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Letter From the Editor

Welcome to the first issue of the *Journal of Military and Government Counseling* (*JMGC*). *JMGC* is the official journal of the Association for Counselors and Educators in Government (ACEG). This journal is designed to present current research on military, veteran, and government topics. ACEG was established to encourage and deliver meaningful guidance, counseling, and educational programs to all members of the Armed Services, to include veterans, their dependents, and Armed Services civilian employees – this mission was later expanded to include all governmental counselors and educators.

This issue represents the culmination of a four-year journey for me. It started at the ACA Conference in Charlotte, March, 2009, when I was new to ACEG. I asked Don Hill (past-president) if ACEG had a journal. I knew there was a good deal of excellent research on military topics being done by doctoral students and thought ACEG would be the local point for that research topic. Don looked me in the eye and said "we don't have a journal." I perceived he was presenting me a challenge – and I took it – not knowing it would take four years to reach this end point.

I must thank Carolyn Baker, ACA Publications, for her tolerating a lot of questions from this novice to the publishing world. Carolyn pointed me toward Rebecca Toporek, who at that time had recently brought the Counselors for Social Justice journal into being as an online publication. Both Carolyn and Rebecca have been quick to respond to my questions and I am grateful for their assistance. Since those initial questions, I've moved in slow steps to this point and still have more to accomplish. Among the unfinished tasks are getting the *JMGC* listed in a database such as ERIC or PsychARTICLES and assigning Digital Object Identifiers.

This first issue is an eclectic collection of articles in practice, theory, and research. My youngest daughter still calls the 15 months I was deployed for Desert Storm her "dark time" – two articles involve school counselors. As a counselor educator, I'm always looking for ways to include graduate students in all aspects of ACA and ACEG. What I hope will be a regular feature in each issue of the *JMCG* is a graduate research paper. The first student article presents a personal journey using existential counseling modalities. My goal is for the *JMGC* to become one of the "go to" journals within military counseling and the American Counseling Association,

Benjamin V. Noah, PhD
JMGC Founding Editor

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The War Within: One Soldier's Experience, Several Clinician's Perspectives

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Abstract

Soldiers returning from deployment are presenting with a plethora of serious mental health challenges, including depression, anxiety, post-traumatic stress disorder, sleep disturbances, and substance abuse issues. This paper will describe the journey of one soldier following his deployment to Iraq and the difficulties he faced during reintegration. Clinicians representing five approaches – dialectical behavior therapy (DBT), eye movement desensitization and reprocessing (EMDR), group systems theory, and motivational interviewing (MI) will provide perspectives on the development of traumatic response symptomology, as well as suggestions for understanding and treating the soldier profiled in the case study.

KEYWORDS: military, soldier, dialectical behavior therapy, eye movement desensitization reprocessing, group development, motivational interviewing, mental health

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The United States Pentagon recently released data indicating that suicide among veterans of the wars in Iraq and Afghanistan is averaging one per day, representing a 50% greater risk of death from suicide than combat (Burns, 2012). This article will profile the journey of one returning veteran (referred to as J.). Following an exploration of J.'s journey, clinicians representing five differing clinical approaches will offer perspectives on J.'s experience and suggest ways in which their particular approach might address J.'s presenting symptoms. Informed consent was obtained prior to researchers interviewing J. and all identifying information has been removed. J. was willing to share his story in the hopes of shedding light on the plight of returning combat veterans for mental health clinicians. The clinical approaches used include: dialectical behavior therapy (DBT), eye movement desensitization and reprocessing (EMDR), group systems theory, and motivational interviewing (MI).

J. is a 26 year old Caucasian male from the southern Appalachian region of the United States. After returning from Iraq, he began receiving full disability for mental and physical injuries. He continues to receive full disability and treatment from the regional Veteran's Administration center, which is a three-hour drive from his home. He lives with his fiancé and visits regularly with his one child, a daughter from a previous marriage. His mother and father also live in town. J.'s father is disabled and J.'s mother works full-time at a large wholesale chain store. J. is currently on five psychotropic medications and is receiving counseling 1-2 times a month. He reports experiencing depression, anxiety, agoraphobia, sleepwalking, nightmares, and hypervigilance. He does not like to be in public and keeps his blinds closed day and night. He has been diagnosed with post-traumatic stress disorder (PTSD) and although he has physical injuries, he is ambulatory.

J. describes his childhood as "very, very happy," emphasizing the close relationship he enjoyed with two brothers. He describes his parents as role models. Other than what J. describes as some fairly typical "wild" behavior during his adolescent years, he views his adolescence as otherwise normal. He married his high school girlfriend immediately after graduation and became the father to a daughter who was diagnosed with autism shortly thereafter. He joined the guard after graduating from high school—ten days after his 18th birthday. Following basic training, he attended the local community college while working at a fast food restaurant. Between his work and school schedule and his deployment, he missed significant periods of time during his daughter's toddler years.

J. was deployed to Iraq in 2004. Prior to deployment, he received a refresher course for three months through the National Guard. Information that J. learned at basic training was reviewed at this time. He was advised to expect significant activity related to "clearing houses" and "clear(ing) a lot of patrols."

J.'s position in Iraq involved participation in what he referred to as "QRF"—quick reaction force. He reported that the position required him to be prepared for combat at all times – including guns loaded, sleeping in uniform, and having trucks set up to respond immediately when called upon. He describes seeing "a lot of stuff" during his three month involvement in QRF. For example, his battalion was typically called upon when another platoon was overwhelmed in a firefight. Following those three months, he spent nine months on patrol;

averaging about 6-7 hour patrols daily. According to J., he was generally the gunner (stationed on top of the truck with a .50 caliber weapon) or a dismount (meaning he would be the first individual to enter a home). Clearing houses involved looking for IED (improvised explosive device) materials as well as determining who was residing in the home. J. indicated that the Iraqi natives were transient and would take up residence informally in houses where families had left or been killed.

J. describes his position as one that required an authoritative mentality—he felt that the Iraqis would be quick to manipulate new soldiers and he was vigilant in maintaining an awareness of the behavior of the locals. When aggressive or combative behavior was observed, it was his platoon's duty to respond immediately and forcefully in order to "keep the peace." J. states that he was exposed to gunfire at least two to three times each day. IEDs were hidden in overgrown canal areas, so two or three guard members were responsible for walking in front of the Humvee (High Mobility Multipurpose Wheeled Vehicle). J. frequently was in the position of walking in front of the Humvee and refers to it as "taking one for the team" (the rationale being that two soldiers being killed by an IED was preferable to all 5 or 6 men in the Humvee dying in an explosion). He also indicated a discrepancy between the training received in preparation camp versus the actual landscape in Iraq. He noted that trash is piled quite high throughout the countryside and cities, making it nearly impossible to spot an IED.

According to J., he felt considerable anxiety and stress early on in the deployment, but that fear eventually took the form of a "survival mode." He indicated that his current therapist explained that his brain acclimated to this consistent stress by "wiring differently" as a coping mechanism. J. explained the abnormal situations became something of a normalcy during this time.

J. eventually was given two weeks' of leave time which corresponded with the Fourth of July holiday. He noted that the sound of fireworks caused him to panic and take cover. He stated that Fourth of July continues to be a stressful holiday due to the association between fireworks and gunfire. Additionally, he learned of his wife's infidelity during his leave and filed for divorce during his leave. He also was occupied with attending to his father's advancing health difficulties. He stated that he was unable to grieve the loss of his marriage because when he returned to Iraq, he had to focus on issues that were life-or-death in nature.

Returning home from Iraq, J. faced a plethora of challenges related to his time in combat. While sleeping, J.'s new girlfriend (to whom he is currently engaged) reported that he would patrol and secure the house wearing boots and carrying a loaded gun. He purchased an AR-15 (semi-automatic) gun for his home because it was most similar to the rifle he had in Iraq. He reported that being in crowds continues to overwhelm him since his time in Iraq – he finds himself scrutinizing strangers, concerned that they might have concealed weapons. He has experienced multiple panic attacks and reported that he was home for approximately one year prior to seeking assistance from the Veteran's Administration. He developed a habit of drinking heavily and staying in a room without windows. He was unable to sleep at night and isolated himself during the day.

He finally sought out VA services when a platoon buddy indicated that he was having similar experiences and found relief through the VA. J. notes that his therapist normalized his experiences, which was very beneficial for him. Over time, he has learned that most of his platoon mates have struggled following their deployment in Iraq. Although they experienced the same events, they reported remembering them differently. Some platoon members have turned to drug and alcohol addiction and many report nightmares.

J. also described the isolation resulting from the geographical spread of his platoon members. He noted that the platoon members became extremely close during their time in Iraq, yet quickly lost touch upon returning home. This reinforced his sense of isolation and prevented him from access to "war buddies" who could potentially listen and relate to his concerns and challenges.

Once he began working with a psychiatrist at the VA, J. noted considerable challenge finding appropriate psychotropic medications and dosages. He estimated that he has been on ten different medicine regimens and is currently taking five. Addressing sleep difficulties has been one of the greatest challenges; J.'s sleep is restless, riddled with nightmares, and often involves him inadvertently striking his fiancé. He also encounters certain neutral stimuli as extremely triggering – for example, IED's were often hidden under viaducts; driving under viaducts currently causes him feelings of panic. Interstate driving is also extremely disturbing, as the enemy would at times use vehicles as IED's and blow up military personnel by tailgating on the highway.

Despite these challenges, J. feels that he has made steady progress since seeking out services at the VA. Even though he is not ready to resume his education, he feels that he will be able to shortly. Once he finishes school, his goal is to seek employment as a park ranger. J. believed that his biggest improvement is his ability to deal with other people. He felt that after Iraq, he had a very "short fuse" and would quickly lose his temper. J. stated that he learned coping mechanisms to remain calm under tense, interpersonal situations. J. reported struggles similar to what many returning veterans experience after deployment from the wars in Iraq and Afghanistan.

Dialectical Behavior Therapy

Dialectical behavior therapy, developed by Linehan (1993), was originally created to address suicidal behaviors, particularly within the context of borderline personality disorder. The therapy integrates mindfulness skills with traditional cognitive-behavioral therapy (CBT) and has shown promise in addressing a number of clinical disorders. Follette, Palm, and Hall's (2004) use of DBT with individuals who present with PTSD symptoms will serve as a template for this section.

Follette et al. (2004) noted that a diagnosis of PTSD can often co-occur with maladaptive attempts at symptom reduction (e.g., substance abuse, sexual impulsivity). The authors encourage analysis of behavior as it relates to function (i.e., what need is being met and how the environment is reinforcing it) rather than form (i.e., how behaviors actually manifest-the behaviors in which the client engages). Analysis of behavior in this context drives case

conceptualization in a purposeful way. The client's strengths are observed in tandem with his or her vulnerabilities. Some researchers (e.g., Naugle & Folette, 1998) caution against viewing maladaptive behavior as related to trauma, yet Linehan (1993) notes that ignoring traumatic events in the client's history can invalidate the client's experience. Clinicians must consistently identify and observe the positive resources available in the client's environment. For J., this includes the support network of his family, his commitment to his daughter and future wife, his camaraderie with fellow veterans and his plans to complete his education and work in a field that interests him. A thorough examination of current life stressors is also appropriate. J.'s life stressors include unemployment, co-parenting a child with special needs, a long commute to the VA for services and the challenges he faces as a result of his PTSD symptoms.

DBT emphasizes two seemingly opposing forces: acceptance and change (Linehan, 1993). Consistently validating the client and his experiences (and perceptions of said experiences), while encouraging the client to face triggers is the dialect of trauma-based counseling. Prior to exposure of traumatic events, however, clients must have the ability to regulate emotions, maintain interpersonal relationships, and manage anger. For this reason, skills training – prior to exposure treatment – is mandatory. The rationale being the clients need to have a degree of stability in their emotional and interpersonal lives prior to examining traumatic events. Because exposure to past traumas is likely to exacerbate clients' vulnerabilities, having a skill set may help offset some of the expected emotional turmoil associated with exposure.

Follette et al. (2004) integrated DBT using a triadic approach: (a) understanding avoidance as a correlate of trauma, (b) implementation of mindfulness and acceptance skills, and (c) treatment of PTSD symptoms by integrating mindfulness with exposure treatment. Although behaviors may manifest differently among clients, these behaviors often have functional similarities. For example, drug use, promiscuity, and excessive gambling may all serve as distractions from traumatic memories and the anxiety or agitation that can accompany such memories. Experiential avoidance can be described as activities to escape emotions, thoughts, or feelings. In this framework, suppressing painful thoughts, feelings, and memories is paradoxical – suppression often brings those very thoughts, feelings, and memories into greater awareness. This awareness is then frequently followed by increased attempts at avoidance and suppression. Skills training serves to teach the client skillful means for affect regulation and anger management. Once skills are learned and implemented by the client, exposure therapy can commence. Exposure addresses the symptoms of PTSD by engaging the client in awareness of the traumatic event. Becker and Zayfert (2001) noted that integrating DBT with exposure treatment may allow 'exposure intolerant' individuals with PTSD to deal with a wide range of difficulties prior to exposure treatment.

Mindfulness is a core component of DBT and is used in group skills training, individual counseling sessions, and treatment team meetings. In the context of DBT, mindfulness is described as intentional awareness to one's thoughts, feelings, and awareness in the present moment. Mindfulness training teaches clients that thoughts and feelings are essentially neutral stimuli that enter and exit awareness routinely. The goal is to teach clients to notice the moment they are presently in. When painful or intrusive thoughts are brought into awareness, clients are taught to ride them out. By "riding the wave" of the intrusive thought, the client will avoid

succumbing to the very behaviors that serve as distractions in the short term yet cause additional suffering in the long term (Follette, Palm, & Hall, 2004).

Application of DBT could address some of J.'s challenges by teaching him mindful awareness of intrusive thoughts and difficult feelings. J. faces multiple stressors including social alienation, financial difficulties, parenting a special-needs child, and post-traumatic reactions to his combat experiences. Using DBT, J. would start by engaging in both group-based skills training as well as individual sessions with a DBT-trained therapist. It should be stressed that trauma-focused therapy would not commence until J. had the requisite "tool-box" of skills needed to manage various issues such as interpersonal relationships and anger management. J.'s DBT treatment team would work in tandem to teach J. mindful awareness of present states without attempting to avoid disturbing or upsetting memories.

Eye Movement Desensitization and Reprocessing

The first guidelines for clinical practice and treatment for Post Traumatic Stress Disorder (PTSD) were published in 2000 by the International Society for Traumatic Studies (ISTTS). Guidelines constructed by the American Psychiatric Association and the United States Department of Veteran Affairs and Defense have followed since that time. Since 2000, significant research has occurred in this area leading to the ISTTS publishing updated guidelines in 2008. Several evidenced-based psychotherapies have been identified through this research and will be described below (Schnurr & Friedman, 2008).

Since 2000, the American Psychiatric Association, the US Institute of Medicine (IOM), the UK National Institute for Clinical Excellence (NICE), a joint practice guideline by the US Department of Veteran Affairs and Department of Defense, and the International Society for Traumatic Stress studies have conducted assessments of the empirical evidence regarding the efficacy of psychotherapy treatments for PTSD and Combat Related Stress Disorders. All have agreed that cognitive-behavioral treatment (CBT), especially prolonged exposure, cognitive processing therapy, and EMDR are evidenced-based treatments for PTSD (Schnurr & Friedman, 2008).

In recent years the United States military has experienced numerous deployments of troops to war zones not limited to but including Iraq and Afghanistan. The physical and emotional repercussion for military personnel becomes more evident with subsequent deployments. Traumatic Brain Injury (TBI) has become common place in current military operations. PTSD and Combat Stress Disorders are experienced by a significant percent of those who serve in combat. Common symptoms present in many service members include, but are not limited to, anger outbursts, rage, irritability, impulsivity, nightmares, night sweats, flashbacks, emotional numbness, hypervigilance, memory and concentration problems, depression, substance abuse, and relationship problems. For some licensed psychotherapists, EMDR has become their choice treatment model in treating soldiers and military family members (Hurley, 2011).

One of the primary goals with EMDR therapy is to restore the client back to a quality of life they had prior to going to war. The overall goal is to assist clients with reprocessing unresolved memories and moving them to adaptive resolution. The client advances to a place where recall of past experiences can occur without becoming mentally and emotionally overwhelmed. During EMDR reprocessing, the level of disturbance associated with memories is decreased to a level where it is no longer emotionally disturbing to recall the traumatic memories. At the same time, new self-reinforcing positive beliefs are strengthened in relation to newly processed memories (Hurley, 2011). The term "collateral damage" refers to unintentional damage that occurs during a military conflict. The war in the mind is collateral damage, moreover, injury that is a consequence related to combat experiences that were not expected or inflicted intentionally (Rozantine, 2011).

The EMDR treatment approach utilizes mentally scanning the body for any physical sensations or discomfort associated with the targeted unprocessed memory. It is common for soldiers to frequently report body sensations related to the intense memories of their combat experiences. Sensory memories are frequently out of a client's awareness until an overall experience is remembered and processed during an EMDR session. Client's body sensations associated with the disturbing memories will often shift in location in the body before decreasing entirely during EMDR treatment. This process can occur within 15-20 minute period in a session. For each subsequent deployment for a soldier comes the increased probability for complex PTSD symptoms. Many soldiers who internalize experiences rather than verbalize them experience more body sensations in relationship to memories processed in sessions. This can be noted in J.'s initial reluctance to pursue mental health treatment and avoid discussing combat after his deployment. Body sensations identified in session can provide helpful insight into additional unprocessed information related to target memories (Hurley, 2011).

