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Letter from the Editor

The *Journal of Military and Government Counseling* (*JMGC*) is into its second year of publication! *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 is an eclectic collection of articles in practice, theory, and research. The lead article describes a community suicide prevention program for military and Veterans in Arkansas. The second article focuses on implications in higher education as a number of Veterans enter mental health counseling programs. The next article is research assessing mental illness stigma and resilience in the military. A practice article presents a method treating complex traumagenic disorders in Veterans. The final article is a graduate student review of the literature on the efficacy of various group approaches for Veterans with PTSD. I welcome grad students to submit an article. To the counselor educators – encourage your students (especially Veteran students) to submit and article or co-author with them.

I welcome more submissions for the JMCG – as of today, I do have enough articles in the queue for another issue and the start toward a third. So, ask around where you work – or try writing yourself. I'm advertising for submissions through ACA channels.

Benjamin V. Noah, PhD
JMGC Founding Editor

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Establishing Community Partnerships for the Prevention of Mental Distress and Suicide in Military Personnel and Veterans

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Abstract

Proactively meeting the mental health needs of Operation Iraqi Freedom, Operation Enduring Freedom, Operation New Dawn (OIF/OEF/OND) Veterans and their families has become a priority for stakeholders both within and outside of the Veterans Health Administration (VHA), Department of Defense (DoD), and other government agencies. The purpose of this article is to describe four VA and DoD community-based participatory research projects that have been used to implement programs that utilize community members and community organizations as supporters of Veterans and gatekeepers to mental distress and suicide. Finally, we discuss the benefits and barriers in implementing community participatory interventions.
KEYWORDS: community partnerships, mental distress, suicide, military, Veterans

Proactively meeting the mental health needs of Operation Iraqi Freedom, Operation Enduring Freedom, Operation New Dawn (OIF/OEF/OND) Veterans and their families has become a priority for stakeholders both within and outside of the Veterans Health Administration (VHA), Department of Defense (DoD), and other government agencies (Bowen & Martin, 2011).

Author Note: Support for this research was provided by the VA Mental Health Quality Enhancement Research Initiative, the VA South Central Mental Illness Research Education and Clinical Centers, the VA Polytrauma Fellowship program, the VA Office of Rural Health, the VA Center for Mental Healthcare and Outcomes Research, and the University of Arkansas for Medical Sciences Department of Human Services Research.
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A common theme is to focus on building individual and family resilience (Bowen & Martin, 2011). Resilient individuals draw upon their internal resources and support in their environment to endure hardship (Weiss, Coll, Gerbauer, Smiley, & Carillo, 2010). Resiliency is of particular significance for members of the National Guard and National Guard Veterans who are frequently embedded within communities that have limited availability to the supportive services and resources typically provided at military bases.

One in five OEF/OIF U.S. military Veterans reside in rural areas and of these individuals, it is estimated that 40% return home with a mental disorder (Tanielian & Jaycox, 2008; U.S. Department of Veterans Affairs, 2012). Unfortunately, suicide is a concern among Veterans returning from the wars in Iraq and Afghanistan. For instance, in 2012, as many as 349 U.S. service members died by suicide or are under investigation for suspected death by suicide, which would be the highest number since the Department of Defense began keeping detailed statistics in 2001 (Starr, 2013). The VA recently reviewed 2010 mortality data and determined that there was an average of 22 Veteran suicides per day in 2010 (Kemp & Bossarte, 2012).

Suicide is a global public health problem and is ranked as the 10th leading cause of death (U.S. Department of Health and Human Services [HHS] Office of the Surgeon General and National Action Alliance for Suicide Prevention [NAASP], 2012). In the U.S., there has been much attention to preventing suicide and other premature mortality in Veterans returning from Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn. Investigators have identified risk factors for suicide, including: a previous suicide attempt, mood disorders, substance abuse and access to lethal means (NAASP, 2012; Suicide Prevention Resource Center & Rodgers, 2011). There are a number of additional stressors linked to service members' risk for suicide, including changes in role responsibility, 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).

In tackling this challenge of suicide prevention, research indicates that it must be done as a collective effort (NAASP, 2012), where individuals learn to identify risk factors, strive to eliminate stigma of seeking help and have knowledge of resources and referral procedures. The National Action Alliance for Suicide Prevention indicates that:

> The largest number of suicidal deaths each year occurs among middle-aged men and women, sapping the workforce we need to grow our economy. The fact that suicidal behavior occurs among some of our most marginalized citizens is a call to action we must embrace. Reducing the number of suicides requires the engagement and commitment of people in many sectors in and outside of government, including public health, mental health, health care, the Armed Forces, business, entertainment, media, and education. (NAASP, 2012, p. 3).

One objective for reducing suicide, as identified by the National Action Alliance for Suicide Prevention (2012), is to encourage community-based settings to implement effective programs and provide education that promotes wellness and prevents suicide and related behaviors. Settings identified to increase suicide prevention efforts include:

- faith-based organizations;
- institutions in the justice system;

- law enforcement institutions;
- organizations providing health care;
- organizations serving older adults;
- schools, youth-serving organizations, colleges, universities, and vocational training institutions;
- Veterans service organizations; and
- workplaces.

Expanding the reach of suicide and mental health education efforts can reduce the stigma of seeking help, increase the identification of individuals at risk, and increase options for help within communities (NAASP, 2012). The purpose of this article is to describe community-based participatory research projects that have been used to implement programs that partner with community members and community-based organizations to support Veterans and act as gatekeepers to services for Veterans with mental distress and vulnerability to suicide. Each of these programs supports Veterans residing in rural areas that are often marginalized due to limited availability of resources, cultural beliefs and stigma toward mental health treatment. We describe below the four VA and DoD community-based participatory research projects, highlighting the significant role of the faith-based community in these projects.

Counselors Joining Forces

Waliski and Kirchner (2013) describe a three year collaborative effort partnering with the Arkansas Counseling Association (ArCA), 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. Together these groups educated and created an awareness of the needs of military children and families so that mental health and school counselors could identify risk factors for life stressors, changes in student or parent behaviors, and symptoms of poor mental health. Once concerns are identified school counselors then provide appropriate services, and make appropriate referrals to decrease distress (Waliski, Kirchner, Shue, & Bokony, 2012).

