Army Nurses with Combat-Related PTSD

(Post-Traumatic Stress Disorder)

Thelma Nicholls

EXPLORING COPING AND ADAPTATION IN VETERAN ARMY NURSES WITH COMBAT-RELATED POST-TRAUMATIC STRESS DISORDER

by

Thelma Nicholls

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A Dissertation Presented in Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy in Nursing

University of Phoenix

The Dissertation Committee for Thelma Nicholls certifies approval of the following dissertation:

EXPLORING COPING AND ADAPTATION IN VETERAN ARMY NURSES WITH COMBAT-RELATED POST-TRAUMATIC STRESS DISORDER

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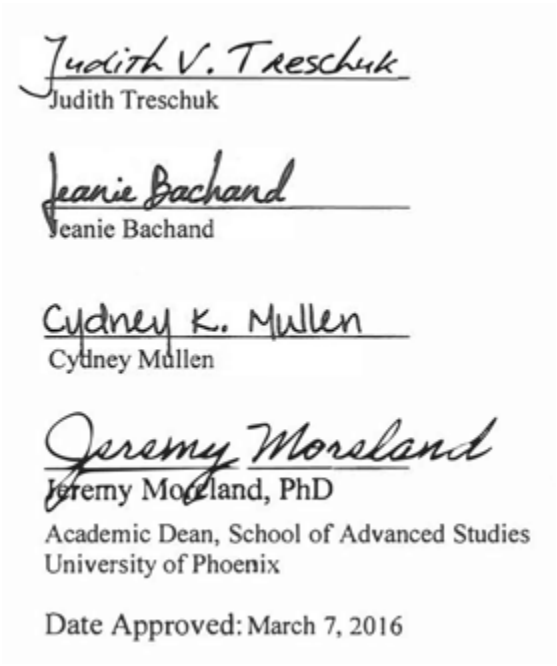

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Copyright © 2017 ASPECT Books, Inc.
ISBN-13: 978-1-4796-0869-0 (Paperback)
Library of Congress Control Number: 2017916546

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ABSTRACT

This research study explored coping and adaptation in veteran army nurses with combat-related Post Traumatic Stress Disorder (PTSD). A qualitative case study method was used to explore coping and adaption in veteran army nurses with combat-related PTSD, and how coping with PTSD affects the concepts of self, the role of self in relation to others, and personal relationships in this cohort of army nurses. A directed content analysis based upon the Roy Adaptation Model (RAM) conceptualization of coping and adaptation was used to analyze the study data. Use of purposeful and snowball sampling method yielded 14 study participants that were either in active duty, retired or separated from active duty status, and who met all other inclusion criteria. Validation of PTSD was accomplished using the PTSD Check List-Military Version (PCL-M). A pilot study with three veteran army nurses with combat-related PTSD and who met the inclusion criteria was used to test interview questions prior to the main study. Analysis of data from the semi-structured interviews was completed with the assistance of NVivo 10 to determine prominent patterns for interpretation. Three themes emerged from data: Strategies for coping and adapting, Poor self-concept, and Relationship challenges. Study findings revealed that veteran army nurses with combat-related PTSD were at the compensatory adaptation level based on the concepts of the theoretical framework. The findings also indicated that veteran army nurses with combat-related PTSD need more targeted assistance and support to employ effective coping and adaptation strategies.

DEDICATION

To God be the glory, for to whom much is given, much is required. This study is dedicated to my husband Robert for his support and encouragement when I felt like giving up; for being the wind beneath my wings and for believing in me. You were content to let me shine. To my mother, my sons Gavin, Gary, and Gregory; my grandchildren Kacey, Kyree, Makhi, Courtney, Gabby, Jazlyn and Tyler, all for whom I strive daily to be a role model. Finally, to my darling Maltese, Max who was my companion many days and nights when everyone else was asleep.