Service men and women face danger and literally put their lives on the line in order to protect and save others. While they give everything they have in terms of effort and energy, they are often plagued with intense feelings of guilt, shame, and powerlessness. Many problems can arise from combat experiences that demand for soldiers to be completely successful all of the time even during chaotic war instances where they have very little control over the outside environment surrounding them. As J. described in his account, he frequently walked in front of the Humvee in order to "take one for the team" if necessary. Many soldiers carry internal guilt inside of them due to these ongoing pressures. Trauma can cause distressing physical sensations and physical disturbances that do not clear up on their own. Many veterans who have symptoms of PTSD often experience profound feelings of perceived failure due to people they may have hurt or weren't able to save in combat. Like all people, veterans can also have experiences in childhood that make them more vulnerable to different problems. War experiences can many times act as a trigger point or tipping point for accumulated childhood experiences that were traumatic to the client. During EMDR therapy, veterans do not lose their memories, experiences, or ability to survive. They can, however, let go of the pain of what they have been forced to do in situations that were well beyond their control. It is clear that people can emotionally absorb many things in life that do not personally belong to them (Shapiro, 2012).

EMDR can help people regain more healthy control in their lives through processing memories of experiences that block a healthy and adaptive lifestyle. Ongoing fear and anxiety

can have a chronic negative effect on a person's overall health. EMDR treatment includes processing (a) past memories feeding current mental and emotional disturbances, (b) current situations that serve as emotional triggers, and (c) new ways to deal with disturbing experiences to prevent future relapse. It is important to process the earlier memories that are pushing one's pain in life (Shapiro, 2012). For J., EMDR could potentially assist him in processing the intrusive memories that plague him from his time in combat. According to Shapiro (2012), "the bottom line here is that unprocessed memories can cause people to react to their world through the emotions, beliefs and physical sensations that were there at the time of their earlier traumatic experiences" (p. 244).

Group Development Perspective

A brief review of specific aspects of military culture which most directly impact post-deployment functioning must be taken in to consideration in order to conceptualize J.'s case thoroughly. Christian, Stivers, and Sammons (2009) indicated that the core of the military culture in the United States is a system that values the idea of collectivism, which distinguishes the military from the civilian culture of individualism. This distinction evokes a certain level of conflict for the soldier and those he/she leaves behind. The collective focus on the needs of the organization, group cohesion, and the primacy of the group goal contrast greatly with the rugged individualistic achievement perspective of the greater civilian culture. In the military, the mission is of primary importance (Martin & McClure, 2000). Mission and the camaraderie of the forces take precedence over all else, including family. Even though this may be a difficult concept to embrace, expressions such as "a distracted soldier is a dead soldier" demonstrate the importance of a single focus on the mission to the exclusion of all else, even those back home. Such an expression is not without good reason. The importance of a single focus on the mission is what, invariably, saves lives. This mindset poses difficulties once the soldier returns home from deployment.

Counselors must consider the ever-changing landscape of the soldier's current realities. According to researchers (Johnson et al., 2007; Lincoln, Swift, & Shorteno-Fraser, 2008), deployment has become increasingly unpredictable, with more frequent rotations over shorter periods of time. As a result, the impact on the wellness of the soldier and their families has grown exponentially.

The return home from deployment phase is often filled with ambivalence, joy, and apprehension around reintegration with the family, and readjustments necessary to accommodate all that has happened to the deployed individual and the unit in her/his absence (Collins & Kennedy, 2008). Many mental health issues (e.g., depression, anxiety, post-traumatic stress, aggression, cognitive impairments, and grief and loss) result from combat return and the implications for counselor interventions are great (Hayden & Wheat, 2009).

As mentioned, the soldier, partner, and family members are all affected in different ways. Counselors must have knowledge of group development and dynamics and its role within family systems' issues such as triangulation, homeostasis, communication patterns, family, and marital roles and rules.

Community-Making Model

Peck (1987) developed a group development model to explain the stages individuals and groups go through (i.e., Pseudo-Community, Chaos, Emptiness, and Community). Through this process individuals and groups learn to identify and go beyond their personal needs in service of the collective transformation. Peck introduced the stages of community-making because he believed that communities, like individuals, are unique and groups that are assembled deliberately to form themselves into communities that characteristically go through certain stages in a unique manner. For the purposes of this paper this model will be used to frame the experiences of the J. and his family. A brief explanation of Peck's stages will be presented with examples of how each stage would look for a soldier on deployment and post-deployment.

Pseudo-community. According to Peck (1987), the natural response of any new group that seeks to become a true community is to fake it. There is a honeymoon period to each new group, where members come together and both consciously and subconsciously hide their individual differences and opinions in an effort to keep the waters calm. This stage is what Peck (1987) refers to as Pseudo-Community. Naturally, a new team would wish to create an environment of camaraderie and cohesion where everyone is welcome and worthy of being a member. This attempt at Pseudo-Community is neither covert nor malicious; rather it is often an unconscious process whereby people want to like and be liked to avoid conflict (Peck, 1987). For example, when a new platoon meets on the first day of training and everyone acts as though they like everyone and there are no differences expressed would be one example of this phenomenon. According to Peck, the essential dynamic of Pseudo-Community is conflict-avoidance, which customarily leads to the disregarding of individual differences. An example of this for the soldier's family could be when the soldier first returns home from deployment and the 'real' issues are avoided as a means to ensure a happy homecoming.

Chaos. According to Peck (1987), the second stage, Chaos, occurs when the individual differences (which have been repressed) find their way out into the open. Chaos is usually a result of erroneous attempts by members to smooth things over. Yet, Chaos is an "essential part of the process of Community development" (Peck, 1987, p. 91). Unfortunately, unlike Pseudo-Community, Chaos does not disappear once it is acknowledged, because now individual differences are out in the open and instead of trying to hide them, members try to eliminate them (Peck, 1987). This stage is marked by a time when the superficial Cohesion (Pseudo-Community) starts to crumble due to the individuals fighting for their roles and voicing their opinions for who deserves what. At this point Chaos ensues. The stage of Chaos is a time for fighting and struggle. However, that is not the real purpose. An example in the military would be when the unit commander assigns roles to the soldiers. At this point individuals no longer require harmony among everyone; instead, dissention and self-interest become prevalent. As Peck indicated, Chaos is necessary and serves a productive purpose once the team is able to "fight gracefully." Even in the most fully developed and successful teams, there are times when a fight or struggle is necessary, but it's the way in which the team fights that matters. For example, a soldier's spouse begins to express the hardships experienced during deployment. The stark reality of real life may be too much to avoid anymore and conflict begins to emerge as roles and identities are redefined.

According to Gentile (2009), even though Chaos is uncomfortable and unproductive and appears to be a step backwards from Pseudo-Community, it does in fact provide the opportunity for genuineness to surface, making Chaos a productive place to be. Peck believed "fighting is far better than pretending you are not divided. It's painful, but it's a beginning" (1987, p. 94). There are two avenues out of Chaos: (1) reorganize back to Pseudo-Community, or (2) enter into the third stage of "Emptiness."

Emptiness. Depending upon the level of cohesion and commitment to the group as a whole, the chosen avenue will be one of regression back to the safe Pseudo-Community or forward to a vulnerable stage of Emptiness. Peck (1987) suggests there are irrefutable stages a group must go through to experience a truly cohesive and productive Community. Yet, Peck (1987) proposes the third stage of his model (Emptiness) to be the most crucial and intense stage of Community development. This is the point at which real trust is developed and demonstrated. Peck is concerned with the interpersonal and deep intrapersonal process' which occur in a team. According to Peck (1987), this is a commitment to the team as a whole, where they empty themselves of the barriers of communication. An example would be when soldiers let go of their need to measure their performance against one another. This is a time for the individual soldiers to let go of their individual egos and accept their role as a part of a unit; a time when members let go of their preconceptions and needs to control and fix the situation. Emptiness is characteristic of a high level of group cohesion and synergy. Without letting go of some of the control, a group cannot truly reach Community.

Emptiness may occur when a soldier recognizes his/her need for help and is willing to ask for it. Furthermore, the soldier and the family or loved ones are open to accepting the need for new roles and rules to be established in accordance with the new reality of a post-deployment family. This is a time marked by openness in clarifying the family's mission and each other's roles in the accomplishment of that mission.

Community. Community is the fourth and final stage of the developmental process. In and through Emptiness is where true Community is possible. Community is a time when the group is acting as a unit rather than as individuals. However, according to Peck (1987), there are times when a group will fall out of Community. For example, a unit may lose a fellow soldier. This loss may in fact send the unit back in to an earlier stage of development, such as chaos. Likewise, a soldier's re-deployment may cause a family to revert back to an earlier stage of development as well.

Community differs from Pseudo-Community (fake Community) in terms of superior communication (Peck 1987). To reach Community, all members must commit to communicate with each other on a genuine and deep level. Genuine communities may experience long periods of time free from conflict. But that is because they have learned how to effectively deal with conflict rather than avoid it. According to Peck (1987), pseudo-communities are conflict-avoiding, whereas genuine communities are conflict-resolving. Once the benefits of Community have been experienced, the desire and drive to achieve that state is often greater (Peck, 1987).

The military works diligently to create an environment of teamwork and community to establish both strength and protection. That community then becomes the element that makes or

breaks a platoon. While many people have been part of a group or team at some point, few have been a part of one in which lives were dependent on one's level of commitment to the group and its mission. Because of the deep level of trust and vulnerability needed to reach community and the drive to continually achieve such a state again, a soldier's departure from this community and returning home will create feelings of isolation and a sense of not belonging.

J.'s Story

J. stated that when he returned from deployment "I came back and you really feel alone anyway when you come back because you're not – you're used to being around (we call them) battle buddies. Your friends. When they're not there you feel all awkward anyway." He went on to share that when he was deployed "It seemed like everybody I talked to was going through about the same thing." He shared that it was difficult to be away from his unit after his deployment. He isolated himself because he felt like he didn't have anyone to talk to or relate to anymore. J. explained "You lose contact with them. They live in different places. They [the Army] consolidate you to go on deployments and get you together. But when you come back there's only a handful of people that live in that I was overseas with even though this is the unit that deployed. The combined units went everywhere. So when you come back you lose touch with everybody that lives farther away. There's even more of an isolation problem. With everybody that I knew lives somewhere else. Everybody I wanted to talk to. Everybody that I'm used to talking to is living in a different place going through their lives and their struggles and everything that they're going through."

This one soldier's story is just an example to illustrate the need to understand and appreciate the value of membership in a community and the enormous impact that losing that community has on the soldier and his/her family. Through an understanding of the military culture, counselors can approach the soldier and their family from a phenomenological perspective. We as counselors must be diligent in our efforts to meet our veterans and their families where they are, understand what they have been through and where they are coming from, so as to facilitate a smoother reintegration process.

Substance Abuse Treatment Approaches

According to the *2009 National Survey on Drug Use and Health* [Substance Abuse and Mental Health Services Administration (SAMHSA), 2010], 52% of Americans over the age of 12 years (approximately 131 million) are current consumers of alcohol and nearly 70 million use tobacco products. Marijuana use and non-prescription use of opiates were also identified as a continuing problem. Of the nearly 24 million who reported needing treatment for an alcohol or drug abuse, only 2.3 million (11%) actually received treatment. Etiological factors contributing to substance abuse are complex and often overlapping. Multicausal theories may be best suited to explain this phenomenon and provide a foundation for treatment. Individuals exposed to trauma or crisis situations tended to have higher rates of substance use and abuse (e.g., DiMaggio, Galea, & Li, 2009; Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997; Rowe, La Greca, & Alexandersson, 2010; Smith, Christiansen, Vincent, & Hann, 1999; Vlahov et al., 2002).

Clients with substance abuse issues can present significant treatment challenges. Common treatment issues include dealing with reluctance/resistance to change, co-occurring mental health problems, exposure to trauma, relapse issues, lack of healthy support systems, and medical complications due to chronic usage. Given the complexity of addiction, treatment providers must not only properly assess and diagnose, but also understand current treatment approaches that target concerns unique to these clients.

Miller, Wilbourne, and Hettema (2003) examined the literature and identified treatment modalities that were efficacious in addressing substance abuse issues. The top modalities included brief interventions and motivational enhancement, community reinforcement approaches, medication, various behavioral approaches (i.e., self control training, contracting, marital therapy), and social skills training. Central to treatment effectiveness is assessing client's motivation to change. Assessing the client's motivation to change is a critical first step as it lays the ground work for selecting the appropriate treatment technique/approach. A commonly used change model to assess client ambivalence is Prochaska and DiClemente's (1992) five stage of change model which identifies specific stages individuals go through in changing substance use behaviors. The five stages in Prochaska and DiClemente's model are:

1. *Precontemplation*, characterized by resistance to change or denying that a problem exists.
2. *Contemplation*, where evidence of ambivalence exists, however, the client is contemplating the effects of substance abuse and the advantages and disadvantages of continued use.
3. *Preparation*, the client has decided that change is necessary but is uncertain of the next steps.
4. *Action*, the client engages in specific change behaviors often through specific goals and behaviors to end pattern of use.
5. *Maintenance,* client has maintained a period of abstinence and is focused on long term recovery by addressing relapse issues and triggers.

Even though the progression through the stages implies a linear process, inevitably change does not occur that simply. Clients often find that movement from stage to stage depends on how much progress they make and how they deal with setbacks. Motivational support often is a key component that is integrated into treatment to assist in the change process. Motivational interviewing (MI) is viewed as an integral component to the change process. Miller and Rollnick (2002) integrated MI into the change model based on the belief that motivation is driven by interpersonal interactions. By implementing MI as part of the stage of change model, Miller and Rollnick (2002) viewed treatment as shifting away from the directive, counselor-driven treatment modality that long dominated the field of addiction and embraced a client-directed, transtheoretical approach drawing on the concept of empathic communication that aligned with client values and beliefs. Four guiding principles facilitate the change process: (a) Expressing empathy, (b) rolling with client resistance, (c) developing discrepancies (i.e., address cognitive dissonance), and (d) support client self-efficacy (Miller & Rollnick, 2002).

Application and Implications of SOC and MI with J.

When working with the client to address his alcohol dependency, it is critical that the counselor accurately assess both where J. is the change process and his level of ambivalence to

change, especially given that his alcohol use appears to play a significant role in how he manages and copes with his PTSD symptoms. If the counselor does not assess or accurately assess where J. is in the stage of change process, then several concerns may arise during the course of treatment. Given that J.'s drinking appears to be a means to alleviate his PTSD symptoms, failing to identify and address the stage of change and understanding the motivation related to his use may likely create increased resistant to treatment and greater ambivalence toward counseling. As a result, the client may discontinue treatment or present as more defiant in session.

Further, by not identifying or accurately identifying where J. is the change process, the counselor may integrate treatment approaches and techniques that are incongruent with J.'s stage of change. Based on the information presented in this case, J. appears to be at the precontemplation stage. This stage is characterized by client resistance and denial that a problem exists. Treatment approaches most beneficial at this stage are establishing trust and rapport, building a therapeutic working alliance, and increasing motivation strategies. Implementing these strategies at this stage will allow J. to begin to focus his awareness on how alcohol use is hastening his recovery from PTSD and possibly exacerbating his symptoms. If the counselor does not identify J. as being in the precontemplation stage, the counselor may inappropriately apply treatment approaches (e.g., reinforcement approaches, stimulus management, cue/trigger responses, behavioral contracting, reinforcing self-efficacy, or relapse prevention strategies) that are not suitable for this stage. Using techniques that do not match J.'s stage of change will likely result in increased resistance and ambivalence.

The counselor must continually assess J.'s resistance to change and motivation and apply techniques that are congruent with client progress. As J.'s motivation for change increases and he moves into the contemplative stage, the counselor will continue to build rapport and may use more clarification and reflective skills, as well as bibliotherapy to help J. explore the pros and cons of his actions and behavior and better understand how alcohol use exacerbates his PTSD. In the preparation stage, helping J. develop support systems related to his alcohol use will minimize the isolation, normalize his experiences with respect to alcohol use and PTSD, and provide additional support to help maintain his recovery. As J. transitions into the action stage, use of behavioral techniques and relapse prevention interventions will assist in reinforcing his commitment to change and provide strategies to deal with interpersonal and intrapersonal factors that can trigger relapse. This approach should be coordinated so to account for any PTSD triggers that may contribute to alcohol relapse. Once J. reaches the maintenance stage, continued application of behavior techniques, relapse prevention strategies, and cognitive approaches such as reinforcing self-efficacy around alcohol use will be beneficial in maintaining abstinence. Given the complexity of this case, the counselor should be working in tandem with J.'s other treatment providers, especially as it relates to maintaining psychotropic medication regimens, addressing PTSD triggers that can lead to relapse, and maintaining support.

Motivational support becomes an integral component to assist in the change process and is woven through each stage of change. The value of instilling MI as part of the change process is essential to address the ambivalence and resistance that hinders the change process at each stage. The versatility of MI is evident in its transtheoretical application, which allows the counselor to easily integrate it into many types of theoretical models.

Working with J., the counselor should integrate MI techniques throughout the stages of change model. MI is a valuable tool not only because it allows for the creation of a menu of treatment options or activities that align with J.'s values and goals, but also it integrates empathy as a key tenet to treatment. Integrating empathy will be beneficial given J.'s co-occurring PTSD diagnosis and the value that counselor empathy has in creating a therapeutic change. As J. progresses in alcohol treatment, different motivational techniques can be integrated to assist with change process. During the precontemplation stage, use of reflective skills such as paraphrasing, affirmations, open-ended questions, reflecting feeling, and summaries can be integral eliciting change while lowering resistance. As J. shifts into the contemplative stage, the counselor can integrate techniques such as the importance ruler (a technique used to help J. evaluate his ability to change behavior), querying extremes (a technique used to help J. examine the effects of not changing or seeing what life would look like if they did change), and looking back or looking forward (a technique to examine discrepancies in the past, present, or forward; Aasheim & Wallace, 2008). In later stages of change where MI can be used to help J. maintain confidence in his recovery, techniques such as reviewing past successes, examining personal strengths and supports (to enhance self-efficacy and level of self-determination), and creating hypothetical change can be beneficial (Aasheim & Wallace, 2008). It should be noted that given J.'s co-occurring diagnosis, MI may not be effective beyond treatment of alcohol dependence since his response to PTSD may result in different motivation reinforcers (Aasheim & Wallace, 2008).