Partners in Care

The faith-based community has emerged as a critical stakeholder in filling gaps in services to those experiencing distress by providing local support, referrals and addressing the psychosocial, emotional, and spiritual needs of these returning soldiers and their families. The Partners in Care (PIC) program was designed to increase linkages between a state's National Guard chaplain office and faith-based communities. Its benefits are to increase access to care and supportive services for National Guard members, Veterans and their families, to increase resiliency, and to reduce their risk for behavioral health problems including risk for suicide. One component of the PIC program is to train faith-based leaders in Operation Statewide Advocacy for Veterans' Empowerment (SAVE).

The Massachusetts SAVE program provides an example of the benefits of coordinating services (Department of Veterans' Services, 2013). The program works to prevent suicide and mental health distress by serving as a liaison between the various agencies within the federal and state governments, ensuring access to benefits and services that address these issues and

contribute to a positive transition to civilian life. Operation SAVE is an evidence-based gatekeeper training intervention for suicide awareness and prevention that has been used extensively by the VHA. To date, research has shown that gatekeeper training for suicide prevention increases knowledge of suicidal warning signs and referral for Veterans exhibiting suicidal warning signs among samples of VA clinical and non-clinical staff (Mann et al., 2005). Operation SAVE (Department of Veterans' Services, 2013) was the first Veteran-specific gatekeeper training program for suicide prevention to be used with front-line VHA staff across the nation. Evaluation of this program with VHA staff indicated an increase in confidence for responding to suicidal Veterans, increased acceptance of suicide screening as part of their job, and enhanced knowledge about suicide (King et al., 2012). Faith-based organizations are not limited in applying these skills to NG members but rather can conduct outreach to any military personnel, Veterans, and their families.

The Substance Abuse and Mental Health Services Administration (SAMHSA) collaborated with the Department of Defense to fund the piloting of the PIC program within the National Guard in five states during 2012. Programs were individually developed based on the needs and resources identified by the stakeholders in each state. The VA Mental Health Quality Enhancement and Research Initiative (MH QUERI) funded the evaluation of the piloting of the PIC program and the results are currently being analyzed and will be disseminated in 2014.

VA Mental Health-Clergy Partnership Program

Similarly in 2009, the VA South Central Mental Illness Research Education and Clinical Center (MIRECC), with funding from the VA Office of Rural Health, began a pilot program utilizing the value of faith-based organizations to create community support for Veterans and their family members. A team of researchers and chaplains recognized the difficulties that Veterans with mental illness can face when accessing mental health (MH) care. These difficulties are exacerbated in rural areas where access to specialists providing MH care may be limited (Ellis, Konrad, Thomas, & Morrissey, 2009). Additionally, individuals in need of MH care might be reluctant to seek care due to the stigma associated with mental illness (Hoyt, Conger, Valde, & Weihs, 1997). The ability to access quality MH treatment is particularly important for Veterans. According to the Veterans Affairs (VA) Planning Systems Support Group, approximately one-third of Operations Enduring and Iraqi Freedom (OEF/OIF) Veterans will return from active duty to rural, or highly rural, areas (Office of Rural Health, 2009). MH problems occur in approximately one in five of these Veterans and suicide rates are significantly higher among rural residents (McCarthy et al, 2012). Previous studies indicate that rural Veterans may not access needed MH care, even when it is available through Veterans Health Administration (VHA) services and outreach programs (McCarthy et al., 2012; Rand Health, 2008).

Investigators and chaplains at Central Arkansas Veterans Health Care system (CAVHS) recognized the importance of developing other channels through which Veterans can learn about MH services and be encouraged to access them. Referred to as the MIRECC VA/ Clergy program, this program involves collaboration between chaplains and mental health providers. The initial purpose of the program was to train pastors as first responders to returning Veterans in the community. An additional purpose of the pilot program was to build networks in rural communities between the churches, community mental health providers, VA, other community groups, and military

support services. In addition to educating community faith-based organizations and enlisting them to provide support and resources to military service members, Veterans, and their family members, team members focused on mental illness, referrals, and access to healthcare.

This program is unique in that it uses a "community based participatory model." The community based participatory model suggests that if you partner equally with community members, the program that develops is more likely to be sustained over time—compared to a top-down approach (Wallerstein & Duran, 2006). As a result, the program is different at each site and tailored to the needs of each community. This community-based approach places the community members in the role of the "experts" in the partnership. The community identifies its own needs and resources around which the partnership revolves.

The complete mission of the VA should not be to reintegrate returning Veterans to the VA, but to reintegrate them into the community from which they came and to which they will return. A community based approach such as the VA/Clergy partnership highlights the unique and significant role that local community partnerships can play in the prevention of suicide. The community is aware of its strengths and weaknesses. As a diverse group, they are aware of the local resources in their community, what organization offers what, and who would be the best resource for a referral tailored to the needs of the person in distress. Communities also realize their limitations. They know their gaps in resources and where the nearest place is that can help fill those gaps. Community partnerships are also effective because community members have a shared history with the Veteran. When various community members come together, someone in the group almost always knows the family of the person in need. They go to the same church, their kids play soccer together, and they shop at the same grocery store. They are often aware of complex family and social histories that might contribute to the harm or wellbeing of the Veteran in crisis. This makes community partnerships more suited for a holistic preventive approach to suicide, particularly in rural areas. All of these community strengths demonstrate the value of community partnerships over individual programs in the prevention of suicide.

Site 1

This group, which adopted the name "Project SOUTH (Serving Our Units at Home)," has focused their efforts in three areas: training and education of faith community, community outreach and awareness events, and promoting Veteran connection to mental health. This group is located in the southern part of the state and was the first site. Several trainings have been offered encompassing issues such as military culture, the effects of combat, the spiritual effects of war on the soul, an introduction to Veteran mental health issues, and suicide prevention. VA staff, OIF Veterans, local clergy, and local mental health (MH) providers were involved in the presentations. Continued monthly meetings resulted in little involvement for the first year. Eventually, a local church and a community leader joined forces and marshaled support from various community groups and churches, eventually forming a faith-based community group committed to the needs of soldiers, Veterans, and their families.

Since Project SOUTH's formation, several community driven activities have taken place. Project SOUTH has provided several breakfasts and Sunday morning devotionals for weekend drills at the local armory. In 2012, Project SOUTH was successful in securing its own local funding from a

foundation and hired a part-time coordinator in the community. Recent events have included an annual military kids camp held at a local Baptist camp, and the beginning of a school library program that is providing military books to libraries and will be recruiting Veterans to come read to school children monthly. Finally, Project SOUTH has established a mental health provider data base of community providers that are willing to see rural Veterans or their family members upon referral. Project SOUTH leadership recently conducted two half-day strategic planning sessions and became fully self-sustaining October 1, 2013.

