Returning Veterans on Campus with War Related Injuries and the Long Road Back Home

Thomas E. Church
Human and Organizational Systems Consultant, Soquel, CA

Abstract

This article reviews the growing numbers of returning military personnel attending higher education based on emerging national trends, including the new GI Educational Bill, amendments to the ADA, and the rising unemployment rate. The trauma of war and the high survival rate have resulted in a high percentage of veterans returning from the Global War on Terror (GWT) who will experience a wide range of health issues as a result of their exposure to combat trauma and blast injuries. Many of these injuries will not be visible and will include physical wounds, post traumatic stress disorder (PTSD), depression, and traumatic brain injuries (TBI) requiring accessible campuses and classroom accommodations. However, many veterans are not utilizing the traditional service providers for students with disabilities in higher education. Therefore colleges and universities need to engage veterans and utilize their strengths in designing welcoming campuses that facilitate success for adult learners.

The first recorded description of *trauma* (based on the Greek word for *wound*), defined as a physical injury or emotional shock with long term psychological effects, was in the Sumerian Epic of Gilgamesh over 5,000 years ago (Reyes, Elhai & Ford, 2008). More recently, Erich Maria Remarque (2001), author of the celebrated *All Quiet on the Western Front*, described the horrors of the front lines in World War I and the difficulties faced by the grizzled German survivors as they returned home from the trenches in defeat in his book, *The Road Back*. Remarque depicts the struggles of the protagonist as he completes his interrupted studies and teacher's examination only to resign later from his teaching position in a rural village due to his post traumatic stress disorder (PTSD) nightmares and his unrelenting feelings of alienation and survivor's guilt. In a recent conversation with this author a Vietnam veteran commented on the book and noted how little things had changed since he was a soldier. Current day combat veterans have also voiced their connection to Remarques' experiences at conferences in higher education for veterans.

Many campuses have seen a dramatic increase in the registration of veteran students returning from Iraq and Afghanistan and the numbers are expected to increase as military personnel transition to civilian life. Colleges and universities located near VA Polytrauma Centers have also seen a significant increase in students with disabilities according to interviews with staff. This article reviews the trauma of war and the resulting impact on returning veterans on college campuses. The signature injuries resulting from the Global War on Terror (GWT) are discussed, including traumatic brain injury (TBI), PTSD, and mental health injuries. A concise discussion of reasonable accommodations is also provided for physical injuries from blast injuries such as vision and hearing loss, burns and mobility impairment, TBI, and the mental health injuries resulting from exposure to combat and related trauma. The culture of the warrior is reviewed, suggestions regarding the application of warrior values to campus programs developed to assist veterans in the successful transition from combat to higher education, and a discussion of peer counseling models.

Colleges and universities that develop welcoming programs to meet the unique challenges of veterans with both visible and invisible injuries will need to take into account that many veterans are not self-disclosing and currently not utilizing the traditional service models existing on campuses for students with disabilities. Within that context, the emerging factors that will have a significant impact in higher education across the nation in the future will be assessed, including the passage of the new GI Bill, the

Americans with Disabilities Amendment Act (ADAA), and an economy in recession. This information will be discussed and recommendations made for campuses to incorporate into their action plans.

Statistics Related to the Global War on Terror

The number of troops deployed in the GWT is estimated at 1.8 to 2.1 million. However, this number is difficult to estimate and may increase due to a buildup of US troops in Afghanistan. The length of tours has been extended, and military personnel that serve multiple tours have increased chances of injury. The length of the war is also a factor that is impossible to predict, although the "anticipated deadline for Iraq is 2012" (Yacoub, Salaheddin, & Abdul-Kadir, 2008). Out of the above troops, an estimated 712,800 to 840,000 veterans are predicted to eventually apply for disability benefits (Stiglitz & Bilmes, 2008). Vietnam era and Gulf War veterans are still applying for PTSD treatment and disability benefits demonstrating the increasing numbers of veterans receiving disability benefits as the population ages (Stiglitz & Bilmes, 2008).