Conclusion

J. is one soldier who experienced deployment in Iraq. Each day, many soldiers are returning following deployments; some soldiers have experienced multiple deployments. As clinicians work to assist veterans in acclimating back to their pre-deployment lives, many search for treatments that will address the complexity of symptoms reported by this clientele. In this paper, the authors posit that case conceptualization from multiple modalities, specifically, dialectical behavior therapy (DBT), eye movement desensitization and reprocessing (EMDR), group systems theory, and motivational interviewing (MI) have been described and applied to the case of one veteran who served in combat.

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Joining Forces: Counselors Collaborating to Serve Military Families

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Abstract

Over the past three years the Arkansas Counseling Association (ArCA) has been collaborating with the Central Arkansas Veterans Healthcare System (CAVHS), the University of Arkansas for Medical Sciences (UAMS), the Arkansas National Guard, and the Arkansas Board of Education (ABOE) Counseling and Guidance Unit, to support military children and families. This manuscript describes the methods the ArCA used to educate its members and serve Veterans and military families in the state and provides a model for branches and divisions of the American Counseling Association to implement Veteran and military awareness campaigns in their state.

KEYWORDS: veterans, military families, military children

As America begins to draw down its troops from Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn, the long term physical, mental, and financial consequences of war are not yet clear, particularly for our military families. Although most of these military families are resilient to the stressors of parental deployment, some individuals and families experience symptoms of anxiety and depression throughout the phases of deployment (Chandra et al., 2010).

Researchers have identified military and Veteran families as at risk of experiencing distress. Separation, shifts in roles and responsibilities, and feelings of loss can affect the family during deployment. Deployment separation, injury, and mental health concerns are life-changing stressors for military families (Chandra et al., 2010; Lester et al., 2010; Sayers, Farrow, Ross, & Olsin, 2009). Spouses experiencing military deployment have reported worrying, waiting, going it alone, pulling double duty, and loneliness as stressors and that keeping busy is the primary coping skill (Lapp, Taft, Tollefson, Hoepner, Moore, & Divyak, 2010).

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Between 15%-20% veterans report symptoms of post-traumatic stress (PTSD), anxiety or depression after returning from war (Lester et al., 2010; McNulty, 2010; Milliken, Auchterloine, & Hoge, 2007; RAND Corporation, 2008). Spouses have reported additional stressors if the Veteran returns with injuries or symptoms such as those related to PTSD (Renshaw 2010; Renshaw, 2011).

Parental stress impacts the children because a child's emotional health is directly related to the emotional well-being of his or her parents or other primary caregivers (National Scientific Council on the Developing Child, 2008). Chandra and colleagues (2010) found that military children experience emotional and behavioral difficulties at rates above the national average. Preschool-aged children display behavior problems, withdrawal, and regression in age appropriate tasks (Barker & Berry 2009; Chandra et al., 2010; Chartrand, Frank, White, & Shope, 2008; Paris, DeVoe, Ross, & Acker, 2010). A study of children aged five to 17 of active duty military personnel determined that 16.7% were diagnosed with depression, anxiety or other mental health disorders (Mansfield, Kaufman, Engel, & Gaynes, 2011).

In addition to the decrease in life satisfaction for members of military families, the mental health of individuals can be far reaching. The National Research Council and the Institute of Medicine (NRCIM, 2009), in a joint study, have indicated that mental, emotional, and behavioral disorders interfere with young people's ability to develop age-appropriate tasks, which may have life-long consequences. Without prevention, the ultimate cost to young people and their families, schools, and communities is an estimated $247 billion annually (NRCIM, 2009).

The literature suggests that military families need community support and services to assist them in being resilient to parental separation due to combat related deployment (Bowen & Martin2011; Walski, Bokony, Edlund & Kirchner, n.d.; Waliski, Kirchner, Shue, & Bokony, 2012). In response to the growing belief that families experiencing deployment needed support provided within their communities, President Obama signed the 2011 Strengthening Our Military Families Act, which emphasized the importance of governmental departments such as Veterans Affairs, Defense, Education, Homeland Security, and Agriculture to pool resources to assist military families (Obama, 2011). In addition, the Joint Forces campaign to encourage all organizations and individuals to serve the Nation's military through volunteering and developing community projects that support the troops (Sherr & Murphy, 2011).

This manuscript describes the methods used by members of the American Counseling Association (ACA), its Association for Counselors and Educators in Government, and its Arkansas branch to 'join forces' with members of the Central Arkansas Veterans Healthcare System (CAVHS), the University of Arkansas for Medical Sciences (UAMS), the Arkansas National Guard, and the Arkansas Board of Education (ABOE) Counseling and Guidance Unit, to support military children and families.

Annual Arkansas Counseling Association (ArCA) Conference

In November of 2008, during a session of the ArCA annual conference, a division leader indicated the increased need for continuing education on assisting military children and families. ArCA began to develop partnerships with the CAVHS and UAMS to organize trainings for

counselors on the mental health of military children and families. Each organization had expertise and services that could assist this population. The CAVHS and the UAMS could offer continuing education and consultation about the military culture, the combat deployment experience, and signs and symptoms of distress in family members. The ArCA provided a link to the ABOE Counseling and Guidance Unit and a network of school and mental health counselors who could act as front line responders to military personnel and their families.

Psychological Trauma of War Workshop

In 2009, members of CAVHS, UAMS, and the Arkansas Counseling Association collaborated to organize a two-day summer workshop to educate school counselors about experiences of Operation Enduring Freedom and Operation Iraqi Freedom families and gain information from school counselors concerning their perceptions of military families from their observations as home-front responders in public schools. Pre- and post-test evaluation results of the workshop, as well as counselor perceptions of military family needs, were published in the *Journal of Rural Health* (Waliski, et al., 2012).

Survey results from participants (n=75; 91% from rural counties) revealed that children of deployed parents may be negatively impacted academically or socially or both in area schools. In addition, school counselors identified childcare and parenting, emotions and behaviors, finances, and barriers to counseling services as challenges for military children and families. Following the workshop, school counselors reported a greater understanding of outreach for schools and communities in working with veterans and their families. They also reported a better understanding of the impact of war on military families and knowledge of local and state resources for this population. Specifically, attendees felt they could better identify issues and needs of OEF/OIF/OND families with young children, recommend parenting skills to assist these families, and recognize their psychiatric or medical issues.

The knowledge gained informed the importance of addressing the mental health disparities of military children experiencing combat-related parental separation and the need to identify protective environments that could provide prevention interventions for this population. Collaboration between the Department of Defense, the Department of Veterans Affairs, and the Department of Education are key stakeholders in providing support to military families and a society facing continued conflicts abroad.

Educational Cooperative Trainings

Once the need for increased education and resources for counselors to assist OEF/OIF families was determined, investigators identified methods to disseminate information throughout the state. Investigators collaborated with the ABOE Guidance and Counseling Unit to provide an educational training session to 15 educational cooperatives and counselors across the state. Through these activities, 315 counselors indicated interest in volunteering and requested to be informed of future research opportunities, service projects, and educational opportunities. Because of these and other efforts to meet the needs of Arkansas Veterans and military families, ArCA received the American Counseling Association's 2011 Southern Region Award for Innovative Programs and gained national recognition for their work with military families.

Going To Combat for Arkansas Children and Families

As the interest in serving military children and families increased, the ArCA kicked off an awareness campaign for military families at its 2010 annual conference. Immediately following the announcement, the Arkansas National Guard Adjutant General gave a compelling presentation identifying the need for military family support from churches, schools, and communities. Those attending the conference were encouraged to build support in their communities and generate awareness and understanding of the challenges faced by families experiencing parental separation due to combat deployment.

Over that next year, ArCA and its partners at the Central Arkansas Veterans Healthcare System (CAVHS) and the University of Arkansas for Medical Sciences (UAMS) worked to organize a three-day conference that would provide educational sessions that focuses on the needs of military families and in turn motivate counselors to use these skills to serve these American heroes. The 2011 annual ArCA conference began with a keynote speech by an Arkansas Army Reserve Colonel who served three OEF/OIF tours of duty while having a young daughter at home. The keynote for the second day was Sonia Manzano, "Maria" from *Sesame Street.* Ms. Manzano spoke about how educators play a significant role in helping children to understand life events and how *Sesame Street* has collaborated with the Department of Defense to create videos to help explain deployment and combat injury to young children. The conference concluded with a two-hour session provided by the Arkansas National Guard Arkansas State Family Program and Joint Service Support staff. During this session Military Family Consultants described all the resources, counseling, consulting services they could provide to counselors choosing to assist military families.

The ArCA provided over 35 educational sessions led by veterans, military personnel, VA employees, and counselors with expertise in assisting military families. Each session concluded with an evaluation requesting feedback on the presentation and identified needs for improvement. In addition, the ArCA conducted a survey of school counselors identifying the needs of military children and families, how counselors have been assisting these families, and how the ArCA, VA, and UAMS partnership can be utilized to provide counselors with the resources needed to assist these families. Data from the conference as well as the survey are being analyzed, and the investigators will submit the results for review and dissemination through the *Journal of Military and Government Counseling* upon completion.

Counselors Serving the National Guard

The success of the 2011 conference led to a new collaborative role for counselors interested in serving military families. The ArCA was asked to join forces with the Arkansas National Guard to provide briefings to service members and their families about managing stress, parenting skills, and behavior expectations when a child experiences parental deployment. Volunteer counselors were asked to attend a two hour training organized by the Arkansas State Family Program Director, Joint Service Support Branch Chief. As needed, these counselors are called upon to attend drill weekends and to provide psycho-educational sessions for attendees.

Discussion

This manuscript describes the methods the ArCA used to educate its members and serve Veteran and military families in the state. This information provides a model for other branches and divisions of ACA to implement veteran and military awareness campaigns in their states. The ArCA plans to continue their efforts to serve military children and families by disseminating the findings of the evaluations and survey conducted at the conference to attendees of the summer Leadership Development Institute, the 2012 annual conference, as well as publishing the findings. In addition, ArCA plans to work with the ACA and the ACEG to help identify the value of counselors in the Veterans Healthcare System and other government agencies.

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Addressing the Mental Health Needs of Gay Military Veterans: A Group Counseling Approach

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Abstract

Until late 2011, the Don't Ask Don't Tell (DADT) policy prevented people serving in the United States military from disclosing their sexual identity to others. Although the law is no longer in effect today, the negative stigma and poor treatment of Lesbian, Gay, and Bisexual (LGB) veterans still exists. This population has unique mental health needs, necessitating the support of counselors. The purpose of this manuscript is to: (a) investigate the impact of the lasting effects of DADT has on LGB military veterans, specifically gay men, (b) examine the benefits of providing this population with group counseling, (c) present an example of a six week group curriculum which employs interventions related to merging two conflicting identities often experienced by gay veterans, and (d) address effectiveness and limitations of the proposed group curriculum.

Keywords: LGB veterans, group counseling, group curriculum

Lesbian, gay, and bisexual(LGB) veterans face personal and professional challenges, such as: (a)integrating their soldier identity with their sexual identity, (b) coming out to their colleagues, and (c) being accepted and respected by their colleagues and leaders. These struggles can lead to depression, feeling isolated, substance abuse, and suicide (Cochran, Mays, Ortega, Alegria, & Takeuchi, 2007). Society has become more accepting of LGB individuals; however, harmful stereotypes still exist and homophobia still negatively impacts the LGB community (Herek, 2004).

Until late 2011, the *Don't Ask Don't Tell* (DADT) policy prevented people serving in the United States from disclosing their sexual identity to others. While this law is no longer in place, LGB veterans returning to the United States are still impacted by the policy. They entered the military when DADT existed, which prevented them from being able to express their true

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sexual identity and their true self. Now they are allowed to identify as an LGB individual; however, it may be difficult for them to express and integrate their sexual identity because it was not accepted as a part of their professional identity. Group counseling within the Veteran's Affairs (VA) program, is an approach to address the mental health needs that may exist as a result of the transition back into the United States, and the challenges of identity integration. Therefore, the purpose of this manuscript is to: (a) investigate the impact of the lasting effects of DADT has on gay military veterans, (b) examine the benefits of providing this population with group counseling, (c) present an example of a six week group curriculum which employs interventions related to merging two conflicting identities often experienced by gay veterans, and (d) address effectiveness and limitations of the proposed group curriculum.

History and Implications of *Don't Ask Don't Tell*

Sinclair (2009) explains that before World War 2, gay men were not permitted to serve; however, great attention was not placed on sexuality. It wasn't until the American Psychological Associated classified homosexuality as a mental illness that psychiatrists carefully screened for homosexuality behaviors before allowing men to enlist (Berube 1990). When applying to enlist, applicants were asked if they were homosexual or have engaged in any form of same gender sexual behavior. If they answered yes, members were denied entry. If any evidence suggested that soldiers had lied, military personnel would attempt to identify those who were dishonest to determine whether or not service people were homosexual (Kavanagh, 1995). This led to many service men and women to being discharged (Berube 1990). In 1993, President Clinton passed the *Don't Ask Don't Tell* (DADT) policy which stated that military applicants were no longer asked about their sexual orientation when enlisting. However, under this new policy, gay men were not permitted to engage in any sexual acts with other men, admit they were having sexual thoughts, or even mention the name of a significant other (Burks 2011). Thus, DADT still forced gay men to deny their true sexual identity.

Camaraderie Paradox – Conflicting Identities

The unit a veteran is part of in the military is reflective of a family system. Within this system, there is limited privacy and it is not unusual for members of the unit to know everything going on within each other's outside families and personal lives; therefore, creating a sense of camaraderie. Trivette (2010) states that there is a camaraderie paradox within the military. While on one hand, there is a high expectation to build strong rapport with other members of a unit, closeted veterans still struggle due to the fact they cannot be their genuine selves. In addition, if straight counterparts discover when others are hiding something, the closeness of the relationship is impacted. The threat of being discharged at any time created a false sense of camaraderie for those individuals as well as an invisible segregation that could not be corrected or even addressed. These opposing viewpoints have the potential of making gay servicemen feel as though they are living a double life. An important factor to consider is how these two aspects of identity conflict with one another.

A foundation of the counseling profession is to enhance holistic well-being of an individual (Myers, 1992); therefore, a primary task of counselors is to encourage clients to develop self-acceptance holistically The DADT policy forced people to do the opposite.

Members in the military report they have no privacy, and intimate space is limited and/or shared with others (Trivette 2010). This limited privacy and the stipulations of DADT, facilitates a dishonest environment for gay men. For example, if a gay soldier was asked about their day, in a routine conversation, it would be necessary for him to monitor what he says to prevent the risk of saying something that would identify his sexual identity. This dishonest environment manifests feelings of severe isolation, considering gay servicemen are not "fully known" by their immediate and closest peer group (Kavanagh, 1995). Therefore, to create an overall sense of wellness, gay veterans should strive to understand how their dimensions of identity intersect, and work through any negative emotions.

Mental Health Implications of DADT

The mental health needs of gay veterans need to be recognized by counselors. According to the RAND National Defense Research Institute (2010), 72% of LGBT report feeling daily stress and anxiety as a direct result of the DADT. Blosnich, Bossarte, and Silenzio (2012) found that lesbian, gay, and bisexual veterans have: (a) increased suicidal ideation than their heterosexual counterparts, (b) decreased mental health, (c) less social and emotional support compared to their straight peers, and (d) limited mental health services. This study was conducted after the repeal of DADT, and identifies sexual minority veterans as a population that needs more research and outreach from the Veterans Health Administration. Counselors need to be aware of the impact DADT has on gay veteran's mental health, and identify both the negative and positive consequences combining two identities has on them.

A Group Counseling Approach

The population of sexual minorities in the military is an understudied group with many needs. Gay veterans are returning home after hiding a key component of their own identity (i.e., sexuality). Many have fought for their country, in life threatening situations, and were asked to pretend to be something they are not. Therefore, a group setting where veterans can share their experiences with each other, and expose both their military and sexual identities in one forum would be an ideal venue to begin working on these experiences. Group counseling will provide gay veterans a place to address their experiences in combat, but also their experiences and feelings associated with of denying their sexuality in their professional life. The proposed six week counseling group (Gladding, 2011), is focused on building a sense of cohesion and camaraderie among group members, as they experienced (or would have liked to experience) during their service. Once this is achieved, activities and discussions will be designed with the goal of merging individual military and sexual identities together. The proposed group counseling curriculum is specific to address the mental health needs of gay veterans; however, the curriculum does not portray all the strategies that may be implemented when working with this population. Furthermore, components of this group (i.e., activities) may be beneficial to use when working with other discriminated groups (i.e., woman or ethnic minorities).

An Ethical Obligation to Gay Veterans

All counselors have both an ethical and professional responsibility to promote a safe and culturally competent group climate to support the holistic development of all members

(Gladding, 2011). Specifically, the American Counseling Association (ACA, 2005) *Code of Ethics* state that "Counselors actively attempt to understand the diverse cultural backgrounds of the clients they serve" (p. 4). Furthermore, the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2009) *Standards* note that a competent group leader understands multicultural counseling issues, as well as the impact of ability levels, stereotyping, family, socioeconomic status, gender, and sexual identity, and their effects on group members. Additionally, according to the *Association for Specialists in Group Work,* group leaders are responsible to seek out professional development opportunities to increase their understanding of the diverse needs of their clients (Thomas & Pender, 2007). Therefore, group leaders have a professional and ethical responsibility to learn about gay veterans and provide services diverse needs.