Site 2

The second site was located in NW- Central Arkansas. The community experienced the suicide of a young Veteran. A lay person, close to the family of the Veteran, was deeply concerned and mobilized pastors and community leaders to come together for a suicide prevention workshop and eventually partnered with the VA/Clergy program. Interest in Russellville from the mental health community grew while clergy interest waned. The existence of a strong ministerial alliance and excellently planned events did not result in much pastor participation.

Focus then shifted to creating a dialogue between pastors and mental health providers. The group invited a dozen of these individuals to a "pew and couch" lunch approximately every three months to talk and get to know each other. This proved to be an effective, non-threatening way to slowly build relationships that have led to increased trust and cross-referrals between therapists, churches, and military support services. The community advisory group grew significantly in 2013 and became self-sustaining in October, 2013. Pastor trust and interest was gained when recruiting emphasis was shifted from "come let us teach you about Veteran mental health" to "come help us treat the moral and spiritual issues of our Veterans."

Site 3

In contrast to the first two sites, which were either bi-racial or mostly Caucasian, Site 3 was in a predominantly African American community where a pastor is focused on identifying Veterans and family members in his own church and then used their stories to motivate other pastors with an interest in reaching Veterans and their families. Work in Site 3 began in August 2011, with the formation of a community advisory board (CAB). The CAB requested training and information on common MH problems among rural Veterans, reintegration challenges following deployment, and resources available to Veterans and their families. The CAB has conducted a number of successful events including a regular Veteran support workout session at a local gym, a Memorial Day parade, and a volunteer-led breakfast at the armory on drill weekend. This site was also chosen for the hiring of a full-time MH Navigator to help identify Veterans in the community and get them the help they need. This navigator is a Veteran himself and also a local clergy member. The efforts of this MH Navigator approach led to more than 60 referrals during fiscal year 2012. Two additional partnership sites have begun in north Arkansas as a result of local interest and funding has been secured for FY14 to begin trainings in five other states on this faith community partnership model to help rural Veterans.

The MIRECC VA/Clergy program has been successful on a number of levels. First, there is an increased awareness in the faith community of the needs of rural Veterans and their families.

Through education and dialogue, they have begun to heighten awareness of the problems associated with deployment and reintegration. Communication and cooperation in the community has also increased. Collaboration has emerged between military support programs, VA mental health providers, and the local faith community. Additionally, the VA/Clergy partnership has led to strong relationships with the Department of Defense (DOD) chaplains in Arkansas that have resulted in increased referrals from DOD chaplains to VA chaplains as a "warm hand off" for getting Veterans into MH care. Greater numbers of Veterans and family members are being referred to MH services by clergy and the faith community as a result of these efforts. Studies have shown that religion and spirituality are associated with rates of mental illness (Baetz et al., 2004, 2006; Braam et al. 1997, 2004; Moreira-Almeida & Koeing, 2006) and suicide (Rasic et al., 2009). Suicide prevention is at the heart of the training that has been offered at all of the VA/Clergy Partnership sites. Suicide prevention outreach materials are regularly made available at monthly partnership meetings and at outreach and educational events in the communities.

The success of the VA/Clergy Partnership in Arkansas has recently led to funding from the VA Office of Rural Health to create similar partnerships in other parts of the country. This particular model is designed to be effective in any community where it is implemented. Because it is not based on a programmatic "one size fits all" approach, the model can be adapted to fit the needs and resources of any community. There is minimal cost involved in beginning partnerships such as these due to the fact that is the community which eventually takes the lead and provides the resources to lead and sustain the partnership in conjunction with local VA facilities. The VA/Clergy Partnership has recently developed a comprehensive training manual that covers the principles behind community partnerships, some of the needs that can be addressed and practical lessons learned from previous local partnerships. Disseminating a community-based partnership approach to other communities is essential to being able to provide preventative and intervention support to those who need it in the communities in which they live.

Linking Student Veterans to Mental Healthcare Services and Community-Based Resources

Investigators and chaplains at CAVHS have also realized through their work on the MIRECC VA/ Clergy program that Veterans also need support as they transition home and pursue higher education. Nearly 3,000 OEF/OIF Veterans in the state of Arkansas use the New GI Bill to matriculate at two-year community colleges and four-year universities in rural communities where there are limited resources to address the often complex needs of Veterans (Field, 2008). While many of the OEF/OIF Veterans are able to successfully balance the demands of higher education, employment, and family life, some struggle to make this transition because of personal, emotional, and psychological health problems (DiRamio, 2008). Supportive services for Veterans can greatly improve student Veterans' ability to achieve academic goals (Lang & Powers, 2011), but there needs to be more ways to encourage student Veterans with emotional and psychological problems to seek support and get help.

There are currently two projects seeking to link student Veterans with mental health and substance use problems to treatment and supportive services; projects that aim to help student Veterans successfully re-integrate into civilian life. The focus of both projects is to link student Veterans attending colleges and universities in rural areas of Arkansas to mental healthcare service and community-based resources. Many returning student Veterans live and attend school in rural

regions where mental health resources are scarce making it especially critical to partner with community stakeholders such as campus leaders and local clergy.

Assessing the Mental Health Burden of Student Veterans

This first project is a DoD-funded research study on the mental health needs of student Veterans attending rural community colleges in Arkansas. The study employs multiple methods, including an online survey assessing the mental health status of student Veterans, their help-seeking behavior, and their attitudes toward mental health care and potential screening and linkage-to-care approaches; semi-structured interviews eliciting student Veterans' preferences for help-seeking and their attitudes toward mental health screening and linkage-to-care interventions; and, focus groups and product development meetings generating information on screening and linkage-to-care models. To date, 230 student Veterans participated in the online survey, 20 students Veterans with mental health problems participated in the qualitative interviews, and one focus group was completed. The qualitative research is ongoing and semi-structured interviews and focus groups will continue to generate more information for the product development meetings.

This work has shed light on the mental health and substance use problems of student Veterans, revealing that they suffer from high levels of psychiatric stress and problematic drinking and are at a risk for suicide. For instance, preliminary findings indicate that 32% of the student Veterans screened positive for depression, 25% PTSD, and 23% generalized anxiety. Thirty-five percent of the student Veterans reported binge drinking in the past two weeks and 10% reported using illicit drugs. In addition, 13% of student Veterans reported seriously thinking about attempting suicide in the past year and 18% reported thoughts of death and self-harm in the two weeks prior to completing the survey (e.g., thinking that they would be better off dead).