ACKNOWLEDGEMENTS

My deepest appreciation to those who agreed to participate in this study. The brave men and women of the Army Nurse Corps who behind the scenes save lives every minute of every day. Thank you. Without you this study would not have been possible. Achieving this doctoral degree would not be possible without the wonderful team that I was blessed with. To Dr. Treschuk. Thank you for being more than my committee chairperson. You were my mentor. You encouraged me to keep persevering and to see the light at the end of the tunnel. To my committee members Dr. Mullen and Dr. Bachand, the guidance you provided was invaluable. As a team, you all were able to make sense out of words that were somewhat incoherent to me at times. Thank you all.

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Introduction and Overview

Just like moons and like suns,
With the certainty of tides,
Just like hopes springing high,
Still I'll rise.
—Maya Angelou (1978)

War is not a new phenomenon for Americans. The 1700s included the Revolutionary War, which was followed in the 1800s by the War of 1812, the Mexican War, the Civil War, and the Spanish-American War. In the 1900s, millions of Americans were affected by World Wars I and II, the Korean War, the Vietnam War, and the Persian Gulf War (Defense Casualty Analysis System, 2013). Despite this history of war, the attacks on September 11, 2001, significantly changed the U.S. military's strategic focus from seeking international peace and reconciliation to defending against terrorism ("9/11," 2011). In 2001, America's leaders launched a global war on terrorism, beginning with Operation Enduring Freedom (OEF), continuing with Operation Iraqi Freedom (OIF), and then Operation New Dawn (OND) (Defense Casualty Analysis System, 2013).

To support America's war efforts, some service members, including nurses, undergo multiple and sometimes lengthy deployments. In preparation for deployment, service members attend extensive training programs away from home, during which they pass through several stages of the emotional cycle of deployment (Deployment Health and Family Readiness Library, 2006). Seven stages of the emotional cycle can cause or amplify stress and turmoil: (a) expecting deployment, (b) disconnecting and distancing self from others, (c) struggling with emotional ineptitude, (d) regaining some stability, (e)

anticipating his or her homecoming, (f) readjusting and reprocessing, and (g) recovering and stabilizing. The first three stages can have profound effects on the psyches of service members who are deployed multiple times, potentially leading to PTSD (Deployment Health and Family Readiness Library, 2006).

Post-traumatic stress disorder (PTSD) is a condition of persistent emotional stress resulting from experiencing or witnessing one or more traumatic events, and is considered one of the most common psychiatric illnesses among war veterans (American Psychiatric Association [APA], 2013). Individuals who suffer from PTSD exhibits symptoms from each of four symptom clusters The first symptom cluster is intrusion, in which the individual experiences involuntary memories, traumatic nightmares, and flashbacks. The second cluster is avoidance, which might manifest through depression, panic attacks, and emotional numbness. The third cluster is negative alterations in thoughts and mood, which often involves blaming self or others for the event, feeling alienated, or feeling uninterested in activities previously enjoyed. The final cluster is alterations in arousal and reactivity, such as having problems sleeping and concentrating, being hypervigilant, and being irritable (APA, 2013).

Approximately 20% of Iraq and Afghanistan veterans have PTSD and/or Depression. As of September 2014 there are approximately 2.7 million American veterans of the Iraq and Afghanistan wars (Department of Veterans Affairs, 2015). PTSD statistics are fluid, and are reviewed over time for veterans. Identifying a more up-to-date and accurate number is difficult. For example, an undocumented number of army nurses, a subcategory of service members in the Iraq/Afghanistan conflicts, have been diagnosed with combat-associated PTSD. For fiscal years 2003–2011, there were 6,555 active duty

nurses in the army, 66% of whom were female. During this timeframe, 43% of females were deployed, versus 65% of males (Defense Manpower Data Center, 2013). This ratio is relevant because Feczer and Bjorklund (2009) suggested possible gender bias by the Veterans Affairs (VA) health care system when diagnosing PTSD. Benda and House (2003) discovered that only 19.8% of the 40.1% females who met PTSD criteria were diagnosed with the disorder. In comparison, 59.1% of the 62.7% males who met the criteria for PTSD were diagnosed. Pereira (2002) obtained similar results from conducting a study involving veterans of the Vietnam and Persian Gulf Wars. The results indicate that though the symptoms of PTSD are the same for male and female veterans, male veterans were more likely to receive a diagnosis of PTSD than were female veterans.