Leadership Style and Preferences

Considering the unique needs of both military personnel and sexual minorities each have their own needs, leading a group with gay veterans is not an easy task. It is important for the group leader to understand the "culture" of military life (Danish & Antonidies, 2009). This culture consists of many transitions and acculturations; such as going into combat, returning and adjusting to home, and then often being ordered overseas again. Veterans often claim that civilians just "don't get it" and might resist opening up to anyone, including counselors, who have not served themselves. Bonar and Domenici (2011) suggest that counselors should identify, appreciate, and become culturally competent to the population if they do not have a service background. For the purpose of this article, *competencies* are defined as a set of skills, dispositions, and behaviors that support counselors in promoting effective services to their group members (Parham, 2002). Multicultural counseling competencies include counselors' (a) awareness of their own beliefs and attitudes toward diverse cultures and people, (b) knowledge and appreciation of diverse cultures, and (c) counseling skills to address the diverse needs of their clients (Sue, 1992). Thus, a group leader requires knowledge and understanding of gay veterans, self-reflection when working with this population, and counseling strategies that foster their well-being.

The group leader needs to facilitate a trusting environment. More specifically, gay veterans experience a positive therapeutic relationship with those who self-disclose their own sexual identity as being gay, or more importantly have a gay-affirming attitude that appreciates the coming out experience as a continuous, lifelong process (Evans & Barker, 2010). Therefore, it is crucial that the leader employs empathy and unconditional positive regard to understand the unique needs and experiences of the group members.

An effective leader should possess a firm understanding of both military and gay culture, and will need to be cognizant of his/her leadership style. Gladding (2011) distinguishes between authoritarian and democratic leadership styles. For the purposes of this group, the leader can begin using an authoritarian style by setting an agenda and preparing structured activities, in order to gain respect and buy-in from all members. Then, as sessions progress, the leader potentially becomes more democratic, giving the group more authority on the directionality of the group.

Pre-Group Planning

Before the group begins, it is important to develop a plan to recruit members. A clever and positive name should be used, such as "Pride and Courage," symbolizing that both "coming out" and serving one's country involves both values. To advertise, counselors should consider partnering with a Veteran's Affairs office in a city with a high population of gay men such as San Diego, CA, San Francisco, CA, Orlando, FL, or Miami, FL. Promotion on the VA's website or in a newsletter may be a valuable recruitment tool. In addition, psychologists and counselors working for the VA's office should be aware of the group in order to make referrals. Another way to advertise the group would be at a large gay pride parade. With DADT repealed, several large cities have begun to include veterans as a part of their gay pride festivities. Once potential participants have been identified, a screening process should occur to identify appropriate participants. An ideal group member for this group will be: (a) comfortable self-disclosing that they identify as being gay, (b) open to discussing their experience being gay in the military and the impact it has had on them, and (c) those who would benefit from a group focused more on the merging of identities than working through trauma. This group is appropriate for any age cohort. Examples of screening questions include: (a) How would you describe your sexual orientation? (b) On a scale of 1 to 10, how far would you consider yourself to be *out of the closet*? (c) How might that number be different if you were not in the military? (d) What has been the highlight for you as you have transitioned home? (e) What has been challenging for you as you have transitioned home? (f) What would you hope to gain from a group experience, where you could talk about being gay in the military? From the screening process, six to eight members are selected to be a part of the group. Those not selected for the group, will be referred to individual counseling.

A Group Counseling Approach with Gay Veterans

Session One

The first session is crucial for establishing rapport with the group to ensure they will return for future sessions (Gladding, 2011). There are three main objectives to this initial meeting: (a) group members establish group rules and goals, (b) group members increase their understanding of the complexities of identity, and (c) the group leader identifies connections between group members to increase cohesion (Yalom, 2000).

The first session begins with an introduction, from the leader, about him/her self and the purpose of the group. The leader asks each of the members to share their name, involvement with the military, something about them outside of the military, and what they hope to gain from the group. After everyone shares, the leader shares more of his/her background, to model appropriate self-disclosure (Gladding, 2011), including if he or she has experience in the military and his or her sexual identity (Evans & Barker, 2010). This entire process should take approximately 15 minutes. Then, the leader facilitates a 15 minutes discussion focused on the rules of the group. A poster board with four rules is used to start the discussion: (a) maintain confidentiality; (b) challenge by choice (Walla, 2008), everyone has the right to speak or be silent; (c) respect one another; and (d) begin and end all session on time. The leader will go over each established rule in depth and then ask the group of they would like to add or amend any of the current rules.

Participants are reminded that they have the option of returning to these rules at any point of their six-week experience.

The leader introduces the main activity for the session, entitled *Identity Sashes* which is adapted from a similar activity focused on dimensions of identity (Gorski, n.d.). In this exercise, group members are given a long white strip of fabric in the shape of an honorary sash, as well as permanent markers. Participants are told they have ten minutes to draw on their sash as many aspects of "who they are" that they can think of. This can be in the form of pictures or words. After ten minutes have passed, the facilitator asks participants to put on their sash, and silently walk around the room, and look at what the other group members have created. Finally, after a few moments of silence, the leader will inform participants that they have five minutes to ask other members questions they have about their individual sashes.

The leader asks everyone to sit down to process the activity. Processing questions might include:

1. What was it like for you to mark different parts of your identity onto a sash?
2. What part of your sash are you most proud of? Are there any parts of your sash you wish you could erase?
3. What was it like for you to show your sash to others?
4. How was it for you to look at the sashes of others and not be able to speak? How does this relate to not being able to share a part of yourself due to *Don't Ask Don't Tell*?
5. What commonalities did you notice you had with others in the room? What differences did you notice?
6. Is there question you wished someone asked you about your sash, but didn't?

This activity has three purposes. First, by reflecting on all aspects of identity, group members might see that gay identity and military identity are part of one bigger picture. Rather than just being labeled as being a "gay man" and a "veteran," participants will begin appreciating the other aspects of their background and identity. Second, participants begin to see what they have in common with the other members of the group in and out of the military, and in sexual minority contexts. Finally, the silence within the activity symbolizes years of not being able to speak about personal realities due to DADT, which may facilitate a discussion regarding what is was like for them to be closeted in the military. After processing this exercise, the facilitator informs the group they have a homework assignment. Group members should reflect, and come prepared with three examples of life situations that involved both courage and pride in some way. Members will be asked to share some of these stories the following week.

Session Two

The second session has two objectives: (a) the group leader will facilitate camaraderie amongst the members to increase cohesion (Trivette, 2010), and (b) group members will recognize that serving in the military and being gay both take a great amount of courage and can lead to great pride. The second session begins with a check-in; the leader asks group members to share their reflections about their experience from the previous week. The leader should revisit the rules which are posted in the meeting room. Participants are given a chance to revise the list of rules. The group leader facilitates a discussion about the homework (to think of three

situations in their lives in which pride and courage were somehow involved). The group leader asks probing, counseling-based reflection questions to find meaning behind the stories that are shared (Yalom, 2005; e.g., When you disclosed you were gay to your family, how did feelings of courage and pride come up for you?)

The main activity of the week is entitled *Choose Your Squad,* adapted from an ethics activity (Blumenfeld, 1991). Group members are told that they are recruiters for the military, and have a list of twelve potential recruits; however, they only are able to select eight from the candidate list. This activity is done independently and in silence. The list of candidates includes:

1. Don – A 21 year old high school graduate who is not pursuing higher education due to lack of funding. He currently works at an auto repair shop, and has a daughter with his longtime high school sweetheart.
2. Jerry– A 19 year old sophomore in college, studying History. Kevin is the president of the Student Republican Club and is very politically active on campus and outspoken about the war.
3. Bill – A 29 year old physical trainer. He mostly dates women, but has recently came out as being bisexual.
4. Matt – A recent college graduate who majored in Physics. He finished third in his class and is feeling compelled to join the military because everyone in his family has served, and he wants to follow in his father's footsteps.
5. Joey – An 18 year old currently pursuing his GED, and is employed at a local fast food restaurant.
6. Tom – A 26 year old, successful advertising agent, who owns his own home, is married, and has two kids.
7. Andy – A 25 year old teacher, who openly admits he is gay and has had the same partner for five years. Andy dreams of giving back to his country.
8. Bryan – An 18 year old who has been home-schooled. He has never left his hometown and hopes serving will allow him to gain new experiences.
9. Timmy – A 26 year old writer and recovering alcoholic. Timmy has been sober for four years and feels as though he can handle the pressure of serving in the military.
10. Anthony – A 25 year old divorcee, whose wife left him last year due to his anger management issues. Anthony is currently in counseling , and feels joining the military would give him a new lease on life.
11. Cam – A 21 year old college senior with a 4.0 GPA. He has no criminal record, however he is on conduct probation with his university for smoking pot in the residence halls.
12. Steve – A 22 year old, outdoors adventure tour guide, who has been diagnosed with Attention Deficit Hyperactive Disorder (ADHD).

Group members have ten minutes to read over the list of potential recruits and make their selections. Then, the leader asks the group to come to a consensus, as a whole, a group of the eight selected recruits. The goal of this exercise is to build cohesion among the members of the group by giving them a task they can complete together (Gladding, 2011). In addition, the leader identifies any verbal or non-verbal attitudes members show towards Bill and Andy (the only two sexual minorities in this list of candidates). If any group members show resistance to specific recruits or the activity itself, this could be something to address after the activity is complete. Once the group has finished, they will have time to process. When asking questions, the leader

should also address any specific observations he/she made while watching the group work on this task. Examples of processing questions might include:

1. What criteria did you have for your squad when you made your selections on your own?
2. What criteria did the group have when they worked together to choose the squad?
3. What was it like for you to come to a consensus with each other?
4. Were there any decisions that you personally were not willing to compromise during this activity?
5. What decisions were easy for you to be flexible on?
6. What were your thoughts on selecting Andy and/or Bill?
7. How would you describe what is occurring in group right now?

After the processing is complete, the leader addresses questions or comments about what the group has done so far. The leader thanks the group members for their participation, and asks participants to think about various messages they have heard about being gay and being in the military for the following week's session.

Session Three

The group has been working with each other for two weeks; thus far, topics have focused mainly on group members becoming acquainting with one another, and building a sense of a team. This session's focus is on the individual journeys of the participants in the group. This session's primary objective is: group members will reflect upon all the various messages they have heard from different entities about homosexuality and military life. Similar to the previous two sessions, this session starts with a ten minute check-in focused on: (a) personal updates, (b) unresolved issues from the past two weeks, or (c) readdressing group goals.

The activity for this session is adapted from a diversity training (DOTS, 2011); it requires three long pieces of white paper taped on the walls around the room prior to the start of the session. Each piece of paper should have a continuum line with arrows; one side of the continuum, the word "AGREE" should be written, and on the other side "DISAGREE" should be written. The pieces of paper should be labeled with three different phrases: (a) homosexuality is a sin, (b) the military is fighting for a just cause, (c) gay men should not be allowed in the military. The content of the posters is hidden until the activity begins. Each group member is given three sets of four different colored stickers: red, blue, yellow, and green. The red stickers represent their own personal view, the blue stickers represent the views of one of their leaders in the military, the yellow stickers represent the views of their peers in the military, and blue represents the views of the general population. Participants stick their different colored stickers on each of the three continuums, one poster at a time based on how they think each party would respond to the statements. After group members finish, the facilitator processes the activity with the group. Suggested processing questions include:

1. What was it like for you to think about the opinions of different groups of people?
2. Which of the four colored stickers was hardest to place?
3. Which of the three statements were hardest to think about?
4. Are there any stickers on any of the boards that surprise you?
5. What is your reaction to the varying opinions of other group members?

The leader assigns homework for the following week. It was previously mentioned that often time gay men in the military had to put on a façade in order to fit in with DADT's standards (Burks 2011). These regulations forced gay servicemen, and likely many of participants of the group, to be silent when perhaps they would have liked to share a part of their own lives. If the law had been reversed early, and the law was *Do Ask Do Tell*, what questions would they have liked to been asked? Each of the participants should come prepared the following week with two or three questions they would have liked to been asked about their sexual minority status.

Session Four

Similar to previous weeks, the fourth session begins with a ten minute check-in and review of group rules. Then, group members are told that this week could be more challenging as they will be sharing more personal stories about their experience serving in the military under the DADT policy. The main objective for this session is: to continue reflecting upon what it means to be a gay veteran, and to begin the process of working through the feelings associated with being closeted in the military. The leader asks each of the group members to share their *Do Ask Do Tell* questions with the group, and explain why those questions are important to them. Then, each member has the opportunity to answer his/her own questions, as well as the questions of others, if they are comfortable. During this exercise, the leader observes, and asks reflective follow-up questions to each member to help them explore a deeper meaning (e.g. What would it be like for you to see this group member raise a child? Or, how might raising a child impact any of your roles in the military?"). This exercise helps group members to explore what is was like for them to keep a part of their identity hidden for so long, and to finally release it by talking about what it feels like to be a gay veteran.

Next, group members split into dyads and participate in a psychodrama exercise with the goal of reliving serving in the military under DADT (Blatner, 2002). One person in the role play pretends as though they are struggling with hiding their sexuality, while the other plays the role of a commanding officer. Each pair speaks as though DADT is still in effective. Then, after approximately five minutes, the roles are reversed. Following the role plays, the group leader asks members to reflect upon what it was like to have those conversations. After 10 minutes of reflection, the facilitator will assign homework for the week. With the intent of helping participants reflect upon progress made thus far, group members will be asked to write a brief letter to their commanding officer (White, 2000). This can be in the form of a persuasive response, political debate, or a "coming out" letter. Participants are reassured their letters will not be turned in, or shared outside of the group. These two activities are intended on creating two heightened emotional responses to being gay in the military.

Session Five

The first objective of this session is to invoke a reaction of what it might be like to come out in the military under the old DADT policy. This process might help group members work through unresolved feelings have toward hiding a part of themselves. The second objective will be to begin the termination process by returning to a topic that was discussed during the first week: identity. Only this time, ideally the disclosure will be much more personal and high risk,

reaching the goal of maximizing the *camaraderie* dynamic and working through the performing stage of the group (Gladding 2011). The leader begins by introducing the topic of termination during the check-in process. The leader summarizes what the group has accomplished and experienced so far, highlighting the various activities and significant moments that occurred throughout the first four sessions. The facilitator reminds the group that they only have two sessions left together. The group is provided an opportunity to share their initial thoughts and feelings about the group coming to an end.

After ten minutes, the group leader reminds the group that the previous week was probably fairly impactful to some, and begin processing by asking for initial reactions to what is was like to write a letter to their commanding officer. The leader invites and encourages participants to share their letters with the other group members. While members are sharing, the leader identifies similarities between the group member's different stories. After everyone has had the chance to share, the facilitator asks the group if anyone has questions about each other's letters, what it was like to share something like that with others, and the roles of pride and courage in this process.

The remainder of the group will be used for another activity. Participants are given a handout with very basic sketch of a house. Then, in the room, the leader will post a sheet of paper with the following identifying labels:

1. Windows – What do you allow everyone to see?
2. Door – Whom do you allow into your world?
3. Foundation – What are your core values?
4. Roof – What is your life's highest point?
5. Attic – What is something you keep hidden from others?
6. Basement – What is something you are saving for later?
7. Gutters – What brings you down?
8. Walls – What are some of your barriers?
9. Welcome mat – What is your message to the world?
10. Driveway – What do you hope to leave behind?

Participants are given ten minutes to label their house, in whichever way they would like, with the appropriate responses to the questions. Then, each member shares their house with the group. During sharing, the facilitator integrates the following processing questions:

1. How was it for you to identify the different areas of the house?
2. Which were most difficult and why?
3. How does this activity relate to being gay in the military?

After processing, the group leader reminds members they one session left. The group leader asks the group to wear comfortable clothes for the final session. A final homework assignment is assigned, to reflect on the use of courage and pride in their lives, after the group terminates.

Session Six

There are two main objectives for the final session: (a) group members create a stronger understanding of their experience of being a gay veteran in the past, present, and future; and (b) group members reflect on their experience in group and how they will integrate it into their lives.

After a brief check-in, the facilitator introduces the topic of a *jogging group* (Childers & Burcky, 1984) and describes this type of group as an integration of physical activity and reflection to increase awareness and group cohesion. This group can be adjusted to address the physical limitations of group members. Group members participate in a 15-minute mini jog around the neighborhood. During the jog, members receive three different prompts they need to think about: (a) for first five minutes they reflect on life serving as a gay man in the military under DADT, (b) the next five minutes, they reflect on what it meant for them to be a part of this group, and (c) the last five minutes, they think about what being a gay veteran looks like in the future. If at this point, any participant feels uncomfortable, the group leader asks them to reflect on these items individually. The leader accompanies the members on the jog, giving reminders when each of the five minutes have passed.

After the jog, group members write, in silence, about their reflections and experience during the jog. Group members are asked to share their experience and thoughts with the group. At this time, the leader incorporates the homework from the previous week (to think about what courage and pride looks like in the future). Participants will be given the opportunity to talk in further detail about what their identity looks like as a gay veteran.

Finally, as a closing exercise, the group leader asks the group members to share: (a) their personal highlight of the group, (b) recognized growth they have seen in other members, and (c) share what they have taken away from their peers. At this time, the leader shares his/her observations of the group and the progress that has been made. The leader thanks everyone for their participation and dismisses the group for the last time.

Assessing Group Effectiveness

The group's effectiveness can be assessed in several ways. The first is by the measure of retention in the group. Since this is an unexplored topic, and residual effects from DADT may occur, there will likely be resistance gaining members and keeping them for all six weeks. Retention can be assessed by comparing the number of participants who started and ended the group. A second way to assess the effectiveness of the group is comparing and contrasting participant messages and attitudes towards gay military identity throughout the process. For example, the group leader may compare responses to the *Identity Sash* activity in week one to the *In My House* activity in week five. Limited disclosure may occur in beginning sessions of group, but will increase due to cohesion between group members (Gladding, 2011). Finally, a third way to assess effectiveness is to compile and analyze responses during the closing activity in which participants share what they have taken from the group. The curriculum can be adjusted based on the feedback from group members.

