF. Many of these cases cannot be substantiated following investigation as they are issues that could have been solved through simple engagement between the school and family systems. Of course, there are some cases that do get substantiated and require significant intervention; the goal here is always to keep the family together, though not always possible.

***The Journey*:** Most migrants and refugees are traveling from Central America, so the first step is often to cross the border into Mexico; from there, it is a 3,000-mile journey to America. The plan is to jump onto trains headed from South America to the USA. The children are instructed to get on board the freight train any way they can, whether that means hopping on top, into an open cargo container, or hanging on the side. It is a perilous trip where it is not uncommon to run out of food and money, or even lose your life. If they do make it to the American border, there is an additional threat of human traffickers who wait there, looking to prey on those attempting to crossover alone. Often, through the promise of food and shelter, children make the decision to go with the traffickers where they then face malnutrition, starvation, and physical and emotional abuse.

When they make it to the border, migrant children have been instructed to look for a customs and border protection agency where they turn themselves in as a minor. From there, they are taken into a detention facility where they undergo an intake and medical exam. Eventually, if a sponsor is identified, and they pass the screening, the child is placed in the sponsor's care until they are due in immigration court. If they do not quality for asylum, they will likely be deported through a removal proceeding.

In addition to the trauma of getting here alone, DCF has seen many cases in which children hadn't eaten or had water for weeks, stopping only at sparsely placed food and water stations throughout the desert. The average age of these children in Connecticut is 15 or 16, though there are children as young as 11 making this journey alone. It is important to remember that all these children are refugees fleeing persecution that their government cannot protect them from.

***Detention Centers*:** The experience for children in detention centers varies and depends on the center itself. The Offices of Health and Human Services, Refugee Resettlement, and Unaccompanied Minors subcontracts with licensed facilities all of which are regulated by the state in which they are located. Once these children

make it to the border there is a deadline to get them to a facility, whether it is the closest one to their identified sponsor or not. Within the Connecticut shelter, there are children heading to Florida, Vermont, New York, and South Carolina; they are simply brought here until their sponsor can be verified or a new shelter is found. This placement process can last from weeks to months on end.

In the shelters away from the border, the children are generally well-cared for with some type of mental health staff in place to ensure they feel safe and connected to the community. For example, a group of children may be brought into a local church to make connections with others and have an opportunity to engage with local folks who speak their language. The deplorable, abusive conditions we are seeing in the media are more reflective of the for-profit shelters on the border where folks scrambled to set up temporary shelter for many children at once.

Countries of Origin

The most typical countries of origin are dependent on whether we are looking at refugees or migrants. For undocumented immigrants, most folks are coming from Central America with the highest concentration coming from Guatemala, Honduras, El Salvador, and Mexico. Many more come from Brazil, first flying to Mexico and making the trip to the American border from there.

Although the focus has been on migration from Central America, it is important to note folks are attempting to cross the border from the north as well. This population consists mainly of individuals from Europe (Ireland, Ukraine, and Poland in particular); they fly to Canada from Europe, obtain a visa and either overstay that visa in Canada or migrate into the United States. The migratory experience of those travelling from the northern border is incredibly different from those travelling from Central America but there are still unaccompanied minors in this group to consider. Often, there are fewer resources when they arrive and any resources that are in place are less regulated than those at the southern border.

Considered even less than those crossing into the United States from the north, are those leaving the United States. After having already migrated from their country of origin to America, many individuals are making the journey again, this time seeking refuge in Canada. Amid fears of the loss of their protected status, many migrants from Haiti, Ecuador and El Salvador are leaving America and crossing the northern border into Canada. Preliminary reports indicate that those migrating to Canada are receiving better treatment than those coming to America.