Signature Injuries from the Global War on Terror

Soldiers are more likely to sustain injuries than to die as they did in past wars based on the ratio of injuries to deaths. Medical advancements and improved equipment, especially protective body armor, contribute to the improved survival rate. The ratio of injuries to deaths in this war is much higher (16/1) than in previous wars due to the use of armor and rapid evacuation from the battlefield. Department of Defense statistics (Bilmes, 2007) estimated a total of 50,500 injuries, including 20% involving the spinal cord or the brain and 18% experiencing serious wounds. The number of amputations (roughly 6%) already exceeds the number from the Vietnam War. Many of these students will require campuses that meet ADA requirements and colleges and universities need to review and update their ADA/504 evaluations on an ongoing basis.

There are three major types of injuries or trauma experienced by veterans of the GWT: physical injuries from blasts such as burns, amputations and orthopedic injuries; operational stress injuries and mental health injuries; and TBI. Blasts are considered the signature cause of injuries in the GWT from Improvised Explosive Devices (IEDs). Soldiers are exposed to a variety of stressful events including combat and the CTI-104 (Comprehensive Trauma Inventory) lists 104 specific traumatic types of exposure to war conditions (Ford, 2008).

Many factors will impact soldiers' response to their experiences in the war zone. Witnessing violence and death have been demonstrated to increase risk for anger and aggressive behavior, anxiety, somatic complaints and, PTSD. The veterans' reaction will range from high levels of PTSD and functional impairment to those who grow and mature from the experiences. Past experience has demonstrated that most returning soldiers become productive citizens, while for others mental-health issues remain a significant public health problem. For example, veterans with PTSD often wrestle with income disparities and unemployment, relationship issues, and aggressive behavior (Stiglitz & Bilmes, 2008).

Returning veterans will have a wide range of medical diagnoses and related health problems that will have a temporary or chronic impact on their living, working, learning, and relationship functions. The availability of a veteran's personal, family and/or community resources will mitigate their experience with a health problem. These conditions may have a significant impact on the individual's strength, endurance and energy levels, and if they are taking medication then there may also be significant side effects.

It is impossible to generalize about the functional abilities or limitations of combat veterans due to the wide range of disabilities, diagnoses, and contributing factors. Table 1 lists some of the possible manifestations that may be experienced individually or in comorbidity by combat veterans in the higher education environment. Many of these will already be familiar manifestations to service providers who work with students with disabilities. It is important for Disability Service (DS) providers and other higher education professionals to be aware that the following conditions may be common to veterans with any type of disability: unpredictable attendance due to pain or other symptoms, scheduled absences due to required travel to VA facilities for medical care, and medication-related issues that impair performance.

Traumatic Brain Injuries

Blast injuries sustained in combat come from grenades, bombs, missiles, mortars, and artillery shells. The blasts alter the cells' metabolism and result

Table 1

Common Manifestations of Various Disabilities from the GWT

Manifestations of Spinal Cord Injuries or Amputations
Interference with physical dexterity to complete laboratory, computer or writing assignments Difficulty with prolonged sitting or standing at a lab table Mobility challenges to and from the classroom and other activities
Manifestations of Sensory Impairments
Difficulty hearing lecture, discussion or advising sessions, etc Difficulty seeing the board, reading course materials, creating written assignments Difficulty accessing the course web site or electronic resources Lack of traditional means of accommodation (American sign language, Braille, for example) due to acquired nature

in eventual cell death, although there may not be any visible signs of injury. Blast injuries create a pressure wave, which affects organs that are air filled, such as the ears and lungs, and those surrounded by fluid filled cavities, such as the brain and the spine. This eventually leads to brain cell death and traumatic brain injuries in addition to possible injuries from impact from debris, burns, and exposure to gases and vapors. TBI results from deceleration forces and blunt or penetrating trauma, that may lead to functional impairments. Due to the brain's complexity, the consequences vary, and treatment is specific to the individual (Defense and Brain Injuries Center, 2008). Approximately 43% of the veterans returning from the GWT have been evaluated for TBI (Kaplan, 2008). Seven percent reported TBI combined with symptoms of depression or PTSD. Table 2 contains a list of key functional impairments caused by TBI.