Potential Limitations of a Group Approach

A group approach with gay veterans has limitations that should be noted before facilitation occurs. First, military identity and sexual orientation are both very complex issues. Addressing them both thoroughly in only six weeks is not easy and may not be possible. This group is not meant to be comprehensive, but rather a way for the population to begin merging two conflicting identities. Second, many military veterans come to counseling with other deeply

rooted issues than identity confusion. In groups like this, presenting issues such as PTSD, aggression, depression, or substance abuse is likely to arise. Since this group is not focused on those topics, counselors should be knowledgeable on how to handle such cases, as well as resources in the area to make effective referrals. Finally, the curriculum targeted in this paper is designed for gay men in the military. While there is certainly a need for lesbians, bisexuals, and other sexual minorities to experience group counseling, since many of the activities are designed to create camaraderie, this specific example caters best to gay men.

Conclusion

The proposed six week curriculum is one way to address the mental health needs of gay veterans when they are integrating their professional and sexual identities. Other groups have also faced challenges with being discriminated against in the military. Gender based discrimination in the Marines has led to poor physical health and higher levels of depression in women (Foynes, Shipherd, & Harrington, 2013). Several activities from the proposed curriculum could be used to address these issues. For example, the *Identity Sash* activity could be facilitated in the same manner due to its identity-driven nature. However, during the processing of the activity, facilitators could focus on women's identity formation by asking questions focused on how women expressed their gender while serving. The diversity activity could be adapted to other groups by changing the questions on the three strips of paper. Overall, counselors can use their professional training and experience to adjust activities with other groups or individual clients. It is critical that individual and group counselors are aware of the difficulties men face in merging military and sexual minority identities together. For many years, they have been forced to hide a major part of who they are. However, with the repeal of DADT, group counseling could play a crucial role to address the mental health needs of gay veterans.

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Serving the Children of Those Who Serve: School Counselor Service Provision to Children of Deployed Military Parents

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Abstract

This study examined the scope and level of school counseling practice with children of deployed military parents within public schools. The study also sought to examine perceived implementation outcomes of these services. Finally, this study explored the relationship of years of experience as a school counselor, school level, and distance from nearest Active Duty military installation with identification of the student population and resource utilization for children of deployed military parents. Only distance from the nearest Active Duty military installation was found to be related to student identification. No relationship was found between the variables presented and resource utilization.

KEYWORDS: school, counseling, children, deployment, military, parents

> *Military deployment doesn't just affect the soldier, but it's the family back home. Not just the spouse but children, too.* Dr. Gregory Gorman (Commander and Assistant Professor of Pediatrics, Uniformed Services University of the Health Sciences, in Salahi, 2010)

As a result of the Global War on Terror, military parents and their families experienced a series of deployments that collectively have lasted longer than World War II. Operations in Afghanistan and Iraq had a greater impact on military families as parental deployments have been longer in duration than previous conflicts. Service personnel also have undergone repeated deployments, and they have encountered hazards unique to these operations, such as improvised explosive devices resulting in traumatic brain injuries and increased prevalence of posttraumatic stress disorder Although all U.S. forces have departed Iraq and service personnel are expected to be withdrawn from Afghanistan in 2014 (Marlowe, 2011), the effects of these deployments will

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continue to impact the lives of returning veterans, spouses, and their children well beyond the termination of operations in the region.

The impact of operations in Afghanistan and Iraq has required both military and civilian communities to address the needs of families and children directly affected by deployment. As students begin to reorganize their lives before, during, and after deployment, assistance may be needed in dealing with these times of transition. School counselors are in an advantageous position to provide support to students of deployed military personnel (Armstrong, Best, & Domenici, 2006; Fenell, Fenell, & Williams, 2005) and to promote student academic and emotional growth and development (Mitchum, 1991). Schools can provide a sense of safety, security, and stability that otherwise may be lacking during these times of transition.

The Pentagon maintains a school system – the Department of Defense Education Activity (DoDEA) – that serves approximately 86,000 military children on bases around the world (DoDEA, 2011a), and over 26,000 of these students attend DoDEA schools in the United States and its territories (DoDEA, 2011b). However, a larger proportion of military children, approximately 500,000, attend regular public schools (APA, 2007). In contrast, nearly all children of National Guard and Reserve parents attend public or private schools. As such, military children can be found in many schools, not just on or around Active Duty installations.

Fenell and colleagues (2005) suggested that school counselors could best meet the needs of children of deployed military parents by identifying all these students within the school, and by helping school personnel to be familiar with the deployment cycle and of the behaviors that military students are most likely to demonstrate. The cycle of deployment has been defined and clarified (Pincus, House, Christenson, & Adler, 2008) as consisting of five distinct phases: pre-deployment, deployment, sustainment, re-deployment (or reunion), and post-deployment. According to current research, varying emotional symptoms and behavior may be evident for students during the different phases of the deployment cycle (Murray, 2002; Pincus et al., 2008; Stafford & Grady, 2003). During pre-deployment, deployment, and sustainment, elementary school age children (5-12 years) are more likely to experience emotions physically, and may complain about stomachaches or headaches, have difficulty sleeping, or have a loss of appetite (Armstrong, Best, & Domenici, 2006). They may increasingly whine, complain or become aggressive when they experience the stress of impending separation and concern for the safety of a loved one, or may revert to earlier behaviors (i.e., thumb-sucking, “baby talk,” clinginess, refusal to go to school) (Armstrong, Best, & Domenici, 2006). There may be an accompanying loss of interest in academic or peer-group activities. These school age children may also appear sad, angry or anxious (Pincus et al., 2008).

Likewise, middle and high school age adolescents (13-18 years) may present with increased somatic complaints or mood changes such as irritability, anger, aloofness, or apathy once the parent or parents are deployed. They may also demonstrate a lack of interest in school, peers, and extra-curricular activities, complain about teachers and situations in the classroom more than usual (Fenell, Fenell, & Williams, 2005), become rebellious or may be involved in physical conflicts with peers. Adolescents also may become involved in more risk-taking behaviors, becoming sexually promiscuous or initiating alcohol or other drug use (Pincus et al.,

2008) or may skip school, quit jobs, or refuse to do chores (Armstrong, Best, & Domenici, 2006).

As students begin to reorganize their lives after experiencing stress related to deployment, assistance may be needed in dealing with this time of transition. With the active components of the Armed Services, military installations provide a community of support, thereby supplying information as well as financial and physical resources. However, school counselors who are not in close proximity to a military installation may not be aware of students with deployed parents within their school. They may lack a formal process to identify these individuals (Fenell, Fenell, & Williams, 2005), and the ability to relate to the unique experience of children of deployed military parents (Fenell, 2005).

Although deployments have been happening for the past decade, researchers have only recently begun to address the need for developing school-based services for children of deployed military parents. Research programs sponsored by the Military Child Initiative of the Johns Hopkins Bloomberg School of Public Health and the Center for Study of Traumatic Stress Child and Family Program have investigated the effects of deployment directly on the individual child. However, there remains a paucity of research investigating school counseling programs as they relate to intervention with children of deployed military parents.

The purpose of this study was to examine the scope and level of school counseling practice with children of deployed military parents within the public schools. In addition, the perceived implementation outcomes of these services were examined. Finally, the relationship was examined between years of experience as a school counselor, school level, and distance from nearest Active Duty military installation with identification of the student population and resource utilization for children of deployed military parents. In order to achieve this purpose, the following four research questions were developed:

1. What procedures are used to identify children of deployed military parents in the public schools?
2. What school counseling services have been provided to children of deployed military parents?
3. What are the perceived outcomes of implementation of school counseling services to children of deployed military parents?
4. Are years of experience as a school counselor, school level, and distance from nearest Active Duty military installation related to the extent of identification of the population and school counseling service provision for children of deployed military parents?

Method

Participants

North Carolina was chosen for this study due to the large military presence within the state, including Fort Bragg, comprising almost 10 percent of the Army's active duty personnel (Pike, 2011, May 7). The participants in this study were selected from among school counselors within the 2,537 public schools of North Carolina as identified through the Education Directory School Systems Listings of the North Carolina Department of Public Instruction website

(NCDPI, 2008). Approximately 20% (500) of the schools were chosen through a combined method of purposeful and stratified random sampling. A purposeful sampling of 500 schools was chosen with 50% (250) selected from counties which host or adjoin a major active duty military installation. The remaining 50% were drawn from non-host/non-adjoining counties. The number and location of each active duty military installation was identified through the use of an atlas (Rand McNally, 2009).

A stratified random sampling of schools from within each pool occurred from elementary, middle, and high school levels. Forty percent (200) of these schools were selected from the elementary level, and thirty percent (150 schools) were chosen from each of the middle and high school levels, respectively. For this study, school counselors from middle and junior high schools were classified as "middle school" participants, while pre-kindergarten and kindergarten respondents were classified as "elementary school" participants. Schools that include more than one grade level (e.g., combined elementary and middle schools, junior high and high schools) were not used for the sake of this study. Within each selected school, one school counselor was requested to participate in the study (to be determined by the school counseling program members) by completing the mailed survey. One hundred seventeen counselors responded to the survey.

Instrumentation

Based on a review of the literature, the primary author developed an anonymous 14-item *School Counseling Services Provision Questionnaire (SCSPQ)*. The questionnaire elicited demographic information from the participant, to include the following: gender; age; ethnicity; number of years served as a school counselor; school level; approximate number of children of deployed military parents served since September 11, 2001; approximate distance of nearest Active Duty military installation from the school; and whether the participant has been contacted by military representatives concerning deployment issues. The instrument was then divided into sections corresponding to each of the research questions presented: Identification of Student Population; Service Provision; and Implementation Outcomes of Services. A pilot study of the instrument was performed by five certified school counselors from three states to clarify questions and to identify areas for improvement. One question was removed due to lack of clarity and partial redundancy, and stylistic formatting and clarity was improved for "yes-no" questions.

Procedure

After securing the University's Institutional Review Board's approval, the primary researcher mailed survey packets to the 500 selected schools. Each packet included (a) an information letter; (b) a copy of the SCSPQ instrument; and (c) a pre-paid, self-addressed stamped envelope. Each survey was coded to determine which schools had participated in the study. A school counselor from each program was asked to participate returning the completed enclosed survey to the researcher within 15 days.

After 15 days, a 20% response rate had not been reached for both of the sampled pools (host/adjoining or non-host/non-adjoining), and a follow-up invitation was mailed to the

remaining selected participants to complete the survey in the manner described above. Subsequently, a total of 117 school counselors responded to the survey, resulting in a 23.4% return rate.

Data Analysis

Data analysis was completed using the Statistical Product for the Social Sciences (SPSS) data analysis system. In order to address the research questions one through three, descriptive statistics were calculated. In order to determine if statistically significant differences in service provision exist by school levels, the number of years of experience of the participants, and distance from the nearest Active Duty military installation as to student identification and resource utilization for children of deployed military parents, a chi-square statistical procedure was used. To determine the amount of interaction of variables, follow up analyses using the Holm's Bonferroni method were also conducted.

Results

Of 117 surveys completed, 63 were from the host/adjoining samples and 54 from the non-host/non-adjoining samples. Respondents were 88% female and 10.3% male with 1.7% (n=2) not answering. The school counselor ages ranged from 23 to 66 with a mean age of 44.7 years. In terms of ethnicity, respondents self-reported as follows: 79.4 % White, Non-Hispanic; 15.7% African American; 0.9% Asian/Pacific Islander; 0.9% Hispanic, and 0.9% Multiracial with 2.5% (n=3) not responding. In terms of years of service, 49.5% had been school counselors for 0-10 years, 27.4% had worked 11-20 years, and 21.4% had served more than 20 years with 1.7% (n=2) not responding.

Identification of Student Population

Research Question 1 sought to determine whether school counselors had identified children of deployed military parents in the public schools. Eighty-three of 117 respondents to the study (72.2%) disclosed that they had provided school counseling services to children of deployed military parents since September 11, 2001. Additionally, 60.2% of school counselors who had worked with children of deployed military parents stated that they had served between 1 and 25 students within this population since September 11, 2001. Another 14.5% served 26 to 50 students during the same time period, while 25.3% served more than 50 students. Eighty-one percent of the participants within the host/adjoining group responded as having worked with the population under study, while 59.3% of school counselors within the non-host/adjoining group reported having worked with children of deployed military parents.

Research Question 1 also focused on the procedures used to identify children of deployed military parents in the public schools. School counselors were instructed to identify all procedures used to identify the population under study. Of those responding school counselors, 31.3% identified children of deployed military parents through registration procedures. A higher percentage of school counselors identified these children through student self-disclosure (74.7%), parents' report (73.4%), or teacher contacts (55.4%).

Research Question 1 also sought to identify student presenting issues. School counselors were instructed to select all issues used to identify the population under study. The most common reasons for intervention were student anxiety (61.4%), poor academic performance (60.2%), depression (51.8%), and family difficulties (47.0%).

Service Provision

Research Question 2 sought to determine what school counseling services have been provided to children of deployed military parents in the public schools. Survey queries further sought to determine which existing resources were used, and what intervention techniques were used with this population. School counseling services that were most commonly delivered to children of deployed military parents were as follows: (a) responsive services (91.6%) such as individual, small group, large group, or family counseling; (b) individual student planning, especially concerning personal goals (65.1%); (c) parent/counselor/teacher consultation (65.1%); (d) guidance curriculum (61.4%); (e) referral for outside counseling services (44.6%); and (f) systems support, such as Student Support Teams (SST)/Student Assistance Teams (AST) (43.3%).

Participants identified multiple resources used to assist children of deployed military parents, including other school counselors or educational professionals, such as school psychologists, social workers, teachers, and administrators (59%). They also relied on professional literature (54.2%), turned to the internet (51.8%), and purchased or used activity books (39.8%). Additionally, 34.9% of the participants reported using other existing sources including a county military school liaison, family readiness groups, military counselors, and workshops. Finally, 32.5% of respondents were provided materials by their school system or by the North Carolina State Department of Public Instruction (22.9%).

Additionally, participants identified specific intervention methods used to assist children of deployed military parents. Ninety-eight percent of respondents reported the use of active listening as the most common intervention approach used. Journaling and utilizing art were also identified as interventions used by 53.0% and 36.1% of the respondents, respectively. Relaxation methods, activity work sheets, bibliotherapy, and game play were used by 34.9%, 34.9%, 36.1%, and 26.5% of participating school counselors, respectively. Finally, 27.7 % of the respondents reportedly collaborated with community programs (4-H, Family Readiness Groups, etc.) as a form of intervention, as well as providing family counseling (27.7%).

Perceived Outcomes of Interventions

Research Question 3 addressed perceived outcomes of implementation of school counseling services with children of deployed military parents. Respondents were asked to complete a Likert-type scale of 1 to 5 (1 = Ineffective; 2 = Somewhat ineffective; 3 = Uncertain; 4 = Somewhat effective; 5 = Effective; NA = Not applicable) as to their perception of successful outcomes of the school counseling services provided to the children of deployed military parents. Table 1 presents the results of school counselor perception of responsive service outcomes for children of deployed military parents. Of the areas evaluated, active listening appeared to have been rated to have the most successful outcomes (mean = 4.53), followed by school counseling

services (4.28), and systems support (4.19). Other responsive services used with children of deployed military children included (in descending order of perceived effectiveness) included the following: individual student planning; community programs; family counseling; art; journaling; game play; guidance curriculum; bibliotherapy; relaxation methods; activity work sheet; and music. The least effective responsive services were sand tray (3.27) and puppetry (3.21).

Table 1
Perceived Implementation Outcomes of School Counseling Services

Descriptor	N	Mean	SD
Active listening	78	4.53	.801
Responsive Services	71	4.28	.897
Systems Support	57	4.19	.953
Individual Student Planning	66	4.18	.840
Community programs	36	4.17	1.000
Family Counseling	35	4.14	.879
Art	42	4.10	.850
Journaling	49	4.08	.932
Other(s)	17	4.06	.899
Game play	33	4.06	.998
Guidance Curriculum	50	4.00	.969
Bibliotherapy	33	3.91	.947
Relaxation methods	43	3.91	.921
Activity work sheet	36	3.75	1.079
Music	18	3.72	.826
Sand tray	11	3.27	1.618
Puppetry	14	3.21	1.477

Factors Related to Identification of Student Population and Service Provision

Research Question 4 sought to determine if years of experience as a school counselor, school level, and distance from nearest Active Duty military installation are related to the extent of identification of the population or resource utilization for children of deployed military parents. A two-way contingency table analysis was conducted to evaluate whether distance from nearest Active Duty military installation impact identification of the population of children of deployed military parents for the total respondent pool. The two variables were distance from the nearest Active Duty military installation with three levels (within 25 miles, 26-50 miles, and 51+ miles) and population identification with two levels (yes and no). Distance from the nearest Active Duty military installation and population identification were found to be significantly related, Pearson χ^2 (2, N = 117) = 9.30, p = .010, Cramér's V = .29.

Follow-up pairwise comparisons were conducted to evaluate the difference among these proportions. Table 2 presents the results of these analyses. The Holm's Bonferroni method was used to control for Type I error at the .05 level across all three comparisons. Pairwise differences that were significant were between the variables "Within 25 miles" and "26-50 miles" from an Active Duty military installation as well as the variables "Within 25 miles" and "51+ miles" from an Active Duty military installation.