How to Help

In Connecticut: Four years ago, when the border crisis was just beginning, the Office of Refugee Resettlement sent out a bulletin asking for foster parents to volunteer to take care of some of these incoming children. Many volunteers came forward in Connecticut; however, a lot of folks missed the fine print outlining that they must meet certain licensing criteria in order to do so. A lot of folks looking to volunteer called the Care Line, The DCF Director of Multicultural Affairs, or the Commissioners Office expressing an interest in becoming a foster parent. Unfortunately, in Connecticut, it isn't handled this way; you must first become licensed to receive foster children. Despite this, Connecticut has a great network of programs including non-profits, volunteer corps, pro-bono providers, and religious groups who have done a great job sponsoring unaccompanied minors and connecting them with resources. What is missing for many is immigration and legal services.

How to get involved: There are several agencies which someone looking to volunteer can contact. There is a FAQ page on the DCF Multicultural Affairs website that provides the background and scope of unaccompanied minors coming to America (see resources below). The best way to get involved is to volunteer at a school or other organization serving immigrants and refugees. New Haven, which has identified itself as a sanctuary city, has done a great job establishing school system FAQs which focus on how to work with sponsors within the school system. Regardless of immigration status, all children go to school so the school systems are quickly getting overwhelmed. Most cities across the state have their own organizations serving these populations; New Haven alone has 18. The state contracts with the following agencies to provide resettlement services: Catholic Charities, Migration, Refugee and Immigrant Services (Hartford), Connecticut Institute for Refugees and Immigrants (Bridgeport), Integrated Refugee and Immigrant Services (New Haven), Jewish Federation of CT (Hartford), and CT Coalition of Mutual Assistance Associations (Hartford). It is recommended that those looking to volunteer contact the agency affiliate closest to them for specific guidance about how to help.

Discrimination in America

When migrants arrive in a new country, they face trauma through language and communication barriers. There is a new field of literature emerging around cross-cultural trauma and how this is expressed through language. It is not uncommon in a counseling session for both the parents and children to identify as fully bilingual, speak English throughout but then struggle to find the English words to describe a certain situation, incident, or emotion. If the clinician isn't bilingual, it becomes incredibly difficult to process the trauma as they can only describe it in their native language.

Furthermore, outside of the therapeutic setting when folks go out to dinner and speak their native language, they are often told to "speak English" or "go back to your country". This experience is further compounded for Islamic and Muslin brothers and sisters as their traditional dress immediately singles them out as "different". Language and religion have become common themes for targeted, explicit, racial and discriminatory practices by those who do not understand other cultures. People are still saying "why don't you go back to your country?" What they don't understand is that these individuals are home; America is their home. These are only some of the ways migrants and refugees experience discrimination in America. In addition, Connecticut has a high rate of racial profiling within law enforcement; this is a reality we must face as we think about the experience of migrants and refugees.

This does not mean that we cannot work to address and ultimately eliminate this inequality. Racist is a hard word for most people; part of the problem is that people do not want to admit that they could be racist. The first

step is to look inward and assess and challenge your own frameworks. Through Project Implicit, Harvard has done a phenomenal job giving folks the tools to assess their biases; categories including language, race, weight, and body size. You can find more information at www.implicit.harvard.edu/implicit. The second piece is more challenging. Once you have identified your own biases and have begun to challenge them, you must call out racism and discrimination when you see it happen. The part that is difficult for people is deciding whether it is worth the risk. We need to consider folks within the person-in-environment system in order to develop tools to assist them in feeling more comfortable challenging discrimination. If there is a benefit to both parties, folks are more likely to stand up for others.