Furthermore, the preliminary findings from the semi-structured interviews with student Veterans have deepened our understanding of their emotional and psychological distress, offered insights on coping strategies and identified barriers that student Veterans face when seeking treatment. Several student Veterans have voiced, for instance, that binge drinking offers them a way to cope with the stress of combat or military sexual trauma. Others have talked about facing campus-specific, military-, and non-military barriers to seeking mental healthcare, including, but not limited to, stigma around mental health, availability of services, and beliefs that only the "weak" seek treatment.

An important finding from this study is that student Veterans want supportive services that are led by Veteran peers. Several have shared their ideas about using student Veterans as liaisons or "buddies" who can screen the student Veteran population for potential problems and link those in need to care. The second project (which we describe below) draws from the insights gained from this study.

Supporting Rural Student Veterans

An important finding from the DoD-funded study described above is that student Veterans wanted supportive social networks led by Veteran peers. Several shared their ideas about using

student Veterans as liaisons or "buddies" who can screen the student Veteran population for potential problems and link those in need to care. Based on these findings and concerns voiced by Veterans and community members involved in the MIRECC VA/Clergy project, CAVHS investigators, chaplains, and team members met to develop a project that would address the needs and preferences of student Veterans. The "Supporting Rural Student Veterans" project uses principles of community-based research (see Sullivan et al., in press, for a review of the approach), building on the strong foundation of community-, clergy- and VA-based relationships developed from the MIRECC VA/Clergy Partnership program to develop a Veteran-to-Veteran support and linkage to care program for students Veterans attending underserved rural 2- and 4-year colleges.

More specifically, the project focuses on building (and strengthening) relationships with local VA providers, clergy, and campus leaders at six colleges in four distinct rural areas of Arkansas and identifying local resources for student Veterans. Through this process local college officials and clergy will be educated on Veterans' mental health needs, including risks for suicide, and will receive trainings on suicide prevention.

An important aspect of this project is to establish Veteran-to-Veteran support and linkage to care programs at the six colleges. The Veteran-to-Veteran program involves connecting upper class student Veterans (Peer Advisors) with incoming student Veterans to assist in navigating college life, identifying challenges, and referring to appropriate resources on or off campus. This program trains student Veterans as Peer Advisors and provides them with supportive services, including on-campus, VA, and community-based resources/services. Team members are hopeful that these efforts will help to increase the student bodies' awareness of student Veterans' needs and community members' involvement in addressing them. Furthermore, team members anticipate that this project will provide a framework on how to establish Veteran-to-Veteran screening and linkage-to-care groups in other resource-poor areas of the South.

Discussion

Fatal and non-fatal self-harm is a challenging problem within the U.S. population that requires multiple strategies for prevention. It is clear that cumulative and long term stress factors impact mental health and support is often needed to alleviate life's stressors. The initial challenge when building supportive environments to promote mental health involves educating people to the signs of distress and decreasing stigma related to seeking and receiving treatment for mental health symptoms. Community based participatory research plays a key role in many of these strategies. Gaining empirical knowledge of the occurrence of suicide and suicide risk factors is critical to eliminating suicide but this cannot be done without understanding the social and environmental contexts for individuals at risk for suicide and implementing supportive networks aimed at decreasing stigma and providing supportive services needed for help-seeking and recovery.

The programs described chose partnering with established organizations that were structured and available to provide resources for Veterans and their families. Student Veterans of all ages could be identified and assisted through University partnerships, Veterans with children could be identified and assisted through public schools, and faith-based organizations have the potential of assisting Veterans in even the most rural areas where resources are limited.

Collaboration with faith-based organizations to provide support for mental health and suicide prevention is important for several reasons. Community and organizational support of mental health can assist in removing the stigma of seeking help. Some religious teachings may prevent suicide, but these organizations also provide social support, comfort, and an opportunity to serve and find meaning in life (Dein, 2010). Additionally, several studies found that the more involved individuals were in religion the faster the remission of depression (Dein, 2010), and religious attendance has also been linked to decrease suicide attempts in the general public and in those diagnosed with a mental illness independent of social support (Rasic et al., 2009).

Each of the programs described above utilized the expertise of key stakeholders within the communities in which they were embedded. Community involvement is imperative for societal change. This is especially important when seeking acceptance to provide support for mental health. This change, however, does not come without the need to overcome barriers and the need for continued evaluation and improvement. Difficulties include engaging appropriate stakeholders in the community to ensure the needs and opinions of all stakeholder groups are represented and enlisting enough people to accomplish the chosen goal, given that these efforts are often voluntary or at a minimum represent an addition to general work responsibilities. The uniqueness of these programs lies in the dedication to making it community-based and the reliance on those in the community to identify the needs, resources, and direction of the partnership in that area. This means that the partnership looks different at every site and that no simple step-by-step formula for best practices exists. It is often challenging, when embedding a program in the community, to simply allow stakeholders and the program to evolve as needs are identified and resources are available.

Patience is often needed to allow this process to evolve if the program is expected to become self-sustaining within each environment. The following guiding principles would be beneficial to those hoping to replicate a similar approach. First, begin by identifying a target location with anchor resources such as a VA community-based outpatient clinic or university. Next, identify key stakeholders and work to build relationships within the community. This step is very time consuming but is, in our opinion, the most important. Finally, hold regular meetings with an "advisory board" to create awareness of Veteran issues. This allows all involved to stay focused on the established goals and invested in the continued progress.

For these programs, building relationships between stakeholders, local VA clinics and community mental health providers is the key to increasing understanding and trust and to facilitating increased referrals of Veterans. Although there is no formulaic approach to establishing community-based partnerships, they are proving essential to social change. Through the continued reporting of lessons learned by programs utilizing community based approaches, best practices for this model will be established.

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A Phenomenological Examination of Veterans Who Become Mental Health Professionals: Implications for the Professorate

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Abstract

Student Veterans are a growing population in higher education (Vacchi, 2012), including in counselor education. The present phenomenological study interviewed nine Veterans about their experiences pursuing a mental health degree; five of the nine respondents were current students, the rest were practitioners. Five themes were identified that depicted the respondents' experiences: (a) personal exploration as preparation for transition, (b) support needed for student Veterans, (c) feeling like an outsider in the classroom, (d) confluence between military and mental health identities, and (e) suggestions for a more Veteran-friendly mental health professorate. The implications focus on creating more Veteran friendly campuses, as well as what mental health professors can do to assist their student Veterans.