There are several important strategies that can be useful in working with veterans with TBI. These include coaching; scheduling; strategies including alarm clocks, planners, pagers, scheduling breaks to prevent fatigue, checklists, memory aids such as tape recorders, supportive phone calls, adaptive technology, and utilizing GPS. Instruction in skill sets such as developing memory strategies, anger management, and programs that incorporate mentoring and peer support can also assist with education and vocational issues (NASHIA, 2007).

Due to the complexity of the injuries, it is important for veterans with brain injuries to be vigilant when transitioning to higher education. Self-pacing is an important factor, and the student may need to adjust gradually to the campus environment. The family's involvement is another important factor to success, and it is critical that students with TBI build on a series of successes to develop self-esteem and the appropriate level of coursework, similar to the educational concept of scaffolding. Table 3 provides a variety of web sites that present more information related to TBI.

Mental Health Issues

With multiple deployments, the probability of exposure to combat trauma increases significantly and the best predictor of depression and PTSD is the exposure to combat. For example, the rate of anxiety and depression increases from 12% to 27% from the first to the third deployment. The rate of suicide has also gone up and may eventually exceed the number of soldiers killed in combat (Tanielian, Jaycoxx, & Schell, 2008). The rate of comorbidity is high among anxiety disorders such as PTSD. A recent study demonstrated that 55% of the patients with the principal diagnosis of an anxiety or depressive disorder had at least one additional depressive or anxiety disorder at the time of the assessment. PTSD and generalized anxiety disorder have the highest rate of comorbidity rates

Table 2

Functional Impairments Caused by TBI

Cognitive problems such as judgment, attention, concentration, processing new information, distraction, language abilities, sequencing, short-term memory, slower thinking
Perceptual problems such as hearing, vision, orientation to space and time, touch, balance and pain sensitivity
Physical problems, which include; motor skills, endurance, fatigue, speech, headaches and seizures
Behavioral and emotional problems such as irritability, impatience, problems with impulse control, stress, self awareness, mood swings, personality changes, reading social cues and dependence/independence
Psychiatric problems that may include depression, hallucinations, paranoia and suicidal thoughts
Symptoms may increase during times of fatigue and stimulus overload.
Decreased ability to self monitor and establish an appropriate pace of learning or working activity
Mild TBI patients' behavior may mimic PTSD and other mental health symptoms, which can contribute to problems in obtaining appropriate services.

Table 3

Resources Related to TBI

Defense and Veterans Brain Injuries Center Website: www.dvbic.org/blastinjury.html
The Centers for Disease Control and Prevention at the Department of Health and Human Services article, "Facts for Physicians about Mild Traumatic Brain Injury". Symptoms discussed include: flashback episodes, nightmares, and frightening thoughts following exposure to trauma. Available at www.cdc.gov/ncipc/tbi/physicians_tool_kit.html
Institute of Medicine (IOM) article, Gulf War and Health, Vol. VII: "Long Term Consequences of Traumatic Brain Injury". Available at www.nap.edu/catalog/12436.html

(Brown & Durand, 2002). There is also a high rate of comorbidity between PTSD and substance abuse. These patients are more likely to experience problems with unemployment based upon longitudinal studies (Ouimette & Read, 2008).