For more information on how to help with the border crisis on a local level visit:

CT Refugee Assistance Program
www.portal.ct.gov/DSS/Economic-Security/Refugee-Assistance-Program
Office of Refugee Resettlement
www.acf.hhs.gov/orr
CT DCF Office of Multicultural Affairs

Ask the Experts: An Interview with Schuyler Cunnnigham, LICSW

by Emily Aber, LCSW

Schuyler Cunningham, LICSW, LCSW-C, Board Certified Diplomate, OSW-C, is an award-winning social worker and researcher. His extensive experience includes practicing social work at the Washington Cancer Institute, the DC Rape Crisis Center, the National Institute of Health Center, and the Washington, DC Center for Neurocognitive Excellence. Schuyler's clinical experience includes consultant status in Eye Movement Desensitization and Reprocessing (EMDR), providing supervision to EMDR practitioners, providing Infra-Slow Fluctuation neurofeedback therapy, and training students in clinical care and research. He is a sought after speaker and has published on various aspects of mental health counseling including an upcoming paper on distress and traumatic stress in people with cancer, first person narratives of cancer related traumatic stress, screening for psychosocial distress in non-oncology patients, cancer rehabilitation, innovative treatments for smoldering multiple myeloma, and palliative care for people with mesothelioma. Mr. Cunningham obtained his master's degree in social work from the National Catholic School of Social Service at the Catholic University of America and holds advanced social work licenses in both DC and Maryland.

1. What is cancer related stress?

Cancer related traumatic stress is what people experience as a result of their cancer journey. So, it's straight forward in that way. But a couple things that are important to note about it: it's not post-traumatic stress disorder; it's usually less severe in terms of symptoms; and it's not a formal diagnosis in the DSM. So, it is certainly a result of traumatic stress exposure specific to cancer.

2. How did you become interested in cancer and trauma?

About ten years ago when I was a second-year intern at the Washington Cancer Institute and my supervisor suggested over dinner that traumatic stress is a part of the cancer journey for people. They argued that it was important not to assume it was post-traumatic stress disorder (PTSD) and to treat people as if they had PTSD but to instead be on high alert for the symptoms of traumatic stress and the typical physical and physiological symptoms. That led me into a deeper interest in trauma where I became certified and am now a consultant in EMDR and was using, and am still using, EMDR for people who have cancer related stress. So, I did it from a real clinical point of view. I started to see compelling changes in the people I was working with and how their mental health began to improve rapidly when they started receiving trauma informed care.

The other thing is, my colleagues will often ask me to consult on cases they think might be trauma related. There were several folks using cognitive behavioral therapy (CBT) or other dynamic approaches with people who had had cancer and their mental health was getting worse. As a result of that, we realized they were likely experiencing traumatic stress that was not at the PTSD level. So, we started to use trauma-informed treatment with them. Right when we started to do that, we really saw how trauma informed care gave them a language and the intervention they needed to be able to process their physiological illness, the overwhelm, the shock etc. We saw a lot of the changes we were looking for.

One of the more compelling cases around that is one young woman who just finished a bone marrow transplant. She had been working with one of my colleagues for several months, using CBT. She was just so overwhelmed with her emotions that the first time I met her for an EMDR session, she cried the whole time. It was difficult to get much history or much of an idea of what was going on. What was tough about the first meeting with her was that she would say "I've been in therapy for six months and it's not working. I'm doing everything my therapist is telling me and it's not working. I now really believe that there must be something wrong with me and that I must really be crazy." That stuck with me because that level of shame and negative self judgement was just so hard for someone to deal with after they've gone through cancer and after they've gone through a transplant. The depth of her pain, mentally and emotionally, has stuck with me.

3. What's different about working with this population?

At the time of diagnosis of cancer and during treatment, especially in the initial stages, often there is a little bit of lag between the diagnosis and the treatment plan. So, they're wondering, am I going to get chemo, surgery, radiation etc., and that window of time can be very difficult for people. Then getting into their treatment cycle can be difficult as well. It's almost cruel in some cases to ask them to drop their emotional defenses, which you need them to do in order to work with them on mental health, because they really need those defenses to stay strong as they go through the treatment process, which can be triggering in some cases, certainly those with stress in certain parts of

their body. For example, treatment for cervical cancer may include inter-vaginal radiation which can be torturous in nature or prostate cancer's many side effects (erectile dysfunction, urinary incontinence). This is a very intense moment in their lives, increasing the need for trauma work.