KEYWORDS: student Veterans, professional counseling, social work, psychology, counselor education.

Due to recent military downsizing, coupled with increases in Veteran benefits, the number of student Veterans in higher education is expected to grow (Vacchi, 2012), a fact that has received increased attention in the higher education literature (e.g., Branker, 2009; Moon & Schma, 2011). In the 2007-2008 academic year, student Veterans comprised 4% of the overall graduate student population, numbering 145,000 students (Radford, 2011). There are no numbers about how many are entering the mental health field, yet it is likely that their numbers will increase across all disciplines. Mental health professors (i.e., faculty in counseling, psychology, and social work) need to be prepared to assist this growing student group; however, the experiences of these student Veterans entering the mental health profession have received no attention to date. The present treatise is the first step towards understanding the experiences of this group as they enter into the mental health profession as providers and not recipients.

Counseling has grown into a culturally aware and inclusive profession (Smith, Kok-Mun, Brinson, & Mityagin, 2008), which should incorporate the military as a cultural group. The military may be considered a culture unto itself due to the shared beliefs, values, rules and practices that unite the diverse military branches (DiRamio, Ackerman, & Mitchell, 2008; Strom

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et al., 2012). Mental health professors need to be educated about the culture of this group; they need to acknowledge and support any unique needs of veterans as they transition to higher education. As such, what follows is a short introduction to military culture in order to provide a context for the larger study.

Military Culture

Petrovich (2012) suggested that when a recruit joins a branch of the military, he or she is in essence joining a new family. Although there are five branches of the U.S. military (i.e., Army, Marine Corps, Navy, Air Force, and Coast Guard) with unique histories and traditions, there are common core aspects of their identities that constitute a military culture (Hall, 2011). The basic values, rules, and practices of the military are initially instilled during boot camp (Watson, 2007), a time of transition from civilian to military life (Vacchi, 2012). The military structure is largely authoritarian, which requires adherence to centralized power (Hall, 2011). A service member's rank denotes leadership and sets the foundation for this hierarchy (Watson, 2007). There is little questioning of this system and its constituents are expected to adhere to its structure.

In addition to respect, the military culture cultivates a number of qualities in members, such as discipline, endurance, and confidence (Petrovich, 2012). The culture promotes unity and self-sacrifice through service to a greater cause (Rahbek-Clemmensen et al., 2012). This unity may help many service members learn to work with people who are culturally or racially different, affording them more culturally inclusive perspectives (Ryan, Carlstrom, Hughey, & Harris, 2011). There is often a shared focus on accomplishing a mission or being a part of something greater, which can be both connecting and rewarding for service members (Hall, 2011). These attitudes inherent in military culture can continue to impact and influence Veterans after they have returned to civilian life (Coll & Weiss, 2011).

It is not uncommon for Veterans to confront a number of issues upon returning to civilian life (e.g., family conflict, alcohol and drug use, trauma; Black, Westwood, & Sorsdal, 2007); however, the most commonly overlooked difficulties have to do with adjustment, including into higher education. The transition into an academic setting can be especially hard, given the cultural disconnect that has traditionally divided these worlds (Watson, 2007). However, many Veterans, utilizing their strengths of discipline and endurance, view education as the next challenge to be overcome in their lives (Ryan, Carlstrom, Hughey, & Harris, 2011). Much of the literature on this growing student veteran group has come from the student services profession, which has examined how student Veterans transition into and succeed in higher education.

Student Veterans on Campus

It has been difficult for scholars to accurately identify and name the student population that encompasses military Veterans. The present study utilized the term *student Veteran*, which has been defined as "any student who is a current or former member of the active duty military, National Guard, or Reserves regardless of deployment status, combat experience, legal veteran status, or GI Bill use" (Vacchi, 2012, p. 17). This is an inclusive definition that focuses on the

impact of military culture, regardless of branch or combat experience, as an influential force on the experiences of student Veterans.

At the graduate level, where mental health preparation programs exist, student Veterans are predominately older married males with dependents and attending school part-time (Radford, 2011). This demographic information gives the group a non-traditional student status on campuses, meaning that they might have needs that differ from traditional students. The cultural experiences of being a Veteran combined with the difficulties of being a non-traditional student lead to challenges for student Veterans transitioning into the academe.

Because of these challenges, higher education needs to be prepared to assist student Veterans in order to help them transition and succeed (Branker, 2009). Summerlot, Green, and Parker (2009) identified three types of campus climates for student Veterans: supportive, ambivalent, and challenging. The *supportive climate* actively supports Veterans with specialized counselors and other resources (e.g., student Veterans organizations, "Green Zone" programs; Nichols-Casebolt, 2012). These programs assist in student Veteran transitions and educational goals (Moon & Shma, 2011; Summerlot et al., 2009; Wheeler, 2012), as well as an increased awareness around the issues that student Veterans might face academically and personally. The *ambivalent climate* is reflected on college campuses where most students are non-traditional, thus framing military service as just one form of pre-college work experience. The final climate, *challenging,* is often found at institutions with a history of anti-military sentiment, which might cause student Veterans to hide their Veteran status. These campuses are most challenging to student Veterans because they typically lack knowledgeable and flexible Veteran affairs staff.

Student Veterans may also struggle connecting with their student civilian peers. Student Veterans have faced challenges as a part of their military service and may feel distant from fellow students as a result (Rumann & Hamrick, 2010), often finding them somewhat immature (Ackerman, DiRamio, & Mitchell, 2009; DiRamio, Ackerman, & Mitchell, 2008; Rumann & Hamrick, 2010). Additionally, student Veterans may feel lonely on campuses, believing that they are the only ones with a military background or experience (Wheeler, 2012). These experiences lend support for Summerlot, Green, and Parker's (2009) concept of a supportive campus climate that reaches out to these student Veterans. Otherwise, many of them may feel like an outsider in the academe (Wheeler, 2012).