Post Traumatic Stress Disorder (PTSD)

According to the 2000 Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) by the American Psychiatric Association, the difference between PTSD and an adjustment disorder is the severity of the stressor, which must be extreme in nature, or life threatening. About 5.2 million people in the United States, or 3% of the adult population, experience PTSD during a given year. With PTSD, the person experienced, witnessed, or was confronted with an event, or events that involved actual or certain death, serious injury, or injury to the physical integrity of self and others, and the person's response included intense fear, helplessness, or horror. This experience results in re-experiencing the trauma through recurring thoughts, dreams, feelings; efforts to avoid the stimulus associated with the trauma such as feelings of detachment; a sense of a shortened future; efforts to control thoughts, feelings and activities associated with the trauma; and avoiding people, places, and activities that recall the trauma. Military troops who are exposed to combat conditions are especially at risk for developing PTSD. The usual rate for PTSD for people in war zones is about 30% (NIMH, 2007). The VA estimates that over 15% of Vietnam era veterans meet the diagnostic criteria for PTSD (Rosenheck & Fontana, 2008). The Rand Corporation (2008) estimates that about 18% of the troops, or over 300,000 soldiers exhibit symptoms of either depression or PTSD. Military statistics indicate there have been 39,366 cases of PTSD diagnosed in military facilities serving in the GWT from January 2003 to December 31, 2007 (Morgan, 2008).

In 2007, Kanter, a staff psychiatrist at the PTSD Outpatient Clinic with the VA in the Puget Sound Health Care System, described problems that include suicidal ideation, issues with trust, development of relationships, unemployment, divorce, and domestic violence (Roehr, 2007). He estimated the costs of care to reach $660 billion. He noted that there were more marital problems and family issues with PTSD, and that there were significant barriers to obtaining care. He recommended that the issue be changed from psychiatry to one of post deployment stress readjustment and reintegration, with mental health screening and treatment as part of a total health care continuum and framing the issues as a part of ongoing health care services provided to troops and veterans. Eliscu (2008) estimates that there will be 500,000 troops from Afghanistan and Iraq experiencing psychological injuries and that they do not qualify for a purple heart, adding insult to injury. Table 4 contains specific characteristics that veterans with PTSD and other mental health issues might exhibit. Table 5 lists problems that may develop as a result of psychological injuries.

Utilizing Veterans' Strengths to Build Welcoming Campuses

Military personnel are trained to withstand the trauma of modern day hostilities. Basic combat training is utilized to develop resilience and a sense of common purpose and teamwork in successful completion of the mission. The individual soldier's self-esteem is attached to the unit and their military tradition and reputation. The unit's success and solidarity acts as a shield that protects the individual members who rely on each other and the team for safety (Ritchie, 2008). Combatants share mutual experiences that bind them together and develop a mutual sense of trust that extends beyond the battlefield. This sense of camaraderie can be effectively utilized by campuses to enable veterans' success as they transition from combat to colleges and universities.

Soldiers subscribe to a moral code of conduct, which evolved from centuries of western and eastern cultures. This culture of ethical self-discipline operates as a barrier separating combatants from non-combatants. The legacy of the warrior incorporates values of honor, sacrifice, bravery, and related archetypes invoking earlier images of the Arthurian legends and the Plains tribes (French, 2003). The code acts as a restraint on behavior and also shields the soldier from the psychological trauma resulting from wartime conflict and destruction (Shay, 1994). Veterans can reapply their efforts of self-development to the classroom and campus environment as they transfer these skill sets established through military discipline to the civilian world.

Peer counseling has been an effective methodology for providing services to veterans. Following the Vietnam War, the VA established community-

Table 4

Characteristics and Hallmarks of PTSD and Mental Health Issues

Trouble falling asleep, emotional numbness, anxiety, irritability, angry outbursts, depression, hopelessness, hyper vigilance, social withdrawal, problems concentrating and survivor's guilt
The families of the victims may also develop the disorder.
Symptoms typically develop within three months of the event, although they may not emerge for years.
Can be accompanied by substance abuse, alcoholism, along with other anxiety disorders or depression
Duration and severity of the illness varies
Recovery range is based upon various factors, especially early intervention.
Treatment includes therapy (cognitive behavioral, exposure) and medication (treat sleep disorder, anxiety, depression).
More information about PTSD is available at:
National Institute of Mental Health: www.nimh.nih.gov/
National Center for Post Traumatic Stress Disorder: www.ncptsd.va.gov/
Department of Veterans Affairs: www.Dartmouth.edu.dms/ptsd