Chapter 1 of this qualitative case study provides insight into the background, problem, purpose, significance, nature, questions, and theoretical framework of the study. A focus on the problem of coping and adaptation of veteran army nurses with combat-related PTSD explores and identifies methods of coping and adaptation that emerged from the perspective of the experiences of 14 veteran army nurses with combat-related PTSD who have been deployed in support of the Global War on Terrorism (GWOT).

Background of the Problem

Every day, nurses provide care to patients, sometimes in extremely stressful situations, and nurses are often exposed to varying degrees of trauma, which are characterized as professional hazards. For the army nurse, providing care is compounded by the additional variables of deployment, challenges of the combat environment, and exposure to horrific human suffering. The human body can demonstrate resiliency after traumatic events; however, the physical, mental, and emotional consequences of war can be severe even for the most resilient person. Exposure to trauma increases psychological stress, which leads to distress and psychiatric illnesses such as PTSD (Ursano, Fullerton, Weisaeth, & Raphael, 2007).

PTSD is an emergent health care issue, one that has significantly plagued the military population. Kulka et al. (1988) reported 15% of veterans had PTSD and 31% were likely to develop PTSD in their lifetimes. The results of more recent research show that 12–13% of service members screen positive for PTSD within three to four months after deployment, and up to 17% screen positive 12 months after deployment. Further, of the veterans who accessed the VA health systems during the Iraq conflicts between 2002 and 2008, 21.8% were diagnosed with PTSD. As the wars continued, the number of service members diagnosed with PTSD increased significantly (Hoge & Castro, 2005; Seal et al., 2009).

In 2004, Major General Gale Pollock, 22nd Chief of the U.S. Army Nurse Corps, made several tours through the country (Boivin, 2005). Her goal was to hear firsthand the experiences of individuals suffering from PTSD. During a military medical conference in November 2004, Pollock addressed an audience of army nurses and acknowledged that PTSD was as much a real and present concern for the military as the condition had been a generation before (Boivin, 2005).

In an interview with Boivin (2005), Major General Pollock emphasized it is normal for soldiers to experience emotional reactions to the trauma of combat and that suppressing emotional reactions can contribute to long-term, disabling PTSD. Furthermore, Pollock declared that the global war on terrorism had transformed the army, requiring nurses in the Army Nurse Corps to adopt a warrior mind-set to survive in hostile situations. In March 2005, approximately 2,000 nurses were deployed to support of the war on terrorism, and the average length of deployment was 1 year (Boivin, 2005).

Problem Statement

The general problem is that military service personnel deployed to a combat zone are subjected to mental and physical stress regardless of their roles in the mission. For some, the physical and mental stress begins at predeployment training, continues throughout the deployment, and even continues post deployment (Hoge, Auchterlonie, & Milliken, 2006; King, King, Vogt, Knight, & Samper, 2006; Wilgus, 2011). Because military personnel are responsible for protecting American citizens, the personnel must develop resiliency to overcome both physical and psychological traumas. This principle applies to members of the Army Nurse Corps because military nurses are subjected to extreme demands in combat zones (Wilgus, 2011). For instance, army nurses are under

significant mental demands to care for the seriously wounded in a timely manner on the battlefield. These nurses must multitask while in a persistent state of heightened awareness.

Researchers have conducted a plethora of studies on PTSD among military service members, including in relation to gender and other demographic variables (Nayback, 2009). The specific problem for the study is the gap in the literature concerning how active duty, retired, and separated veteran army nurses cope and adapt while living with combat-related PTSD. Recent studies have been focused on nurses in general, including civilian nurses and licensed practical nurses. Further, PTSD and resiliency have been examined in regard to soldiers as a group, which includes army nurses, civilian nurses working in military treatment facilities, licensed practical nurses, and combat medics (Phillips, 2011; U.S. Army, 2010; Weidlich, Ugarriza, & Doris, 2015).