To learn more about student Veterans' experiences in higher education, Wheeler (2012) interviewed student Veterans enrolled at a community college. She conducted nine interviews, eight of which were with males, and presented several emergent themes. First, she noted that many of her participants went through shifts in their personal relationships. Whether these were with old friends or family members, their relationships were typically more distant or felt less connective upon returning from the military. Second, her participants cited disconnections with their peers in college, who were often 2-3 years their junior. This occurred around issues of disrespect for professors, lack of focus on studies, and a general lack of maturity. Finally, her findings depicted student Veterans' frustration with the benefits process, whether the G.I. Bill or health benefits. Respondents frequently observed the confusion around how the benefits worked and which benefits would be most useful in their particular situations. Ackerman, DiRamio, and Mitchell (2009) reported similar findings from a study of 25 student Veterans working towards

their bachelors. The researchers interviewed the participants and found that the frustration student Veterans felt around transitioning into college and figuring out the benefits programs where almost universally shared.

The above research by Wheeler (2012) and Ackerman et al. (2009) both used qualitative methods, which allowed student Veterans to speak for themselves. The themes that emerged are informative for both faculty and administrators in higher education. However, the studies focused on a general population of student Veterans, assuming that their experiences were all similar. There is no research or theoretical work to date that has addressed the experiences of student Veterans in a particular field, such as mental health. The present study was aimed to fill this gap in the research, particularly for faculty in mental health programs; whether in counseling, psychology, or social work. The goal of the study is to inform mental health professors about the experiences of this student group and how to assist in their success.

Methods

The purpose of this phenomenological study was to explore the experiences of student Veterans in mental health preparation programs so that mental health professors may understand and support this group. The goal of phenomenological research is to understand the experiences of the participants, as it relates to a particular phenomenon (Creswell, 2007). In the present study, the goal was to understand the phenomenon of student Veterans in mental health preparation programs. The study was guided by the following three research questions:

1. How do student Veterans experience their transition into the mental health profession?
2. What were/are their experiences in mental health preparation programs?
3. What suggestions do they have for mental health professors working with student Veterans?

Participants

The participants were nine Veterans of differing ages and military backgrounds. Each of them was either pursuing or had pursued a degree in a licensable mental health field (i.e., counseling, psychology, and social work). Participants were solicited via convenience and snowball sampling methods along three lines (a) colleagues from three universities were contacted about student Veterans in their programs; (b) counselors at a state conference in the northeastern United States were informed about the call for participants; and (c) participants were asked if they knew other mental health student Veterans who would be willing to participate. When a potential participant was identified via one of these means, they were contacted by email about the study and provided an informed consent. At the time of interview, the participants were residing in three states: New York, Pennsylvania, and Virginia. Additional demographic information is located in Table 1.

Table 1
Participant Demographic Information

Name	Age	Sex	Race	Branch	Rank	Military Status	Combat Zone Service	Conflict	Mental Health Field	Student Status
Dale	63	M	C	A	SPEC-5	D	Yes	VE	C	G
Allen	39	M	C	AF ANG	Captain Sergeant	AG	Yes	OIF/OEF	C	G
Bill	65	M	C	MC ANG	Gunnery Sergeant Master Sergeant	D	Yes	VE	SW	S
Francis	56	F	AA	AR	Sergeant	D	No	NA	C	G
Carl	29	M	C	MC	Sergeant	D	Yes	OIF/OEF	P	S
Dan	28	M	C	MC	Corporal	D	Yes	OIF/OEF	C	S
Sue	28	F	H	ANG	Staff Sergeant	AG	No	NA	C	S
Ned	69	M	C	A	Sergeant	D	Yes	VE	SW	G
Maria	27	F	C	MC	Sergeant	D	No	NA	C	S

Race: C = Caucasian, AA = African American, H = Hispanic; Branch: A = Army, AF = Air Force, ANG = Air National Guard, AR = Army Reserve, MC = Marine Corps; Military Status: D = Discharged, AG = Active Guard; Conflict: OIF/OEF = Operation Iraqi Freedom/Operation Enduring Freedom, VE = Vietnam Era; Mental Health Field: C = Counseling, P = Psychology, SW = Social Work; Student Status: S = Student, G = Graduate.

Interviews

The interviews took approximately 50-75 minutes and were conducted for eight of the nine participants via telephone (one interview was completed face-to-face). The technology required to record interviews over the phone was readily available at the time, while the ability to record internet-based conversations was not a feature of more visual programs (e.g., Skype). The interviews started by inquiring about demographic information, which included military history and mental health training. The interviews were guided by five general areas of interest that addressed: (a) history of military service; (b) attraction/interest in the mental health field; (c) military strengths in the mental health field; (d) challenges of being a student Veteran in a mental health program; and (e) suggestions for the mental health professorate for training student Veterans. The researcher used additional questions if respondents required clarification or shared information relevant to the present study, but needed further prompting.

Data Analysis

The interviews were completed prior to beginning the phenomenological data analysis. The basic steps of the analysis were informed by the work of Auerbach and Silverstein (2003) and conceptualized using Moustakas' (1994) updated Stevick-Coaizzi-Keen method. First, the transcripts were examined in light of the research purpose (i.e., to understand the experiences of Veterans becoming mental health professionals) and statements that reflected this purpose were

selected as meaning units. Second, the meaning units were grouped into themes based upon repeating ideas, which were then titled for easy identification. Third, themes were grouped into categories based on commonalities between participants. Fourth, these commonalities were narrated into a textural-structural description, which focused on the experiences of this cultural group. Finally, the narrative was reintegrated with the language of the participants to ensure that their voices were reflected in the results.

Trustworthiness Strategies

Creswell (2007) suggested using at least two strategies to increase a study's trustworthiness; I employed a peer review and a member check. A counselor educator who specializes in qualitative research assisted in the peer review. I sent her my research materials, which included both the transcripts and records of analysis. After her review of these materials, she and I discussed my interest in the topic and pre-existing assumptions about the phenomenon as a form of bracketing (Rolls & Relf, 2006). She provided feedback about my process and encouraged me to consult with someone more versed in military culture. Her review confirmed the presence of the results in the data and she made suggestions to reorganize the results to reduce repetition.

A second peer review was conducted at the suggestion of the first reviewer. A copy of the manuscript was sent to a physician Veteran who served as the director of a treatment center that provided both medical and mental healthcare. He examined the manuscript to ensure relevancy for both the mental health field and military culture. He educated me about military culture and emphasized the importance of accurately depicting the participants' military histories. As a result of this consultation, I included more literature on military culture in the introduction and indicated whether the participants' had served in a combat zone.