Table 2
Results for the Pairwise Comparisons Using the Holm's Bonferroni Method

Comparison	Pearson chi square	*p*-value	Cramér's *V*
Within 25 miles vs. 26-50 miles	4.41	.036	.24
Within 25 miles vs. 51+ miles	9.28	.002	.37
26-50 miles vs. 51+ miles	0.72	.395	.10

The probability of a child of deployed military parents being identified in the school-age population was about 1.3 times more likely when the school counselor worked within 25 miles of an Active Duty military installation as opposed to working between 26 to 50 miles from an Active Duty military installation. Likewise, the probability of a child of deployed military parents being identified in the school-age population was about 1.1 times more likely when the school counselor worked within 25 miles of an Active Duty military installation as opposed to working 51 miles or more from an Active Duty military installation. As to the scope of resource utilization for the population under study, none of the variables were found to be significantly related.

Discussion

This study examined the scope and level of school counseling practice with children of deployed military parents within the public schools. In addition, the perceived implementation outcomes of these services were examined. Finally, the relationship was examined between years of experience as a school counselor, school level, and distance from nearest Active Duty military installation with identification of the student population and school counseling service provision for children of deployed military parents.

First of all, it is noteworthy to discuss the level of school counseling services provided to children of deployed military parents. It is apparent that not all school counselors are aware of the needs for provision of counseling services to children of deployed military parents. The current study revealed that 27.8% of participating school counselors has never provided

counseling services to those children of deployed military parents. Among the ones who have, the majority of the school counselors (60.2%) worked with less than 2.5 students per year on average over the last decade, during which deployment was most prevalent and there was an increased need for such services. These results may indicate that overall counseling services provided to children of deployed military parents at public schools have been limited.

Furthermore the results of this study indicate that that school counselors are more likely to take a passive role in identifying these students. Only 31.3% of those responding school counselors who had worked with children of deployed military parents identified the presence of children of deployed military parents within their schools through registration procedures. Otherwise, a majority of the school counselors reported that they were able to identify these children mainly through student self-disclosure (74.7%), parental report (73.4%), and teacher contacts (55.4%). These findings may indicate that school counselors need to take a more active role in identifying children of deployed military parents who may need help in school.

As far as the scope of school counseling services are concerned, it appears that school counselors who had worked with children of deployed military parents were comprehensive. They worked at all four domains of the ASCA Model: responsive services, guidance curriculum, individual planning and system support. School counselors who worked with children of deployed military parents also used diverse counseling approaches (e.g., journaling, artwork, relaxation, work sheet activity, bibliotherapy, game, and family counseling) at differed levels. They (27.7 %) also collaborated with community programs (4-H, Family Readiness Groups, etc.) as a form of intervention.

However, it seems that most services were provided in the type of individual counseling with emphasis on listening. Ninety-eight percent of respondents reported the use of active listening as the most common intervention approach used. The very approach was also reported to be the most effective approach with the population. Individual planning and parent/ counselor/teacher consultation followed next with 65.1% of respondents reporting to have implemented each of the interventions. In such a confusing time for the children, focused discussion on the career plan for the future for individual child and having them feel receiving parental and teacher's support would be an effective way of developing resilience among these children. Intervention effectiveness evaluations should be conducted by receiving feedback from children themselves in order to such evaluation outcomes to have high validity in the future studies.

While school counseling services provided are broad in scope, it seems that many school counselors operate with the counseling knowledge and skills that they possess when they work with children of deployed military parents. Seeking help from either professional colleagues (e.g., psychologists, social workers, teachers, and administrators) or information sources (e.g., professional literature, internet, and related materials) turned out to be less than 60 percent for the current participants. Furthermore, provision of relevant materials by school system or the State Department of Public Instruction was even less. Approximately thirty three percent of respondents reported that they were provided materials by their school system and 22.9% by the North Carolina State Department of Public Instruction. These findings may strongly suggest that an active action needs to be taken at both collective and individual levels to provide school

counselors with professional development opportunities and with relevant resources in order to refine their knowledge in understanding the target population and the best ways to work with them.

The current study revealed that the most common reasons for intervention with children of deployed military parents were student anxiety (61.4%), poor academic performance (60.2%), depression (51.8%), and family difficulties (47.0%). Study findings such as this seem to support previous research concerning student symptomology during deployment. During the actual deployment phase, spouses and children may report a number of emotional and physical symptoms, including difficulty sleeping, numbness, anxiety, loneliness, feeling overwhelmed, disorientation, sadness, depression, and anger (Armstrong, Best, & Domenici, 2006; Fenell, Fenell, & Williams, 2005; Murray, 2002; Pincus et al., 2008; Stafford & Grady, 2003). As such, this period in deployment may represent the necessary time to provide school counseling services and interventions to children of deployed military parents.

In addition as it can be easily speculated, results of the study implied that children of deployed military parents were more likely to be identified within a school that is located within 25 miles of an Active Duty military installation. The location of the school was the only variable which demonstrated a difference in the level of identification of children of deployed military parents among the three variables studied; school level, counseling experience and distance from the nearest Active Duty military base. This may indicate that school counselors working beyond 25 miles radius of Active Duty military installation need to be regularly reminded of their needs for being conscientious about identifying and helping children of deployed military parents at their schools.

Limitations

Although collecting data in survey research through mailed self-report questionnaires is common, one notable limitation of this approach concerns the rate of response and return of completed surveys. After an initial mailing and a follow-up letter, a 23.4% return rate was acquired. In a comparative analysis of 141 papers including 175 different studies in five international/national journals, Baruch (1999) found that the average response rate was 55.6 with a standard deviation of 19.7. As the current study falls outside of the suggested return rate, the adequacy of the study results may be in question. Likewise, only one state was surveyed through this study. Although the state does contain six military installations (including Fort Bragg – the largest in the U.S.) because the study was conducted only in North Carolina, the results may not be generalizable to other states or regions.

Also, the survey was a self-report instrument and, therefore, the responses of individual counselors representing the programs at each school may have been subjective in nature and could have impacted the findings of this study. Likewise, school counselors may have also attempted to present responses in a positive light either consciously or subconsciously, due to the need for social desirability – to appear to colleagues as doing what is expected within the profession rather than what actually occurs. This too may have impacted the findings of this study.

Additionally, this survey was developed by the author for the purpose of gathering information as to the status of school counselor service provision to children of deployed military parents. Sufficient, reliable measures for this construct do not presently exist as such and the School Counseling Services Provision Questionnaire was created. Although the instrument was submitted to for review of consistency and clarity prior to its use, issues of reliability and validity have not been externally confirmed.

Implications for Practice and Research

Practice Implications

Units within the National Guard, Reserve, and Active Duty components of all branches of the military – Army, Air Force, Navy, and Marines – have been deployed in support of operations in Afghanistan and Iraq. As such, military communities are no longer limited to the areas near a military installation; service members may be mobilized from anywhere in a state. The use of registration procedures is recommended to identify this population within all of the public schools, not only in North Carolina, but in all states. As suggested by Fenell, Fenell, and Williams (2005), "school counselors are the key to designing school-wide programs to support these students" (p. 129) and identifying the population early, even before issues relating to deployment occur, can help increase trust between school counselors and military families and promote the building of pre-therapeutic relationship with children of deployed military parents.

In order to be effective during periods of parental deployment, school counselors should have an understanding of the cycle of deployment and have an awareness of student behaviors during this period of vulnerability (Fenell, Fenell, & Williams, 2005). According to Kennedy (2007), "by being aware of this cycle and the emotional ramifications of each stage, school counselors and educators can lessen the impact of separation on these students and identify issues before they reach a crisis point" (p. 16). The cycle of deployment has been defined (Morse, 2006; Pincus et al., 2008) and its use by school counselors can assist children of deployed military parents during such periods of vulnerability. Understanding which behaviors and symptoms may occur during particular stages of deployment can assist in prompt and appropriate interventions with these students. As such, school counselors (and school counselors-in-training) should expand their knowledge base in order to provide competent, ethical service to all students. Such training can be acquired through one of the free workshops presented around the country by the Military Child Education Coalition (MCEC, 2012), or through military-focused learning institutes offered by state or national counseling conferences, such as the American Counseling Association (ACA, 2012).

Recommendations for Future Research

Although this study has focused on the services provided by school counselors to children of deployed military parents, it was not designed to take into account the individual experiences of those under study, namely school counselors and students. One or more qualitative studies using an interview approach focusing on the school counselor, military child, and even military family experiences would better inform not only the counseling profession but also assist academic and other professionals working with the military community.

Conclusion

As a result of continuing deployments and the lasting effects of combat to service members, there will remain a need for counseling assistance for this population and their families. Deployments have been linked to a variety of symptomatic behaviors in school-aged children including increased anxiety, depression, and academic difficulties. School counselors are in an advantageous position to identify and assist children of deployed military parents during periods of vulnerability such as deployment. Results of this study seem to indicate that school counselors are more likely to identify students in this population if they live near a military installation and that a variety of services have been provided to assist this population with varying degrees of perceived success. Further research is necessary to determine the effectiveness of the approaches and services provided which were reviewed in this study. School counselors have the opportunity to make a lasting, positive impact in the lives of children of our service members and veterans not only in the present but throughout their school experience.

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The Military Success Model: An Introduction

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Abstract

The Military Success Model (Duchac & Stower, 2011) utilizes a three phase approach to treatment of service members and their families. Encompassing factors such as life concerns, family issues, stress, finances, and the toll of multiple deployments, this model can be integrated into most strength - based counseling theories. The acronym Sundae Cup represents a model of approach focusing on elements of the service member that are important to understanding when treatment is sought. This model further recognizes the impact of developing a new identity based upon past experiences.

KEYWORDS: military, service members, military families, mental health

According to the Department of Veterans Affairs (DVA, 2012), nearly 1.7 million service members have been deployed to Afghanistan and Iraq during the past 11 years. Nearly three hundred thousand are estimated to potentially suffer from Post-Traumatic Stress Disorder (PTSD), major depression, or generalized anxiety disorder. Still others who have been physically injured may suffer from Traumatic Brain Injury (TBI). Any of these illnesses can be debilitating and cause a reduction in an individual's functioning as well as a significant disruption in the family unit. The purpose of this brief paper is to discuss the background and significance of these disorders as they relate to veterans, active duty service members, and their families. Moreover, an introductory approach termed the Military Success Model (MSM) will be introduced and presented as a treatment option when working with the military population (Duchac & Stower, 2011).

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Background Information

The Department of Veterans Affairs (DVA, 2012) indicates that there are approximately twenty-five million living veterans with seven and a half percent of these being women. Of these 25 million there are 7.2 million who are enrolled with veteran's services at any given time; of these, 5.5 million receive healthcare services and 3.4 million are receiving financial benefits. As of 2007, there have been nearly eight hundred thousand service members from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) who are eligible for medical services (DVA, 2012). In 2007, the average age for veterans was 60 years old with the average for males being 61 and the average age for females being 47. There are approximately 7.9 million veterans from the Vietnam War representing the largest current contingent of veterans. Ethnic backgrounds vary, with Caucasians accounting for nearly 81 percent of veterans, African Americans 11 percent, Hispanics 5.6 percent, Native Americans .8 percent, Pacific Islanders 1.8 percent, and other nearly 1.3 percent. It is estimated that on any given day there are 150,000 homeless veterans residing on the streets across America. Veterans are estimated to be two to three times more likely than the general population to be susceptible to suicide (DVA, 2012). The DVA Inspector General estimates that the rate of suicide may be up to 7.5 times more likely than the general population with nearly 1000 suicide attempts occurring in DVA facilities each day.

Post-Traumatic Stress Disorder (PTSD)

One area or criterion needed for a diagnosis of PTSD is the recollection of the stressor. From a social determinant perspective, it is possible that past recollections from a childhood trauma could contribute to a future diagnosis of PTSD, thus predisposing an individual to become more susceptible to stressors later on. In other words, if a service member had experienced a significant stressor, and then experienced another stressor during the time of war, the individual could potentially receive a PTSD diagnosis. Other social determinants to be considered are those from a lower socioeconomic status who may be more prone to enter the military service in the first place. As an example, those from families with a lower financial status appear more likely to join the military than those from families with a higher income (Lutz, 2008). From an environmental determinant perspective the agent of change is the environment and the war that is present. In combination these two factors contribute to the overall difficulty and thus the existence of PTSD.

There is no known cure for PTSD, but with time and treatment the symptoms seem to subside. Yoder et al. (2012) conducted a study examining PTSD in veterans from the Vietnam War, the first Gulf War, and the wars in both Iraq and Afghanistan. In this study, it was determined that prolonged exposure therapy was equally beneficial to all groups. There were 12 participants in the overall study. Prolonged therapy includes four specific components: A psycho-educational component related to how people deal with stress, a self-assessment of one's current stress level, exposure in-vivo to stressors from the given war for an extended period of time leading to desensitization, and finally re-exposure to see if there is a difference to the first response (Yoder et al., 2012).

In another PTSD related study conducted by Cigrang et al. (2011), best practices were examined among active duty soldiers. In this study it was determined that the preferred method for treatment was cognitive behavioral therapy. In cognitive behavioral therapy, participants were asked to examine their thought patterns. Overall, this study sample consisted of 15 original participants with two dropping out when memories surfaced. The study concluded that one-third of the participants saw a reduction of symptoms to the level where they no longer met the criteria for a PTSD diagnosis. In the other cases the symptoms were significantly reduced based upon the results from the PTSD Checklist - Military Version. These results suggest that the application of CBT with active duty service members would be beneficial.

McLay et al. (2011) conducted a study that examined virtual reality therapy as it related to those active duty soldiers experiencing PTSD. In this study, participants were presented stimulation similar to what would be experienced in a combat situation for the purpose of desensitization. Given this type of presentation, it was determined that 70 percent of the participants saw a thirty or more percent reduction in symptoms based upon a clinician rating scale. The given results were much better than the 30 percent rate of success based upon previous treatment modalities. Though the sample size only consisted of ten participants the results suggested promise.

Buchanan (2011) conducted a qualitative study that was participatory based. In this study, 34 couples were interviewed to determine the impact that PTSD resulting from war had on intimate partner relationships. This study was conducted around military bases in North Carolina and was done in partnership with a local community center and university. The idea behind this type of collaboration was that as members of society, everyone has an obligation to assist and educate our active duty service members and to a larger extent all veterans who have defended and supported the United States. Nearly two thirds of those who participated in the study had received no formal education regarding PTSD and its overall impact until the study took place. Active duty military personal returning from Iraq and Afghanistan may also be challenged by other mental health issues such as depression, anxiety and/or a dual diagnosis of traumatic brain injury. Co-morbid issues such as depression, anxiety, and mood swings tend to be more prevalent in service members who are recently returning from the war zone. Major depression and anxiety may be experienced by a military member for many reasons; separation from family, fear of the unknown, deployment into a war zone, multiple deployments, injuries, or reintegration issues such as not knowing what to expect from friends, family members, or a community upon returning (Slone & Friedman, 2008; Whealin, DeCarvalho, & Vega, 2008).

Major Depressive Episode

Major depressive episode can be a debilitating and life threatening issue and it is treatable. According to the DSM-IV-TR (APA, 2000), individuals must meet specific criteria before a diagnosis is made. Five of the following indicators must be met within a two-week timeframe and have impinged the individual's functioning in some manner: depressed mood, lack of interest or pleasure, weight loss or weight gain, insomnia or hypersomnia, psychomotor agitation, fatigue or loss of energy, feeling or worthlessness or inappropriate guilt, not able to think or concentrate, and recurrent thoughts of death (suicidal ideation). If the individual meets at least five criteria, the diagnosis would then be major depressive disorder (APA, 2000).

Generalized Anxiety Disorder

The individual who exhibits symptoms of generalized anxiety disorder will have to meet certain criteria set forth by the DSM-IV-TR (APA, 2000): excessive anxiety or worry concerning several events for six months, several times a day, difficult to control the worry, anxiety and worry are associated with three of more of the ensuing symptoms (restlessness/feeling keyed up, being easily fatigued, difficulty concentrating, irritability, muscle tension, sleep disturbance). The emphasis in not limited to an Axis 1 disorder, the anxiety/worry causes distress in the ability to function in daily life and is not caused by substance abuse or a m medical condition (APA, 2000). The following studies discuss treatment options for military personnel.

Wesson and Gould (2009) posit that United Kingdom military clinicians use eye movement desensitization and reprocessing therapy (EMDR) for treating personnel with symptoms of acute stress, witnessing traumatic events or who have been diagnosed with PTSD. They further acknowledged this intervention is offered to active duty military personnel after noticing the onset of symptoms or the traumatic event usually within a two-to-four week time span. EMDR enables the individual to process the issue without having to tell their story. Wesson and Gould (2009) reported positive results with the individual requiring a minimal amount of treatment.

In October of 2004, the Department of Veterans Affairs and the Department of Defense approved EMDR for the use with United States military members. According to Dr. Hurley (2012), EMDR was originally approved for treating PTSD but has since been proven to work well with individuals diagnosed with depression and/or anxiety.

Cognitive behavioral therapy has long been utilized by the military. A study completed by Stecker, Fortney, and Sherbourne (2011), based on cognitive behavioral therapy created a safer atmosphere than traditionally received CBT with less of a stigma for military members requiring treatment for mental health disorders. The first session is approximately fifty to sixty minutes long. During this time a clinician provides an overview of what this treatment will "look like." The clinician discusses the negative core beliefs and self-talk (inner critic). This initial session begins to change the way the individual views the treatment process. Subsequent sessions utilized the same structured intervention though content was changed based upon participant.

Schmitz et al. (2012) completed a study regarding troops deployed to Iraq and Afghanistan between 2006 and 2007 who requested assistance for mental health disorders developed while in a combat zone. These soldiers were treated in a traditional manner; receiving prescribed medications, counseling, behavior modification, and psycho-education. Transportation and the challenges of war coupled with operational need often taking priority made mental health treatment in a combat zone very challenging, but still allowed the researchers to note the need and affirmation of treatment. Access concerns were noted to be similar for those in need both off base and even with those residing on the same base as the practitioner. Overall, PTSD and anxiety disorders were the most commonly diagnosed cases. Quick mental health encounters are considered essential and hopefully aid in the treatment of post-deployment conditions.