Post-treatment is typically when trauma symptoms start to appear. At this point, you can help them drop their defenses safely because they no longer need such a robust defense system to get them through the stages of treatment. Oftentimes survivorship, really begins when the last treatment is over. They can take a step back and say, "What did I just go through?"; that's when the real treatment for mental health and trauma-informed care can begin.

4. What tools or tactics do you believe are important for a therapist when they are treating someone with a trauma history?

First, you must do a proper assessment of the traumatic stress symptoms. There are a couple resources that are good for that. Obviously, a clinical interview where you assess what a patient's presenting problems are, what their goals are, what's important, how they developed the issues, how they contextualize their issues, how they believe their issues impact their life, and their quality of life. It's also important to ask people what they believe the impact or influence of the treatment process was on their loved ones and support system as often people will be very upset about the burden, they feel they've placed on others.

I recommend a basic symptom inventory with 18 questions (BSI-18) where you use the questionnaire to look at the stress symptoms. For example, the LEC5, the Life Events Check List which categorizes events that tend to cause traumatic stress throughout a person's lifespan can address any pre-existing issues that might exacerbate someone's trauma responses. This is a free tool that can be found on the Veteran's Affairs website. Another free tool I recommend is the PCL-5. It is about 17 questions assessing the prevalence of PTSD symptoms and can be found on the Department of Veteran's Affairs website.

You do not need to do full PTSD testing, you just need to get a sense of where they stand. Once the assessment is done and you identify that you are dealing with someone that has traumatic stress exposure, it is very important to use trauma informed care. This is important because many symptoms of cancer treatment can mimic symptoms of depression or anxiety; for example, chemotherapy can cause fatigue or loss of connection. So, is that depression or is that a side effect of chemotherapy? Teasing these things out can be very important.

Earlier, I mentioned a client whose treatment included CBT. She was withdrawn and felt like something was wrong with her. Once we started using a trauma informed intervention it addressed the physiological symptoms of the traumatic stress which began to lift the sense of shame which helped her resolve some of these symptoms. These trauma-informed approaches like prolonged exposure therapy, EMDR, and neuro-feedback interventions are essential. It's very important to me because a lot of folks get the wrong type of mental healthcare after they've gone through their cancer experience simply because it isn't trauma-informed.

An Overview of Military Trauma

As we know, experiencing trauma while serving in the military often leads to post-traumatic stress disorder, most commonly referred to as PTSD. Since 2001, approximately 2.7 million service members have been to the war zones of Iraq and Afghanistan; with over half having been deployed more than once (Hunt, 2015; Itzhak, 2015).

Trauma is defined as a psychological, emotional response to an event, which is deeply distressing or disturbing. Nearly 30 percent of veterans who served in Iraq and Afghanistan have PTSD (Reno, 2012). Combat veterans, both men and women, often lived through a life-threatening traumatic event that caused them to fear for their lives; they may have also witnessed the death of their friends, experienced guilt and/or sadness, and overwhelming helplessness.

Symptoms of PTSD are often exhibited through uncontrollable anger and irritability, sensitivity to unexpected noises, numbness to people close to them, living in a constant state of "fight or flight," and difficulty initiating and maintaining sleep (NIH, 2016). Frequently, the symptoms are more pronounced when they return home. People around them, who have not served, do not understand. People expect veterans to be the same person they once were before deployment, but no one goes to a war zone and comes home unscathed. Combat veterans know something is wrong but won't and can't acknowledge this to anyone. So veterans isolate themselves from people, hoping to contain the often-extreme levels of anxiety and rage that can easily emerge (NIH, 2016).

However, despite the many symptoms of trauma, veterans can be helped. First, veterans must seek help; whether it is overcoming the stigma of seeing a professional mental health counselor or due to the persistent encouragement of others, a veterans' decision to finally reach out for help is a sign of courage. They are finally ready to face their inner fears and to acknowledge what is not working in their life.