Research is needed on active duty, retired, and separated veteran army nurses with combat-related PTSD to understand how this specific group copes and adapts when experiencing PTSD. Without this research, it is unclear whether and how veteran army nurses with combat-related PTSD cope and adapt. For those veteran nurses who continue to provide care for other service members, it is possible they may be vicariously reliving the trauma of war. It is imperative to understand how veteran army nurses with combat-related PTSD cope and adapt to living with PTSD, especially those who continue to provide care to other service members and their families. The results of this research may indicate the need to refocus treatment modalities across all branches of the military.

Purpose Statement

The purpose of this qualitative case study was to explore how veteran army nurses diagnosed with combat-related PTSD cope and adapt. To understand the concepts of coping and adapting in this specific population, the theory of Roy's adaptation model (RAM) was used. To achieve the purpose of the study, interviews were conducted with 14 veteran army nurses who have or had combat-related PTSD and who lived in the southwestern United States. The semi-structured interviews contained open-ended questions that elicited detailed responses from the participants. The data were analyzed via content analysis (Appendix A) to uncover several emerging themes.

Significance of the Study

Nurses strive to promote health and wellness through caring, which is the essence of nursing and the focus of nursing practice. Every day brings new emotional and psychological challenges for nurses as they enter into covenant relationships with patients. Nurses are effectively positioned to help individuals who are experiencing significant stressors and strains to improve or recover from their distress through interpersonal connections. By establishing these connections, nurses can empower individuals to find and employ effective coping and adaptation skills (Roy, 2009). Morrison and Korol (2014) discussed the possible depletion of empathy and compassion in nurses, especially those close to trauma. Researching coping and adaptation of veteran army nurses with combat-related PTSD could enrich nursing knowledge by using and building on data from the study, and ultimately lead to helping military service members cope and adapt with PTSD.

The research study is significant for leadership and nursing. The insights gained from the results of this study have potential to be of significance to leaders of Medical Command, military services, the Veteran Administration (VA), and nursing organizations. The findings do indicate the need to develop and implement strategies to provide specialized mental health services to veteran army nurses experiencing combat-related PTSD. Finally, the study findings have the potential to provide a foundation for successful coping and adaptation in veteran nurses from all branches of the military, as well as other service members.

Nature of the Study

Qualitative methodology and case study design were used for the research. The methodology was chosen as an appropriate way to explore the phenomena of coping and adaptation in the population of veteran army nurses with combat-related PTSD. Qualitative research places emphasis on the universal and individual characteristics of the human experience (Vivar, 2007). The qualitative method was appropriate for uncovering the complexities of a phenomenon through acquiring extensive data (Strauss & Corbin, 2008). Using the qualitative method in the study resulted in ample description of the intricacies of human resiliency in military nurses.

Overview of the Research Method

The data in qualitative research are textual rather than numerical, as in quantitative research; thus, qualitative data are not statistically analyzed but are textually examined to understand the meanings of the responses (Strauss & Corbin, 2008). The theoretical background of qualitative research relates to the humanistic approach, in which the goal is to examine how individuals observe reality. This research method

corresponds with the theoretical postulations of RAM where the personal encounters of the individual are captured and recounted from that person's perspective (Perrett, 2007). Using quantitative methodologies was inappropriate for this study because this approach involves quantifying variables and measurements, as well as applying statistical tests (Hoe & Hoare, 2013). With quantitative research, the investigator is detached from the participants. By contrast, in qualitative research the investigator interacts with participants within their social and cultural environment (Lincoln & Guba, 1990).