counseling centers largely staffed by peer counselors. There are currently about 207 Vet Centers staffed by veterans located across the United States (Rosenheck & Fontana, 2008). Peer counseling programs provide campuses with a low-cost option to provide basic counseling services to students, and funding is available through the VA with work-study programs. Veterans may be distrustful or alienated from institutions and bureaucracies; peer counseling programs use the camaraderie and trust that veterans experience with their peers. Peer counseling programs utilize the military traditions of shared values and experiences and provide a bridge that allows veterans access to more traditional DS offices on campus for students.

There are several innovative approaches that are being implemented on campuses as they develop programs that accommodate the growing numbers of returning veterans. Providing veterans with a safe and welcoming campus requires collaboration between the veterans' community and higher education leadership. For example, Veterans of America provides a nationwide framework to establish an active

Table 5

Manifestations of Psychiatric Disabilities

Interference with cognitive skills, judgments, memory, concentration, organizational skills and motivation
Difficulty coping or performing under pressure
Side effects from medication such as fatigue, drowsiness, slow response time and problems initiating interpersonal contact
Problems sustaining concentration and difficulty retaining verbal directions, problems maintaining stamina, and combating drowsiness due to medications
Difficulty managing assignments and performing multiple tasks with time pressures, and prioritizing tasks
Difficulty interacting with others and responding appropriately to social cues
Problems with authority figures and approaching instructors
Problems with negative feedback and interpreting criticism
Problems with unexpected changes in coursework, and dealing with interruptions
Anxiety resulting in poor performance
Unpredictable absences
Problems with frightening thoughts, flashbacks and reminders
Distrust of systems and alienation
Possible social withdrawal
Sleep difficulties

student group on campus and establishing a safe place on campus for veterans to meet informally and contributes to a welcoming environment. Programs such as Combat2College also offer campuses an inclusive program model that provides services to all veterans by utilizing the strengths approach and providing health care as comprehensive service that incorporates mental health rather than focusing on the disability. This approach also utilizes existing resources, veterans' camaraderie, and established social networking systems (Sachs, 2008). Universal Design (UD) provides solutions to many of the barriers that veterans will be encountering as they transition from the trauma of the battlefield to the roles of civilians and adult learners (Branker, this issue). By developing and working with student veteran leadership the campus staff and faculty can develop an empathetic campus and increase accessibility.

Emerging Trends

There are several emerging trends that will impact returning veterans and the campus environment. The passage of the new GI Educational Bill increases educational benefits for veterans (Chronicle for Higher Education, 2008), while the amendments to the ADA will increase coverage for individuals with a disability defined as substantially limiting a major life activity without regard to mitigating measures (Shackelford, this issue). Concurrently, the economy has entered a prolonged recession resulting in a rapid increase in unemployment. There will be significantly reduced employment opportunities for veterans as most of the job losses have been in manufacturing and construction, industries traditionally dominated by males. In addition, veterans are still experiencing treatment gaps and not obtaining appropriate mental health services, which results in a cascading effect and increased problems with families, employment, and education (Rand, 2008).

As many as 70% of the 1.6 million veterans serving in the GWT will not obtain mental health treatment at the DOD or the VA, which means they will likely seek treatment through the public and private mental health system, including campus health centers (Kaplan, 2008). Only 53% of the returning military personnel from the war have seen a physician or mental health professional for treatment during the last year and of that group only about half had received sufficient treatment. Efforts are underway to reduce stigma and encourage treatment as many veterans chose not to address mental health issues. However, when PTSD and depression are not treated, these psychological injuries often lead to cascading problems including unemployment, family problems, and substance abuse (Kaplan, 2008).