Traumatic Brain Injury with Co-morbid Issues

A study provided by Schneider et al. (2009) indicated soldiers returning from the current war(s) diagnosed with a traumatic brain injury will have co-existing issues cognitively, emotionally, behaviorally, and psychosocially. All health care providers need to be ready to care for our veterans. While this type of injury is multifaceted and challenging to work with, it is important that health care providers establish a multidisciplinary partnership regarding the individual's treatment. This team would provide evidence-based treatment unique to this one individual and would consist of many professionals such as doctors, mental health professionals, occupational, speech and physical therapists, and nurses. Treating patients from a multidisciplinary approach will enable several professionals to share treatment options and concerns.

The Military Success Model (MSM)

The military success model (Duchac & Stower, 2011) is a new approach to working with service members and family members making use of inherent strengths and experiences. Further, the level of anxiety seems to decrease during the session as the client actively participates. Stower (2010) identified an approach used in counseling sessions with military families that provide clients with the ability to relate particular concepts in their life through the use of acronyms created for each stage of deployment and the reintegration process. The MSM utilizes a SUNDAE CUP as an acronym to identify the experience of the service member. Each letter is represented below:

S- Sense of Duty
U- Uniqueness of experience
N- Noteworthy achievements
D- Determination
A- Apprehension to engage
E- Empowerment

C- Courage/Capability
U- Understanding/ utilization
P- Poise

Making use of this acronym provides a distinct way of understanding and conceptualizing the unique experience of the given service member and how this interacts with the family. This model is broken up into three phases of counseling. Each phase lasts three to four weeks.

Phase I

Phase one is a recognition phase and consists of the first three to four sessions of the therapeutic relationship. During this time frame, factors that were influenced by deployment come into perspective. Symptom presentation and the initial exacerbation of symptoms is observed. During phase one a core relationship is established and the service member begins to trust the counselor. The overall goal of the first phase is the recognition that a problem exists.

Phase II

The second phase of the MSM consists of another three to four counseling sessions. This phase is referred to as the challenge phase and is characterized by the notion that there is a problem and help is needed by a trained professional to solve the areas of concern. This phase allows for the integration of differing theories, but a focus on strengths would be consistent with the ideas that the military tries to incorporate in its service members. The overall goal of phase two is awareness.

Phase III

Phase three lasts five to six sessions and is where therapy is actually taking place. The goal of the final phase is to promote and support family unity. The counselor during this phase is making use of the acronym to its extent and has a fuller picture of the deployment experiences of both the service member and the family members. The acronym is so important at this phase because it is a way of working through the cognitive and emotional context of the given sessions.

Conclusion

There have been nearly two million service members that have been deployed to Iraq and Afghanistan. With the return of these service members there has been a plethora of illnesses to include PTSD, major depression, generalized anxiety disorder, and traumatic brain injury. The military success model represents a method of framing and conceptualizing a service members experiences utilizing the acronym SUNDAE CUP in working with the member and family members. This model operates within three phases and in the end focuses on success utilizing the strengths of the clients as a perennial base. To date this suggested paradigm has been utilized informally with noted success as specified by positive participant comments and recommendations for a formal research review.

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Logotherapy to Treat Substance Abuse as a Result of Military-Related PTSD

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Abstract

This paper proposes a theoretical approach to using Viktor Frankl's (1970) logotherapy to treat substance abuse that occurs as a means of coping with military-related post-traumatic stress disorder (PTSD). Logotherapy assumes that human nature revolves around seeking meaning; unfortunately, military-related PTSD can result in the development of perceived purposelessness (Southwick, Gilmartin, Mcdonough, & Morrissey, 2006). As a result, substance abuse occurs as a coping mechanism (Somov, 2007). One study of the United States military found that substance abuse is the most prevalent concern (NIDA, 2011). While cognitive interventions merely extinguish the destructive behaviors which act as a coping mechanism (Buckenmeyer, Didelot, & Hollingsworth, 2012), logotherapy has the potential to ameliorate the substance abuse, while replacing it with personally meaningful pursuits (Somov, 2007).

KEYWORDS: logotherapy, substance abuse, PTSD, military

It is abundantly clear that the terrorist attacks of September 11th, 2001 have forever altered both the landscape and priorities of American culture. Over the last 11 years, the United States has been fighting in a Global War on Terrorism. Our warriors in the Armed Forces often embark on multiple military deployments to Forward Operating Bases (FOBs) in Iraq, Afghanistan, and elsewhere in the world in defense of our nation. Unfortunately, many return home with diagnosable, military-related PTSD. The debilitating symptoms of PTSD, particularly when occurring as a result of combat, can lead to the development of co-morbid substance abuse. Only after ten years of war is it becoming clear that substance abuse is quickly becoming an epidemic within the US military, and current cognitive approaches to treatment only temporarily modify service-member behaviors (NIDA, 2011). It is time to begin assessing the effectiveness of humanistic approaches for the treatment of substance abuse that not only lead to recovery, but include skills that encourage recovery maintenance. One such humanistic approach to substance abuse recovery, particularly when it co-occurs with military-related PTSD, is Viktor Frankl's (1970) logotherapy.

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Scope of the Problem

According to the National Institute on Drug Abuse (NIDA) in 2011, the Millennium Cohort Study (MCS), the largest longitudinal assessment ever conducted, is currently in the process of tracking mental health issues with service members from 2001 to 2022. This study is beginning to find that, while there has been a marked decrease in tobacco consumption and illicit drug use, alcohol remains the most prevalent problem in the United States (US) military. One explanation for why alcohol remains an epidemic in the US military is that, according to the MCS, many service members report concerns about substance abuse; however, few are referred for treatment. They also found that 27 percent of US Army soldiers who saw combat during their deployments developed diagnosable substance abuse within as little as three months of returning home (NIDA, 2011). When analyzing co-morbidity of mental disorders with substance abuse in the military, Kennedy (2009) found that 20 percent of service members with diagnosed PTSD have driven while intoxicated and have been involved in alcohol-related domestic violence.

Alcohol was involved in 30 percent of fatal suicides and as many as 45 percent of non-fatal suicide attempts in the US Army between 2003 and 2009 (NIDA, 2011). NIDA also identified that Reserve/Guard personnel, as well as those Active Duty personnel who are younger in age and have experienced combat during a deployment are at the highest risk for developing diagnosable substance abuse. Interestingly, according to the Diagnostic Statistical Manual of Mental Disorders IV-TR (DSM-IV-TR; APA, 2000, p.466), young age is an identified risk factor for the development of PTSD. Unfortunately, younger service members who experience combat while on a deployment may be at an extremely high risk of developing a co-morbid substance abuse disorder when diagnosed with military-related PTSD.

According to Kennedy (2009), the US military's substance abuse problems have grown to such extremes that the government has been unable to provide enough mental health professionals to meet the demand. As a result, the US Army developed a virtual *video doctor* that service members can access online (Kennedy, 2009). This video doctor, according to Kennedy, determines an appropriate counseling response based on the answers given by service members to pre-determined questions related to substance abuse; remarkably, this site receives as many as 20,000 hits per day. The MCS has determined that there is an apparent need for new interventions, as current cognitive approaches lead to relapse (NIDA, 2011). The US Army has begun creating smart-phone, bio-feedback applications that can predict and warn service members in real-time when relapse becomes likely, as indicated by measured stress patterns (NIDA, 2011). While this project shows the government is attempting to address the substance abuse epidemic, it is not in accordance with the military's preference for interventions that are cheap, simultaneously accessible to a high number of individuals, proven, easy, and immediate (Kennedy, 2009).

Logotherapy

Viktor Frankl (1979), the creator of logotherapy, faced some of the most egregious situations in the history of the world as he was placed in a Nazi concentration camp as a result of being Jewish. Though he was an existential psychiatrist prior to being imprisoned, he was able to put his ideals to the ultimate test, finding meaning in a seemingly meaningless situation (Frankl,

1979). He asserts that though we cannot always change the specifics of what has or may occur, we can accept the challenge and responsibility to create meaning in spite of uncontrollable circumstances by recognizing our freedom of will (Frankl, 1979). This idea, that we cannot always control external forces that act on our lives; but rather, we can find growth and meaning as a result of these forces is one of the main tenets of existential psychotherapy (Yalom, 1980). Rollo May (1975) experienced a difficult childhood, two unsuccessful marriages, and serious illness, the result of which he learned to appreciate in terms of their potential to develop educational and attitudinal values. It was as a direct result of these tough situations that May (1975) decided that for humans to grow, they must not be afraid to face the difficult situations as they are opportunities for growth. May argues that by avoiding these trials, people deny themselves the potentials for finding purpose and meaning.

Logotherapy is based around the idea that with meaning comes amelioration of existential angst, the cause of most neuroses (Frankl, 1979). The premise is that by empowering clients to discover meaning, they will be armed with the presence of mind to overcome any difficulty life presents them (Frankl, 1979). Logotherapy uses techniques such as paradoxical intention, where the client learns to wish for the very thing they are afraid of most, under the assumption that when one focuses on a fear, anxiety about that specific phobia begins to co-occur (Frankl, 1979). By wishing for what you fear, you eliminate the anticipatory anxiety associated with the feared event or action (Frankl, 1979). Another logotherapeutic technique, entitled dereflection, works under the premise that humans have a capacity for transcendence and for self-detachment (Frankl, 1979). Hyper-reflection occurs when an individual constantly reflects on his or her current situation and becomes self-absorbed (Frankl, 1979). Dereflection aids the client to focus less on his or her self and more on other people or his or her goals and meaning potentials (Frankl, 1979). This is important because it grounds the client in the here-and-now rather than dwelling on past events (Frankl, 1979). Dereflection has been used effectively in group and individual counseling environments where the members are discouraged from focusing on victimization, but rather, are encouraged to discuss their traumatic experiences in terms of how they promote meaningful, attainable goals (Reichenberg & Seligman, 2010).

Rationale

According to the DSM-IV-TR (APA, 2000, p. 467), PTSD involves persistently re-experiencing the traumatic event. Assuming this 'intrusive recollection' is unavoidable, veterans experiencing this may develop substance abuse as a means of coping. Another symptom according to the DSM-IV-TR (2000, p. 467) is, "persistent avoidance of stimuli associated with the trauma and a decrease in responsiveness." Avoidance might be another coping mechanism which might explain the NIDA (2011) finding that at least 27 percent of veterans who experience combat develop alcohol abuse within three months of returning home. Increased arousal, often in the form of autonomic nervous system hyperactivity, is another identified symptom of PTSD, according to the DSM-IV-TR. Hyperarousal may catalyze alcohol abuse due to its property as a depressant, acting to mitigate the symptom and return the individual to a state more closely resembling homeostasis. The final requirement for a diagnosis of PTSD, in accordance with the DSM-IV-TR (APA, 2000, p. 467), is that the aforementioned symptoms last a minimum of six months and cause, "…clinically significant distress or impairment in important areas of functioning." According to my hypothesis, the addictive component of substance abuse may lead

to repeated use and subsequent continued avoidance. This continual avoidance through substance abuse may correlate with the length and severity of PTSD symptomology, in accordance with my theory.

According to Southwick, Gilmartin, Mcdonough, and Morrissey (2006), traumatic events may also lead to a decrease in perceived meaning and hope which provides evidence that it may also increase isolation and decrease positive emotionality. These symptoms are in accordance with Frankl's (1978) tragic triad, which consists of anxiety due to fears of death as a result of living a life of perceived meaninglessness, suffering in response to the trauma, and guilt which often manifests in the form of survivor-guilt. These symptoms, within my theory, may lead to coping behaviors to deal with the *existential vacuum* left in the wake of Frankl's tragic triad, often manifesting in the form of substance abuse. The substance abuse likely leads to a further decrease in perceived meaning and hope, increased isolation, and even less positive emotionality. Logotherapy would, in effect, increase perceived meaning and hope through the identification of meaning potentialities, decrease isolation through relational meaning, and an increase in positive emotionality, thus countering Frankl's (1978) tragic triad. The aforementioned changes are in alignment with Frankl's (1978) tragic optimism, wherefore, the individual transforms death anxiety into an acceptance of the responsibility to lead a life of meaning; suffering transforms into a human achievement and guilt into meaningful action towards a life of purpose.

As the prevalence of alcohol abuse in the US military continues to grow as an epidemic, in accordance with the preliminary findings of the MCS (NIDA, 2011), mental health professionals need to be prepared to implement new interventions in accordance with the MCS's findings that current cognitive approaches are not effective in the long-term as a result of relapse (NIDA, 2011). According to Buckenmeyer, Didelot, and Hollingsworth (2012), cognitive approaches lack the existential analysis of meaning potentialities required for relapse prevention. They go on to assert that cognitive approaches such as cognitive behavioral therapy (CBT) merely modify the client's behaviors to end his or her substance addiction; however, the addiction acts as a coping mechanism that, once removed, results in almost inevitable relapse if it is not replaced with new ego-defenses.

In *The Will to Meaning*, Frankl (1970) discusses evidence that supports logotherapy's effectiveness in treating both substance abuse disorders as well as severe drug addictions. He discusses the findings of a logotherapy addictions counselor by the name of Alvin Frasier who worked at the in-patient Narcotic Addict Rehabilitation Center in Norco, California. According to Frankl, in 1966, Frasier became the only counselor at this facility with a three-year, 40 percent success rate, as compared to the facility average of 11 percent. In this case, success was defined by the percentage of clients not returning within one year of release. Interestingly, Frasier was the only counselor not using cognitive interventions; instead, he exclusively used logotherapy (Frankl, 1970). There is not, however, any information provided regarding the number of clients Frasier saw in comparison to the other clinicians, nor did it mention the types of addictions logotherapy worked to ameliorate. Their success is, however, in conjunction with the findings of other counselors who exclusively use logotherapy to treat substance and drug abuse addictions such as Somov (2007) and Buckenmeyer et al. (2012) who provide evidence towards similar success.

According to Frankl (1978), logotherapy would act to eliminate the addictive and destructive coping mechanism and replace it with existential meaning in the form of progress towards meaningful pursuits, love of another, or post-traumatic growth. Logotherapy can, in effect, empower the client to fill the 'existential vacuum' left in the wake of military-related trauma that had once been occupied by substance abuse. If the veteran undergoing logotherapy for the treatment of substance abuse also received logotherapy for his or her military-related PTSD, continuity of care may factor positively towards recovery. Logotherapy requires psychoeducation of its principles regarding the potential sources of meaning and if the client has already been 'primed' in this subject matter, he or she may fair better in similar treatments for substance abuse.

Measurements

Logotherapy's use of abstract concepts such as meaning and purpose makes it difficult to provide adequate pre- and post-diagnostic measures to gauge client progress. What further entangles this task is being able to provide a standardized measure of meaning and purpose that adapts to the innumerable possibilities presented by clients. Crumbaugh and Maholic (1969) developed the Purpose in Life (PIL) psychometric instrument which provides a standardized measurement for current client perceptions of meaning and purpose. In 1977, Crumbaugh followed up the PIL test with the Seeking of Noetic Goals (SONG) assessment which measures the degree to which a client is currently striving to ascribe meaning and purpose in his or her life. These two tests were created to be used in conjunction with one another as pre- and post-measures for logotherapists for assessing their clients and it works under the assumption that the SONG and PIL are negatively correlated. This makes sense because the more the client perceives meaning and purpose in the client's life; the less the client would be actively seeking these goals (Cousins & Reker, 1979).

In 1979, Cousins and Reker conducted an analysis of the construct reliability and validity of both the PIL (Crumbaugh & Maholic, 1969) and SONG (Crumbaugh, 1977). The results confirmed that both the PIL and SONG showed high reliability and validity. As intended, the SONG did, indeed, show a statistically significant negative correlation with the PIL at a significance level of .001. These findings are significant because humanistic approaches to psychotherapy are notoriously hard to empirically measure; however, the PIL and SONG have shown to be psychometrically sound. According to Cousins and Reker (1979), the PIL and SONG work by analyzing client-specific factors related to purpose, goal seeking, goal achievement, and contentedness with life. Logotherapists can use the PIL and SONG along with standardized substance abuse measures to track client progress as well as counselor effectiveness.

One glaring limitation to the use of the PIL (Crumbaugh & Maholic, 1969) and SONG (Crumbaugh, 1977) is that they are primarily used as diagnostic measures and may not be suitable for analyzing outcomes based purely on intervention techniques. Many insurance providers and government organizations find cognitive approaches auspicious because they are empirically validated. These interventions use extremely detailed manuals which must be strictly adhered to in order to ensure internal reliability and validity of their outcome measures. While statistical data that supports the effectiveness of cognitive interventions is stronger than many

other approaches due to its strict control of intervention conditions, it may sacrifice client-driven spontaneity within sessions that could prove more useful towards recovery. Logotherapy makes use of client-driven spontaneity during sessions (Frankl, 1970); hence, a manual would likely only impede progress towards recovery. It is, however, important to use diagnostic tools such as the PIL and SONG to ensure client progress towards perceiving meaning potentialities, as this becomes the main catalyst for recovery.

Techniques

Frankl's (1978) logotherapy uses three main techniques known as paradoxical intention, dereflection, and Socratic dialogue, along with psychoeducation to help empower clients to strive towards finding personal meaning and purpose in their lives. Paradoxical intention works towards alleviating anticipatory anxiety which stunts progress as a result of hyperintention towards a specific end, such as striving to achieve happiness. As aforementioned, logotherapy maintains that while external events that may cause suffering are often uncontrollable, people can control how they react in response to these events through recognition of their freedom of will (Frankl, 1977). Unfortunately, when traumatic events cause unavoidable suffering, it can leave people in a perpetual state of contemplation about their situations, which he calls hypereflection. When clients are observed to be hypereflective, logotherapists employ dereflection, wherefore; they redirect their internalizations towards external, meaningful pursuits such as community service or the creation of art.