Denzin and Lincoln (2008) encouraged qualitative researchers to emphasize the structured nature of reality in a social context, the intimate rapport between the researcher and the topic, and the conditional restrictions that shape inquiry. Qualitative researchers pursue answers to questions relating to social experiences and how those experiences are given meaning. The quantitative method is different from the goal of this study, which was to explore the unique, personal experiences of how veteran army nurses with combat-related PTSD cope and adapt. To reduce participants to the level of statistical numbers is to overlook the uniqueness of the participants' experiences. A credulous relationship between the researcher and participant influenced the therapeutic benefits of the interviews for the participants, as well as increases the richness of the data (Murray, 2003).

Overview of Design and Appropriateness

The case study design was appropriate for the study because the objective of the study was to explore how veteran army nurses cope and adapt with combat-related PTSD. The case study design was also appropriate because all participants were selected from one case (James, 2013), namely nurses with combat-related PTSD who lived around a military base in the southwestern United States.

A single case or multiple cases can be the focus of case study research. The single-case focus was more appropriate than the multi-case focus for the study because all participants were members of the same bounded system (Yin, 2009, 2012). The multi-case approach involves examining multiple groups with distinct qualities and bounded systems (Baxter & Jack, 2008; Houghton, Casey, Shaw, & Murphy, 2013). The focus of the multi-case design is on contrasting the groups (Baxter & Jack, 2008). The focus of the study was not on contrasting different cases of coping and adaptation with PTSD. Therefore, the single-case design was appropriate for the study.

Other qualitative designs did not align with the objective of the study. For instance, the ethnographic design was not selected because the focus of this design is to explore features of a culture, such as actions, beliefs, and languages (Pensoneau-Conway, & Toyosaki, 2011). Participants in the study were not limited to one cultural group; consequently, this design was inappropriate for the study. Grounded theory design was also inappropriate for the study because the objective of grounded theory is the development of a theory about the phenomenon studied (Charmaz, 2006). The study is founded on RAM, and the intent was not to develop a new theory, though the results of the study might validate or extend the concepts of RAM. The phenomenological design

was not chosen because the intent of this design is to understand the lived experiences of individuals from their perspective (Moustakas, 1994).

Research Questions

Three research questions were used to guide the study and to achieve the purpose of the study, which was to explore how veteran army nurses diagnosed with combat-related PTSD cope and adapt. The research questions were:

RQ1: How are veteran nurses coping and adapting after being diagnosed with combat-related PTSD?

RQ2: From the perspective of effective adaptation, what does coping and adapting with PTSD mean for veteran nurses?

RQ3: How does coping with PTSD affect the concept of self, the role of self in relation to others, and personal relationships?

Theoretical Framework

Roy's Adaptation Model was used as the theoretical framework for exploring coping and adaptation of veteran army nurses with combat-related PTSD. This model provided a value-centered perspective for recognizing issues for scholarly inquiry. The model's concepts provide several methods for researchers to develop unified knowledge of the health of people as individuals and groups (Roy, 2011a).

Overview of RAM

Sister Callista Roy developed RAM in the 1960s by building on the ideas of experts in other disciplines. A fundamental concept in RAM is adaptation, and the concept is based on both scientific and philosophical assumptions that Roy developed during her career. The scientific assumptions related to Bertalanffy's general systems

theory and Helson's adaptation-level theory (Roy, 2009). The philosophical assumptions are rooted in the general principles of humanism, cosmic unity, and veritivity. Roy introduced the concept of veritivity in 1988 to introduced the idea that all firmly established knowledge is related (Roy, 2009). Roy (1988) defined veritivity as "a principle of human nature that affirms a common purposefulness of human existence" (p.30). As Roy used new knowledge about other cultures and the origins of the universe, the model evolved and Roy developed a new philosophical concept called cosmic unity. Through the concept of cosmic unity, Roy (2009) emphasized that people and the earth share similar patterns and relationships.