A total of over 2 million jobs were eliminated in 2008, and according to some economists, this number may increase up to 3 million lost jobs by 2010. The global recession has resulted in the largest level of jobless claims in the United States since the fall of 1982. However, according to the US Department of Labor (2008), the labor market is about 50% larger. The growing numbers of unemployed is currently 4.4 million and the unemployment rate is 6.7%, a 15 year peak which does not take into account the large number of underemployed people and those who have stopped looking for work and are no longer counted in the statistics (Rugaber, 2008). In addition, an estimated 13.5% of the workforce is either underemployed, discouraged and not actively seeking employment, or unemployed with 524,000 jobs lost in December, 2008 (Evans & Maher, 2009).

In summary, higher education will continue to see an increase in enrollment of students returning from the GWT as these veterans transition from combat to civilian life and pursue their educational and career goals. The new GI Bill combined with other resources available to veterans including the Montgomery GI Bill and Chapter 31 VA Vocational Rehabilitation benefit will provide thousands of veterans with opportunities to pursue their career aspirations through higher education and to obtain employment. The ADA/504 and ADAA amendments provide increased civil rights protections and accessibility for veterans with disabilities including those who benefit from mitigating measures such as medication, artificial limbs, etc.

Summary

Each generation of veterans has made their unique contributions to social change and equality (Madaus, Miller & Vance, this issue). Colleges and universities can facilitate this process by working with veterans to integrate UD on campus and to establish veteran-friendly campuses that facilitate the educational goals of adult learners. Our society has an ethical duty to prevent veterans from the GWT adding to the existing 250,000 homeless veterans (25% of the homeless population) already living on the nation's streets

and shelters (MSNBC.com, 2007). Due to the high survival rate of this war and the injuries from blasts and prolonged exposure to trauma, there will be a large number of veterans with disabilities. With the Rand report (2008) a combined 31% of the deployed veterans surveyed reported either TBI, PTSD or depression, or a combination (7.3%). Many of these veterans will have hidden or untreated medical conditions and may choose not to self-disclose. They may also not be aware or not utilize the traditional service models on campus. Peer counseling programs and programs that build on their strengths, military values and shared experiences and focus on a comprehensive team, and integrative medical approach (rather than focusing exclusively on the disability) similar to the Combat2College model, have been effective with veterans.

Much has been accomplished in the past year in improving opportunities for returning veterans as they transition from war to civilian life. The ADA was strengthened with the ADAA and veteran's educational benefits were expanded with the GI Educational Bill. Campuses need to work with veterans to develop programs that meet their needs. Colleges and universities provide veterans with an opportunity to integrate their experiences and focus on their career goals and adaptation to society. Veterans will face many challenges during their transition and the postsecondary environment can provide them with the resources to achieve their academic goals.

References

American Psychiatric Association. (2004). *Diagnostic and statistical manual of mental disorders (4th Ed.)*. Washington, DC: Author.

Bilmes, L. (2007). *Soldiers returning from Iraq and Afghanistan: the long-term costs of providing veterans medical care and disability benefits*. Harvard University, John F. Kennedy School of Government, RWP07-001.

Brown, D., & Durand, M. (2002). *Abnormal psychology*. Canada: Wadsworth.

Center for Disease Control and Prevention. (2007). *Facts about mild traumatic brain injuries* Retrieved August 2, 2007 from www.cdc.gov/ncipc/tbi/physicians/_tool_it_html.

Defense and Veterans Brain Injuries Center (2008). *Blast injury*. Retrieved February 25, 2008 from www.dvbi.org/blastinjury.html.

DO-IT. (2007). *The faculty room.* Retrieved February 15, 2008 from www.washington.edu/doit/Faculty/Strategies/Disability/Psych.

Eliscu, J. (2008). The troubled homecoming of the Marlboro marine. *Rolling Stone.* Retrieved July 13, 2008 from www.rollingstone.com/politics/story/19733160.