Frankl's (1977) version of Socratic dialogue works under the assumption that the knowledge to heal can come from within the client. For example, if a client fails to perceive various meaning potentialities that could lead to the amelioration of troublesome symptomology, the logotherapist can use a series of investigative questions to increase the client's perception of potentially meaningful pursuits, in accordance with information about him or her gained by the counselor during sessions. Finally, psychotherapy is used to teach knowledge about where meaning and purpose can be derived, as well as to instruct logo-specific skills that can aid in the maintenance phase of recovery.

Paradoxical Intention

Frankl (1977) asserts that often times, the teleological energy directed towards goal accomplishment, such as finding meaning in spite of unavoidable suffering, is stymied due to what he calls *hyperintention*. Hyperintention occurs when clients focus a majority of their energy striving to accomplish a particular end, such as recovery from substance abuse. Hyperintention, as aforementioned, causes anticipatory anxiety which prevents goal accomplishment. As the client's progress towards a specific end becomes static, even more anxiety occurs, further blocking movement towards an aspired end-state. Frankl (1970) discussed this cycle, wherefore, a symptom evokes a phobia, which evokes a symptom, which further evokes the phobia, resulting in slowed or stunted progress.

An example of how this might play out with a military client in treatment for substance abuse can occur when he or she wishes to avoid thinking of the trauma. As a means of avoidance, he or she abuses substances such as alcohol. The client finds, however, that the more

he or she strives to avoid thinking about his or her trauma, the more he or she actually reflects on it, further increasing the likelihood of substance consumption. Frankl (1970) might ask the client to make a *paradoxical wish*, in which, the client literally plans his or her day around scheduled and approved *anxiety time*. He or she would be encouraged to examine how much of his or her day is spent experiencing anxiety from avoidance so that he or she can plan around those times. The client might be asked to literally write the word 'anxiety' on his or her schedule (Weisskopf-Joelson, 1968), and during that time, try and worry as much as humanly possible. If done correctly, the client will engage in hyperintention towards feeling anxious which reduces its likelihood because the more the client tries to make his or herself anxious, the more it is stymied by hyperintent. The strategy of having the client plan to engage in anxious behaviors was originally used by Weisskopf-Joelson (1968) to reduce college student test-anxiety and was hugely successful. According to Weisskopf-Joelson, her students who engaged in this type of paradoxical intention faired far better on tests than those who expressed anxiety and did not attempt the technique. According to the students that had success, once they planned for and made attempts at becoming anxious, they failed to do so, allowing them to deal with only normal student anxiety as opposed to dealing with that, with the addition of anxiety about anxiety as well (Weisskopf-Joelson, 1968).

Paradoxical intention makes use of the uniquely human capacities of self-transcendence and self-detachment (Frankl, 1970). When substance abuse co-occurs with military-related PTSD, it is often used to avoid reflecting on or dealing with the existential vacuum clients are left with as a result of their traumas (Somov, 2007). Substance abuse leads to little or no healthy progress towards recovery from PTSD and can even make it worse (Kennedy, 2009). When clients are encouraged to wish for the very thing he or she is afraid of, anticipatory anxiety drops and progress towards recovery can begin. Of course, asking a client to make such a 'paradoxical wish' (Frankl, 1970) should be done in as humorous a way as possible. According to Frankl, humor is yet another uniquely human capacity which allows us to disassociate and transcend our suffering. The type of avoidance from suffering discussed above is known to Frankl (1970) as *flight from fear*, which can manifest as a fight for pleasure or fight against obsessions and compulsions. It seems apparent that substance abuse, in terms of the way it allows for temporary, short-term avoidance of pain and suffering, can be seen as a *fight for pleasure* that may be reversed through effective usage of paradoxical intention (Frankl, 1970).

Dereflection

Dereflection is based on the idea that at times, particularly during suffering, we become hyper-reflective, constantly focusing inward on ourselves and our perceptions (Frankl, 2006). Dereflection gets the client to deflect internalization, which he suggests manifests as perpetual self-observation in an attempt to focus on external meaning-seeking behaviors. Frankl states that we are able detach from ourselves through dereflection in order to become a part of some larger, more meaningful pursuit. The deflection away from hyper-reflection allows the client to refocus on more meaningful, purposeful pursuits which is essential to achieving wellness according to existential psychotherapy (Frankl, 2006). For example, if a client with military-related PTSD is constantly internalizing what he or she experiences and is in a perpetual state of self-observation, particularly during substance-related intoxication, his or her ability to seek and find meaning in his or her traumatic experiences becomes greatly inhibited. Fortunately, through dereflection,

this client will be able to replace his or her self-observation with a meaningful pursuit which is essential for achieving existential wellness.

Frankl (1970, p. 128) asserts that, "identity does not result from concentration on one's self, but rather, from dedication to some cause, from finding one's self through the fulfillment of one's specific purpose." Just as paradoxical intention made use of the uniquely human capacities of self-transcendence and self-detachment, dereflection can also make use of these through humor and external, personally meaningful pursuits (Frankl, 1970). Dereflection can occur as the result of working to achieve goals in work, activities, or in service to others (Frankl, 1970). According to Buckenmeyer et al. (2012), veterans engaged in logotherapy for substance abuse recovery can engage in dereflection through becoming role-models for others working to recover from their addictions. It seems paradoxical that self-observation, which would seemingly lead to insightful self-awareness, actually inhibits recovery; however, when viewed through a logotherapeutic lens, when self-observation exceeds a certain point, it can divert attention away from meaning potentialities. According to Weisskopf-Joelson (1968), US students rate self-interpretation above self-actualization which supports the need for techniques such as dereflection.

A specific example of how dereflection (Frankl, 1970) might be used in the treatment of a veteran attempting to recover from substance abuse addictions that co-occur with military-related PTSD, starts with knowledge acquisition by the logotherapist with regards to the client during session. As the logotherapist gets to know the client, he or she can begin exploring what client-specific things could act as meaningful pursuits to replace the substance abuse addiction left in the wake of military-related PTSD. One avenue for derflection to occur is through the creation of art. If the veteran in question has a love for drawing, Frankl (1970) might suggest that the logotherapist make use of this information to dereflect unhelpful hyper-reflection that inhibits progress towards recovery. Frankl (1978) used this exact technique with a female recovering from depression due to co-morbid schizophrenia and though she worried greatly about the task of recovery from her horrendous disorder, she found great comfort in creating works of art that eventually, contributed to her full recovery.

Socratic Dialogue

Finally, Socratic dialogue is a technique that was created by the philosopher, Socrates, and was later incorporated by Frankl (2006) into logotherapy. It is also known as *Meiutic* dialogue, which is Greek for *mid-wifing*. This technique incorporates questioning intended to provoke the patient's own wisdom, in effect, *mid-wifing* to consciousness knowledge that the client already possesses (Southwick et al., 2006). This technique incorporates the use of Socratic questions which aid the client in taking ownership for his or her responsibility to lead a life of meaning and purpose (Frankl, 2006). Socratic questions should, "stand with one leg firmly in the client's way of looking at her world, and the other in the new territory" (Welter, 1987, p. 1). For example, he suggests using questions such as, "As you look back on your life, what are the moments when you were most yourself?" or, "What is life asking of you at this time, even in all your suffering?" These questions are intended to objectively 'mid-wife' the meaning potentialities of the client's experiences for which the client intuitively concludes might be meaningful.

According to Fabry (1988), logotherapists engaging in Socratic dialogue for substance abuse recovery should remain attuned to 'logo-hints' which include non-verbal and verbal clues that indicate client-specific meaning potentialities. According to Fabry, this requires the use of basic attending skills such as verbal tracking. According to Somov (2007), these 'logo-hints' give information as to the positive attitudes and values held by each specific client. Fabry (1988) goes on to discuss the importance of facilitating client self-discovery by pointing out meaning potentialities; however, the final responsibility of pursuing these, once discovered, is on the client. One example of how this might be used to treat veterans recovering from substance abuse that co-occurs with military-related PTSD begins with client value-exploration. For a veteran that places a high degree of importance on how his or her family is negatively affected by his or her substance abuse, yet fails to use this information in a way that promotes recovery, might benefit from the awareness of how this could serve as a meaning-potentiality through Socratic questioning (Frankl, 1970). Questions can increase awareness of how his or her recovery might benefit those he or she holds dear and once clients willfully admit that recovery might become meaningful as a result of alleviating the stress it places on others, recovery may fill his or her existential vacuum leaving no need for substance abuse.

Psychoeducation

Psychoeducation is one of the most important techniques employed by logotherapists as it teaches clients the important skills required for perceiving and maximizing their unique meaning potentialities. According to Fabry (1988, p. 123), psychoeducation provides clients with, "tools for restructuring their lives in ways that are meaningful to them, so that their daily behavior more nearly expresses their values." Logotherapeutic psychoeducation, according to Somov (2007, p. 317), should include information on how "existential review, search for meaning and assuming responsibility are pivotal to the substance abuse recovery arc." Psychoeducation, according to Somov, is particularly important when used for substance abuse recovery as clients, once in the maintenance phase, ask, "What now?" He makes salient the phenomenological reality clients face of having to make sense of the life that has been restored to them through recovery. The angst of recovery is, according to Somov, a positive 'existential vital sign.'

Clients undergoing Logotherapy for substance abuse are taught, "validating 'existential language' towards motivational enhancement that frees the client from self-deprecating guilt and towards focusing on responsibility to recover" (Somov, 2007, p. 317). Frankl (1970) identifies the 'spirit' as the foundation of human beings. Buckenmeyer et al. (2012) suggests that it is imperative for logotherapists to include the spiritual dimension in substance abuse recovery. They further codify this with the idea that without the spiritual component, clients lack the ability to fill the existential vacuum which instigates the use and abuse of various substances. Buckenmeyer et al. also make it clear that by addressing the spiritual during psychoeducation, clients will better identify meaning potentialities that stem from life experiences and increase their awareness of the opportunities for growth in spite of their addictions. The main idea, according to Buckenmeyer et al., is to celebrate and honor the clients' pasts as, though they were difficult, they were transformed into *human-achievements* (Frankl, 1970) by acceptance of the responsibility to grow and develop in their wake.

Buckenmeyer et al. (2012) suggest that when engaging in logotherapeutic psychoeducation for substance abuse recovery, counselors should explore the idea that the clients are more than their addiction. By removing themselves from harmful labels such as *addicts*, they are then able to transcend their struggles through external assessment as *omniscient observers* (Buckenmeyer et al., 2012). They also suggest that psychoeducation should empower clients to acknowledge their 'defiant spirits' which allow them to transcend and transform their struggles into important opportunities for growth and development, as well as increase client awareness of attitudes towards life and addictions that may negatively affect them.

Perhaps the most important goal for logotherapists engaging in psychoeducation for the recovery of substance abuse is to boost awareness of how the will to meaning (Frankl, 1970) can be found through creative, experiential, and attitudinal change (Buckenmeyer et al., 2012). Frankl discusses the applicability of finding meaning through love, suffering, and work. Substance abuse often causes isolation; however, love of another human may enable clients to become aware of their meaning potentialities. Frankl (1970) asserts that meaning can be found as the result of unavoidable suffering and that once anguish becomes inevitable, humans must adapt in order to overcome. It is the positive changes that come as a result of uncontrollable situations that afford the client meaning and purpose. Finally, meaning can be found in work through finding meaning and purpose in how the client uniquely approaches his or her occupation (Frankl, 1977).

Limitations

According to Buckenmeyer et al. (2012), logotherapy is most effective during the action phase of substance abuse recovery and during maintenance once behavioral extinguishment has occurred. In that same article, they assert that counselors who use logotherapy need to understand the differences between spirituality, religion, agnosticism, and atheism, both as they apply to clients, as well as themselves. Counselors must also understand the difference between healthy and unhealthy client language and behaviors that either progress or inhibit meaningful action (Buckenmeyer et al., 2012).

Perhaps the most difficult aspect of implementing any logotherapeutic intervention is the idea that counselors must be able to self-monitor their own values and attitudes towards spirituality, religion, agnosticism and atheism, as well as explore the beliefs held by their clients (Buckenmeyer et al., 2012). Counselors who lack a high level of awareness of personal beliefs and biases run the risk of unintentionally influencing client behaviors, inhibiting logotherapy's ability to promote awareness of personally meaningful pursuits which could aid in the creation of positive change. Logotherapy is Eurocentric as it was created by a Jewish, Austrian psychiatrist and as such, may unintentionally alienate non-European clientele. Finally, logotherapy requires at least a moderate degree of intelligence and understanding of abstract concepts such as meaning and purpose, and as such, may not be as effective with children and adolescent populations. Moderate intelligence, more specifically, can be defined as having the ability to understand philosophical tenets that are not always directly, nor physically tangible. One example of this is being able to understand the existence of an 'existential void,' which, according to the terminology is counterintuitive because though it is described as a 'void,' the

effects of this metaphysical gulf, such as depression or substance abuse, can still be experienced directly by clients.

Multicultural Considerations

According to Buckenmeyer et al. (2012), logotherapy can be effective in the treatment of substance abuse across all spiritual and religious beliefs. Frankl (1970, p. 143) states that "logotherapy does not cross the border between psychotherapy and religion. But it leaves the door to religion open and leaves it to the patient whether or not to pass the door." According to Vontress (2008), existential psychotherapy has the potential to be effective across a wide diversity of clientele, as nearly every culture on earth addresses the importance of meaning and purpose, though this should not be assumed. Logotherapy emphasizes empowering the client to derive personal meaning which requires an exploration of his or her specific beliefs, allowing it the ability to adapt. Schwarzberg (1993) established existential psychotherapy's effectiveness across sexual orientations and health-status during a study that illustrates its potential to increase perceived meaning with homosexual males diagnosed with autoimmune deficiency syndrome (AIDS). Logotherapy is particularly effective across ability-status as it has been shown to be effective with veterans dealing with mental and physical injuries as a result of combat-related trauma (Lantz, 1992).

Personal Testimony

As a six year veteran of the United States Marine Corps, particularly during the War on Terrorism, I took refuge in the writings of Viktor Frankl (2006). Frankl's (2006) book, *Man's Search for Meaning*, gave me the mental frameworks I needed to put my own challenges and struggles into perspective. Military deployments contribute to a lot more stress than just that experienced in combat, such as being away from friends and family, losing nearly all personal freedoms for extended periods of time, as well as losing the time to embark in meaningful pursuits outside of what is required of the mission at hand. Military deployments require the service member to focus on little more than protecting his or her comrades-in-arms. This amalgam of stressors puts the service member in a position where he or she must put aside his or her own well-being for those that he or she has grown to love.

Frankl (2006) created logotherapy and practiced existential psychotherapy prior to being imprisoned in a Nazi concentration camp; however, he was able to put his ideals to the ultimate test as he also had to find meaning and purpose in putting others' well-being ahead of his own. He survived countless unimaginable atrocities by encouraging and supporting his fellow prisoners. Frankl worked towards empowering his fellow detainees to find meaning and purpose both during and in the aftermath of the Holocaust. His courage and purposeful action in spite of the obstacles he faced have inspired countless individuals, such as mental health professionals and service-members.

Finding myself in a similar situation while working in South America with Royal Dutch Marines, I attempted to inspire and encourage my colleagues to seek meaning and purpose in both their actions and their perceptions of what was to occur in their wake. Having witnessed the effects of military-related PTSD first-hand, I have come to realize that logotherapy offers one

avenue in the way of relief for service members who face the horrors of humanity. Whether it's a loss of sleep, constant intrusive recollections, or fear of daily tasks such as driving, my interactions with these individuals made salient the idea that these can be ameliorated through a re-analysis of their attitudes towards what they experienced. Frankl stated that humans can never remove the inherit freedom to choose their attitudes regarding suffering (2006). This is a message that could potentially benefit a wide variety of service members, regardless of the severity of their traumas as well as prospectively ward off substance abuse.

Conclusion

There is now evidence to suggest that military-related PTSD can lead to the development of substance abuse (NIDA, 2011). As argued by Somov (2007) and Buckenmeyer et al. (2012), substance abuse can be seen as an attempt to fill an existential void and, as I argued in this article on innovative applications of logotherapy for the treatment of military-related PTSD (2012), military trauma can leave veterans with a similar existential gulf. As the MCS (NIDA, 2011) and Kennedy (2009) have begun to reveal, substance abuse has become the most prevalent problem in the military and current cognitive interventions are only providing short-term relief. The government relies on cognitive based approaches to recovery because they offer easily measurable, empirically validated techniques. The time is now to begin researching the effectiveness of alternative, non-cognitive based therapies such as logotherapy using instruments like the PIL (Crumbauch & Maholic, 1969) and the SONG (Crumbaugh.1977) to ensure our service men and women receive the treatment they deserve in reciprocation for their sacrifices.

Logotherapy has been shown to work in treating both military-related PTSD (Lantz, 1992) as well as substance abuse addictions (Buckenmeyer et al., 2012); however, I am not aware of any research that looks at its effectiveness in treating them when they co-occur. It seems logical that logotherapy for the treatment of substance abuse, particularly when it was already previously used for the treatment of military-related PTSD, would ensure both quality and continuity of care. This may be the case because logotherapy relies heavily on psychoeducation and having been exposed to this content during past treatments, clients may find it easier to adjust to subsequent logotherapeutic interventions. Though the potential for logotherapy to be effective in helping this particular demographic may be possible, it must first overcome such limitations as its Eurocentric roots and pre-requisite moderate intelligence. Logotherapy is particularly effective with diverse military demographics as it adjusts its approach based on client-specific information; however, for this to occur, counselors must have a large degree of self-awareness of personal biases, values, and beliefs (Buckenmeyer et al., 2012). As the US military fights to ensure American freedom and protection, the US public has a moral obligation to respond with ethical, competent care, and logotherapy may be just the humanistic approach to provide such assistance.

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