Humans are seen as a unitary adaptive system involving components of the body, mind, and spirit working together as a whole. When one of the components is out of alignment, the individual has to find ways to adjust and adapt to remain functional. Roy (2009) theorized that humans adjust to, and affect their environments through thinking and feeling.

Coping and Adaptation Processing

Coping and adaptation processes are intrinsic or learned habits of interrelating with, recognizing, or reacting to a stimulus in the changing environment. These innate or acquired coping processes are categorized as the regulator and the cognator subsystem (Roy, 2009). The regulator subsystem responds to internal and external stimuli through physiologic channels, whilst the cognator subsystem responds through cognitive-emotional channels. The individual uses the emotions to develop defenses that are used to find relief from anxiety and to make emotional judgements.

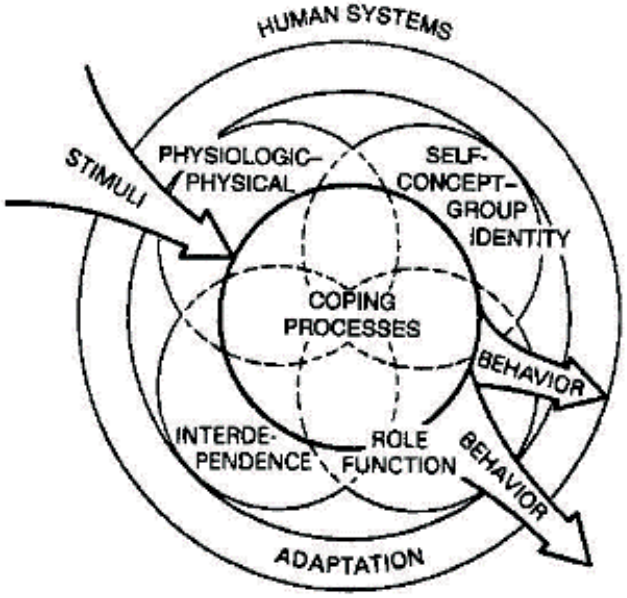

Figure 1. Diagrammatic representation of the human adaptation system. Reprinted with permission (Appendix B).

The ability to understand cognitive and emotional processing done by the cognator subsystem is necessary to understand how individuals are adapting (Roy, 2009). Cognitive processing is essential to devise a planned response to a stimuli (Roy, 2011a), and the process of devising that plan is managed by the cognator (2009). From this perspective Roy developed a middle range theory of coping and adaptation (Figure 2) to demonstrate the phases of cognitive processing. Roy combined the four adaptive modes with the middle range theory of cognitive processing, which resulted in a middle range theory of coping and adaptation processing (Roy, 2011a).

Appendix O

Non-Disclosure Agreement

_____, LCSW, acknowledges that in order to provide the services to [redacted] (hereinafter "Researcher") who is a researcher in a confidential study with the University of Phoenix, Inc. _____ must agree to keep the information obtained as part of her services (as more fully described below) confidential. Therefore the parties agree as follows:

1. The information to be disclosed under this Nondisclosure Agreement ("Agreement") is described as follows and shall be considered "Confidential Information": in providing any counseling needed for the participants. All protected health information inclusive of, but not limited to names, characteristics, or other identifying information, questionnaires, scores, ratings, incidental comments, other information accrued either directly or indirectly through contact with any participant, and/or any other information that by its nature would be considered confidential. All information shall remain the property of Researcher.