Evans, K., & Maher, K. (2009). Yearly job loss worst since 1945. *Wall Street Journal,* p.A1. Retrieved January 10, 2009 from http://online.wsj.com/article/SB123150742539367897.html

Ford, J. (2008). War trauma. In G. Reyes, J. Elhai, & J. Ford (Eds.) *The Encyclopedia of psychological trauma*. Hoboken, NJ: John Wiley and Sons.

Institute of Medicine. (2008). Long term consequences of traumatic brain injury. *IOM - Gulf War and Health, VII*. Retrieved on December 12, 2008 from www.nap.edu/catalog/123436.html

Kaplan, A. (October, 2008). Untreated vets: A 'gathering storm' of PTSD/depression. *Psychiatric Times*, XXV. No. 12, 13-14.

Morgan, D. (2008). Post Traumatic Stress soars in US troops. *U.S. Military Statistics*. Retrieved on May 27, 2008 from http:// webmail.aol.com/36743

MSNBC.com. (2007). Study: Vets a Quarter of the Homeless. *MSNBC.com.* Retrieved November 16, 2007 from www.msnbc.com/id/21678030/

National Association of State Head Injury Administrators. (2007). *Traumatic brain injury facts*. Retrieved July 28, 2007 from www.nashia.org.

National Institute of Mental Health. (2007). *Facts about post traumatic stress disorder*. Retrieved July 27, 2007 from www.nimh.nih.gov.

Ouimette, P., and Read, J. (2008). Alcohol Use Disorders. In G. Reyes, J. Elhai, & J. Ford (Eds.) *The Encyclopedia of psychological trauma*. Hoboken, NJ: John Wiley and Sons.

Quinn, P. (2008). US Turns over Green Zone to Iraq. *AOL News*. Retrieved January 2, 2009 from http://news.aol.com/article/us-turns-green-zone-to-iraq/278743.

Remarque, E. (2001). *The Road back*. Translated by Denver Lindley. Safety Harbor, FL. Simon Publications.

Reyes, G., Elhai, J., and Ford, J. (2008). *The Encyclopedia of psychological trauma*. Hoboken, NJ: John Wiley and Sons.

Ritchie, E. (2008). Military Personnel. *The Encyclopedia of psychological trauma*. Hoboken, NJ: John Wiley and Sons.

Roer, B. (2007). *High Rate of PTSD in returning Iraq War veterans*. Retrieved November 14, 2007 from www.medscape.com/viewarticle/565407.

Rosenheck, R., & Fontana, A. (2008). U.S. Department of Veterans Affairs. *The Encyclopedia of psychological trauma*. Hoboken, NJ: John Wiley and Sons.

Rugaber, C. (December 12, 2008). New jobless claims pass expectations. *Mercury News*. Retrieved December 12, 2008 from www.mercurynews.com.

Sachs, R. (2008). Valuing veterans. *Inside Higher Ed*. Retrieved July 1, 2008 from www.insidehighered.com//views/2008/06/12c2c.

Shay, J. (1994). *Achilles in Vietnam*. New York: Scribner.

Shay, J. (2002). *Odysseus in America*. New York: Scribner.

Stiglitz, J., & Bilmes, L. (2008). *The three trillion dollar war*. New York: W. W. Norton and Co.

Tanielian, T., & Jaycoxx, L. H. (2008). *Invisible wounds of war*. Santa Monica, CA: Rand Center. Retrieved on July 11, 2008 from www.rand.org.

Yaccoub, S., Salaheddin, S. & Abdul-Kadir, S. (2008). Iraq's government approves security pact with U. S. *AOL.com* Retrieved November 16, 2008 @ http://new.aol.com/article/iraqs-government-approves-security-pact/249917cid=13.

About the Author

Tom Church, M.Ed., M.A, CRC, is completing his dissertation on student success in higher education for wounded veterans transitioning from combat stress and trauma. He has been in the field of higher education since 2000 counseling employees and students, lecturing and managing the disabled students' services office and has provided services to rehabilitation clients and students including veteran for over 20 years.