Finally, a member check was completed with the nine respondents, which involved checking with participants to ensure the accuracy of the results (Creswell, 2007). The participants were asked to review the materials and confirm that the findings were representative and respectful of their viewpoints. Five of the nine participants responded to the contact, each confirmed that the language and the framing accurately reflected their experiences. One of the five participants noted that a statement she made was not accurately interpreted, which I augmented to clarify her intent. These three checks (i.e., two peer reviews and one member check) increased the trustworthiness of the study's findings and helped me check my biases.

Researcher Bias

Researchers bring assumptions to their research by projecting their biases into the findings, thus requiring the use of epoché (Moustakas, 1994). This entails the suspension of judgment or biases during the research process. I engaged in a form of bracketing interview (Rolls & Relf, 2006) with my first peer reviewer to explore my biases. The following experiences influenced my experiences of the data collection and analysis process.

I am a civilian with a family history of military service on my father's side of the family; my father, uncle, grandfather, and cousin. I have worked with Veterans as a counselor and as a

counselor educator; as a result, I was biased towards a positive evaluation of student Veterans. I assumed that the student Veterans would report pride in their military service and cite their military training as an asset for success in graduate school. I also assumed that student Veterans would indicate a desire to work with Veterans after graduation; reporting ambitions to change the mental health system to be more veteran-friendly.

Findings

Using the process of data analysis described above, five themes emerged that reflected the experiences and perceptions of the student Veterans. Quotes from the interviews have been integrated into the narrative descriptions in order to ground the findings in the voices of the participants. The results are presented as sequential and discrete concepts, which are a byproduct of the data reduction process. In contrast, the actual interviews reflected more of a confluence between the five themes depicted below.

Personal Exploration as Preparation for Transition

Five of the respondents indicated that they did some form of self-exploration prior to attending school for a mental health profession. This took the form of personal counseling, mental health seminars/conferences, or structured personal growth experiences (e.g., a spiritual group). These experiences often laid the foundation for choosing a degree in the mental health field. Bill explored multiple avenues of personal growth, "I went to a men's group, explored religion, and met with a counselor. I became a mentor to other men." Carl was also impacted by personal exploration, but his were in a larger group setting, "I went to a conference on grief counseling with trauma survivors. I thought a lot about what I was going through and about working with Vets. And I thought that [counseling] was work I'd like to do."

Some student Veterans might expect that taking mental health courses will be therapeutic. Ned is both a social worker and professor, observed, "An overabundance of people who have personal issues and hope that the academic experience will have them resolved." His comments were applied equally to student Veterans and civilians, but emerged from a discussion about the former. Carl disclosed that he benefited personally from his coursework, "As far as really beginning to understand myself, we did a lot about self-care [in class] and really paying attention to how we are feeling. That's when a lot of my own personal reflection started." Bill shared that he returned to Vietnam as part of his social work education, during which time he maintained a weblog. "When I was in Vietnam and I kept a blog, there's a lot of stuff on there and I've never done that before [i.e., share feelings and experiences]. It started slow, but it started as a way to document the experience and how it was affecting me and how to communicate with friends and family back home." These responses suggested that personal exploration could assist in catalyzing, preparing, and facilitating the transition from the military to the mental health field.

Support for Student Veterans

When first addressing the transition from the military to higher education, three respondents indicated how these two worlds were tied together. For some it was the presence of

the GI Bill that first got them to enlist, while others viewed the GI Bill as justification for continuing education. The latter was the case for Maria, who decided to keep going to school so long as the GI Bill was paying for it. Dan reported that education was his is primary emphasis, "My goals were focused on education, knowing that a higher or advanced degree would lead to new career decisions." With a focus on similar goals, Allen indicated, "I didn't qualify at the time for the GI bill since I was an officer, so I enlisted in the National Guard because I wanted to be an infantry member and I wanted the experience and I also wanted them to pay for my school."

The transition between military and higher education was a struggle for seven of the respondents. A particular challenge was the assumption from faculty and administrators that student Veterans were savvy with in higher education because they were coming in with completed course credits. Maria stated, "When I first was accepted and started the process I had no idea what I was doing. They assumed that I was familiar with the process, the terms, and the expectations. People were very helpful when I asked, but I was so lost about the process. I still don't know how to find the books for my class." Orientation support, along with well-staffed and knowledge student veteran offices were important to five of the respondents. In particular, those who were still active duty in the Guard found it difficult to connect with the appropriate offices if they were deployed. Sue shared an experience being deployed, "They [the university] don't have military services or places for help. Like last summer I got called to duty and deployed the next morning and I tried to call to tell them, but there was nobody to call. There was no protocol in place, there wasn't anything in place. So I called my professors." The importance of having various types of supports on campus was emphasized by respondents, even by those who had largely positive experiences.

Feeling like an Outsider in the Classroom

Many student Veterans have been a minority in different parts of the world and they have faced challenges to their safety during their service. Carl reflected, "I would reflect and think that things are so much better now than they were. At least here I'm not waking up and getting shot at each day. So it has definitely given me a lot of perspective." Some of these experiences may afford student Veterans a wider perspective on the issues discussed in the classroom. In particular, five of the respondents noted how their experiences in other countries and with diverse cultural groups gave them a greater understanding of multiculturalism in mental health. Allen observed, "I felt that whenever they [professors] spoke of things like diversity, that they really had very little life experience about what it is. I feel that the way diversity was presented to me was the perspective of if you were a white European Christian type of person, by virtue you were an oppressor. I think that's an inaccurate statement. The fact of the matter is that there are places where you [i.e., European/White Christian] are not the oppressor at all, but you just haven't experienced that. We are not dominant everywhere in the world."

Student Veterans also noted how they have been acculturated to a set of standards (e.g., timeliness, respect of authority) that are not always present in higher education. Six of the respondents indicated their frustration with student peers for not being timely or being disrespectful in the classroom. Bill shared his initial anger in higher education, "I could be extremely irritated by the student schlepping in 20 minutes late. I've talked to some of the

Veterans and they've said they wanted to slap that dumbass." Respondents alluded to these differences, as well as age differences, as being the reason that they frequently felt like outsiders in the classroom. Sue noted how this difference separated her and also makes her attractive for particular types of relationships, "Sometimes it's hard to make friends in class and my role is like this mom figure. Some students come up to me in class and ask how I did certain things. I take on this role rather than friends."