2. _____ agrees to keep in confidence and to use the Confidential Information for *counseling* only and for no other purposes.
3. _____ further agrees to keep in confidence and not disclose any Confidential Information to a third party or parties for a period of five (5) years from the date of such disclosure. All oral disclosures of Confidential Information as well as written disclosures of the Confidential Information are covered by this Agreement.
4. _____ shall upon Researcher's request either destroy or return the Confidential Information upon termination of this Agreement.
5. Any obligation of _____ under this Agreement shall not apply to Confidential Information that:
6. Is or becomes a part of the public knowledge through no fault of hers.
7. _____ can demonstrate was rightfully in her possession before disclosure by Researcher/ research subjects; or
8. _____ can demonstrate was rightfully received from a third party who was not Researcher/research subjects and was not under confidentiality restriction on disclosure and without breach of any nondisclosure obligation.
9. _____ shall defend, indemnify and hold the Researcher and the University of Phoenix harmless against any third party claims of damage or injury of any kind resulting from _____ use of the Confidential Information, or any violation of by _____ of the terms of this Agreement.
10. In the event _____ receives a subpoena and believes she has a legal obligation to disclose Confidential Information, then _____ will notify Researcher as soon as possible, and in any event at least five (5) business days prior to the proposed release. If Researcher objects to the release of such Confidential Information, _____ will allow Researcher to exercise any legal rights or remedies regarding the release and protection of the Confidential Information.
11. _____ expressly acknowledges and agrees that the breach, or threatened breach, through a disclosure of Confidential Information may cause irreparable harm and that Researcher may not have an adequate remedy at law. Therefore, _____ agrees that upon such breach, or threatened breach, Researcher will be entitled to seek injunctive

relief to prevent _____ from commencing or continuing any action constituting such breach without showing or providing evidence of actual damage.

The interpretation and validity of this Agreement and the rights of the parties shall be governed by the laws of the State of Texas.
The parties to this Agreement agree that a copy of the original signature (including an electronic copy) may be used for any and all purposes for which the original signature may have been used. The parties further waive any right to challenge the admissibility or authenticity of this document in a court of law based solely on the absence of an original signature.

IN WITNESS WHEREOF, each of the undersigned has caused this Agreement to be duly executed in their names and on their behalf:

Printed Name of Licensed Counselor: _____

Signature: _____

Address: _____

Date: _____

Printed Name of Researchers _____

Signature: _____

Address: _____

Date: _____

Appendix P

Letter of Instructions to Participant

Dear:

I want to thank you again for your willingness to participate in the research study of *Coping and Adaptation of Army Nurses with Combat-related PTSD*. Attached is a transcript of your interview. Please review it for accuracy. If you have any concerns, corrections, or would like to clarify any of the information in the transcript, please annotate them in the right margin of the transcript in red ink. Then, return the complete transcript with a signed copy of this letter in the enclosed self- addressed stamped envelope within 5 days.

By signing this letter in ink, I acknowledge that I received a copy of the transcript of my interview with instructions, and that I understand the instructions provided to me. I also understand that the transcripts with a signed copy of this letter must be returned within 5 days
using the self-addressed stamped envelope.

_____

Name (please print legibly)

_____ _____

Signature Date

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THE STRUGGLE IS REAL.

If you or anyone you love has experienced PTSD, then this book is for you. While this book specifically focuses on Army nurses who experienced trauma on the front lines and who were consequently diagnosed with PTSD, anyone can use the coping strategies found here as they deal with post-traumatic stress disorder.

Remember, you are not alone. Many, many people struggle with PTSD on a daily basis. Family members may not understand that fear, that drive, to sit in a dark closet to escape the torment, but this book aims to show them the very real battle fought to live a normal life after a PTSD diagnosis.

Throughout the pages of this book you will not only read about the devastation PTSD can cause and traditional treatments, but you will read about finding hope and peace and how God's loving kindness can help someone cope with this very serious mental health condition.

Dr. Thelma Nicholls is a recently retired Major of the Army Nurse Corps. Dr. Nicholls' career spans more than thirty-five years, fifteen of which were spent in the Army. She was born in Jamaica and spent most of her childhood there before coming to America, where she earned her nursing degree and met her husband, Robert. The author studied at both Duke University in North Carolina and the University of Phoenix, where she earned her Ph.D. in nursing.

Thelma and Robert have three grown sons and one daughter—Gavin, Gary, Gregory, and Tricia. She loves the Lord and enjoys working for Him. In her spare time she enjoys poetry and crafting.

ISBN 978-1-4796-0869-0
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