There is a wide array of trauma treatments offered at the Veterans Administration and in the community. Some of these include Cognitive Behavioral Therapy (CBT), Prolonged Exposure Therapy (PE), equine therapy, mindfulness, yoga, art therapy, and Emotional Freedom Techniques (EFT).

Cognitive behavioral therapy (CBT) helps patients understand the thoughts and feelings that influence behaviors. In PE therapy, individuals are asked to examine — in both imaginary and real-life settings — situations, places, and people they have been avoiding. The repeated exposure to the perceived threat may not be true to individuals' expectations of experiencing harm and over time leads to a reduction in their fear.

EFT can be particularly helpful, but what is it? The EFT process starts with the client choosing to bring to mind a distressing emotional trigger. This trigger activates the amygdala—an almond-shaped mass of gray matter in the brain associated with feelings of fear and aggression—and arouses the threat response originally connected to the triggering event: fight, flight, or freeze. While picturing the scene, the tapping of certain acupoints with two fingers has a calming effect on the amygdala. The hippocampus—

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Featured Resource:
The Connecticut Women's Consortium Community Film Series

The Community Film Series is open to the public and endeavors to stimulate connections, raise awareness, increase knowledge, and encourage dialogue about current issues impacting our communities through film and panel discussion. Past topics have included veteran's mental healthcare, self-care, human trafficking and sex work, incarceration and criminal justice, addiction and recovery, and the opioid crisis. Each film is complemented by a panel discussion featuring local experts. Past panel members have included First Lady Cathy Malloy, State Representative Robyn Porter, Kim Bogucki, Babz Rawls Ivy, Kelvin Young, Daryl McGraw, and many more.Films occur every other month (January, March, May, July, September, November) and typically run from 5:30 – 8pm. Please visit www.womensconsortium.org/communityfilmseries for more information about upcoming films.

Who's Been Reading Trauma Matters? William C. Moyers!

Pictured left to right at the 2018 *Opioid Use Disorder: Prevention, Treatment & Recovery* conference: Connecticut Women's Consortium (CWC) Executive Director Colette Anderson, CWC Director of Education & Training, Shannon Perkins, William C. Moyers, and CWC Community Programming & Development Lead, Kathleen Callahan.

William C. Moyers is the vice president of public affairs and community relations for the Hazelden Betty Ford Foundation, based in Minnesota. From "carrying the message" about addiction, treatment, and recovery to working in public policy and philanthropy, Moyers brings a wealth of professional expertise and an intimate personal understanding to communities across the nation. He has appeared on Larry King Live, the Oprah Winfrey show, Good Morning America and National Public Radio. Moyers is the author of several books including *Broken: My Story of Addiction and Redemption*, a New York Times best-selling memoir published in 2006.

(An Overview of Military Trauma, continued from page 5)

the part of our brain concerned with basic drives, emotions, and short-term memory—realizes that the trigger isn't as strong anymore. This changes our neural pathways so that the trigger no longer creates distress (Church et al., 2018)

With EFT, a specific emotional pain can be released quickly. Tapping for one or two minutes on targeted acupoints allows negative sensations to be released and processed out of the body (Church et al., 2018). The mechanics of the technique can easily be learned; thus, the client isn't dependent on meeting with the therapist to feel better. The client can tap whenever necessary while acknowledging his or her distress or negative beliefs.

Unfortunately, there is no cure for PTSD and trauma is not just a hardship to overcome. With treatment, trauma can be transformative, ultimately allowing combat veterans to return to positive day-to-day life. Initially, the changes are reflected through negative symptoms of rage, nightmares, hypervigilance, anxiety, and depression. They struggle, and after time, many start to heal, learning to integrate the past with the present leading to strength, wisdom, and joy. This newfound resilience gives new purpose to who they are, who they want to be, and what they want to fight for; this is called post-traumatic growth.

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A publication produced by The Connecticut Women's Consortium and the Connecticut Department of Mental Health and Addiction Services in Support of the Connecticut Trauma and Gender Initiative
www.womensconsortium.org

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