This feeling of being removed was often exacerbated by challenges to the military that might come up in the classroom, as reported by four participants. Francis, a former police officer and Reservist, reported that in general students were friendly, but she stressed, "Counselors [mental health professionals] don't like cops and military, which was challenging for me with fellow students." Other Veterans experienced similar discomfort, like when Ned went to school after returning from Vietnam. He reported that professors and students alike were hostile about the military and his history of service. Ned stated that he sought out "a-political types" in order to make friends on campus. Similarly, the challenges that the respondents met in the military (e.g., boot camp, long exhausting shifts, and combat) made the concerns of their student peers seem small. Carl indicated, "I think people just didn't understand that there is more to life than worrying about a paper or completing an assignment."

Confluence Between Military and Mental Health Identities

Seven of the respondents cited a call to service when deciding to become a mental health professional. Bill noted that, "Having served, I then want to turn around and serve others; it seems like the right place." Similarly, Allen stated, "I was originally a police officer and I figured that I was getting people at the end of things. So I thought maybe I could make a better use of my time by being a therapist, to help prevent bad things from happening." Carl shared, "I want to help people that can't necessarily help themselves or take care of those who need the extra help." The call to service was a part of the student Veteran's intention for pursuing a mental health degree.

The desire to serve led respondents to the larger mental health field, but six of them did not distinguish one specialized field over another. Allen shared his decision, "I majored in psychology and part of my decision for counseling was my absolute ignorance of the career field. I thought it was the same as a psychologist at the time. At the time they were the same to me, I didn't know much about the professions to know which was which so I went with counseling. I knew they were all mental health." Similarly, Carl chose based on limited information, "I think there was something about the title, counselor that appealed to me, so I Googled counseling programs in the area." There seemed to be a focus on getting the requisite skills to be of service and not a value placed on professional distinctions.

The stigma surrounding counseling in the military was a problem cited by seven of the participants, which caused them to indicate that they wanted to serve Veterans and/or work in for the Department of Veterans' Affairs (VA). Dale focuses on working with Veterans diagnosed with posttraumatic stress disorder (PTSD) in private practice and he is a part of a national study examining the treatment of Veterans with PTSD. Similarly, Ned shared how he has assisted Veterans throughout his career by providing direct services or in connecting them with appropriate services. He has even reached out to Veterans in other states, helping them work out their mental healthcare benefits. Carl expressed his desire to work with Veterans, "I would like

to work with Veterans. I think even that as much I want to give other Veterans they give something back to me too because they understand." This suggested that he and other Veterans are positively impacted by the connection they share through the military.

It was universally agreed that Veterans are in an ideal position to relate to and support Veterans. Being able to "speak the same language" or to empathize with shared experiences, caused respondents to believe that they were well equipped to work with this group. Dan stated, "I think I would be able to connect to my clients or there would be common knowledge there. The guys know if you've been in the military or not and knowledge in that area can help me break barriers with future clients if they are Veterans." In particular, it may be that Veterans would be more willing to share their combat experiences with other Veterans, with the belief that they might have a better understanding than a civilian. Ned commented, "The few who were in combat won't share the nitty-gritty with those who aren't combat Veterans. They feel you don't understand and there is nothing to be gained except reliving an experience in sharing that with them. So on many levels it's a closed community."

Eight of the respondents noted how counseling was an extension of their military mindset or skill set. This emphasized fostering brotherhood, taking responsibility, moving towards difficulty, protecting the powerless, sticking to a difficult job, and seeing the bigger picture. Francis stated, "Counselors can be cowards sometimes. I run towards trouble. Counselors should run towards crisis." She gave an example wherein a client came into the waiting room and started to yell at center staff. Francis indicated that she moved towards the shouting, whereas her colleagues stayed in their offices. There were other types of integration of qualities, like Dan, "Knowing myself and knowing that I'm pretty comfortable in stressful situations is to my advantage. It's something I can use with consumers." The military experience also shaped the respondents approach to counseling. Three respondents indicated that their military experience catalyzed interest in particular theories, such as cognitive behavioral therapy or solution focused brief therapy, because of their "straightforward linear process." Similarly, another respondent was attracted to existentialism because of its emphasis on purpose and meaning, which became more present for him after being in combat.

For five respondents, these military born qualities were evidenced in their clinical work as well as in a move towards advocacy. The latter ranged from local systems (e.g., workplace) to international systems (e.g., advocating for global children's rights). Sue shared local efforts, "I talked to our family services coordinator and I asked what are we doing for these [military] families through the deployment cycle. They're the ones who take the brunt of the blame. It's all about the awareness and coming up with ideas and support for them." In a similar way, Dan and Carl shared information about the military with others in their programs and Francis was supporting Veterans groups on campus.

Veteran-Friendly Mental Health Professorate

The mental health professorate play an important role in facilitating both comfortable and meaningful educational experiences for student Veterans. Respondents made several suggestions for professors when supporting student Veterans or when making programming choices. First, respondents indicated that it could be, or has been, very helpful for professors to acknowledge a

student Veteran's military service. This may help students feel like they have support in the classroom when otherwise they may feel like outsiders. Francis suggested, "Draw out Veterans in class and support their development."

Second, student Veterans may feel supported by being able to approach professors with an "open door policy." In other words, when a professor is available to meet and discuss issues with students. Such an open relationship can allow for student Veterans to express concerns, solve problems, or keep professors abreast of difficulties. Sue considered that this could sometimes feel like a "grey area" for her because she is going to a professor for support. However, she acknowledged that she sometimes needed this from her professors and that it contributed to her and other Veteran's success.

Third, professors can create opportunities for student Veterans to explore/share military culture/interests through structured or unstructured assignments. Through reflective journals, open topic assignments, and other activities, student Veterans can construct meaningful and reflective projects. As several respondents noted, this can assist in their education as well as their personal wellness and satisfaction. Carl reflected, "A lot of [self-care] started in grief counseling class when we took the time to do weekly journal entries. I will read through those sometimes and it grounds me in how far I have come." It can also create opportunities for student Veterans to educate other counseling students about military culture and Veteran's issues.

Fourth, respondents noted that mental health professionals needed to learn about the military culture and the mental health needs of Veterans. Respondents indicated that this was frequently missing from their training and that future counselors may be ill prepared to support this population. Francis and Dan had similar suggestions, the latter stated, "Include information about PTSD and realize that there is a stigma about counseling in the military." The military has its own set of expectations and norms for its members; respondents stressed the importance of knowing about this culture in order to be successful in treating Veterans. This knowledge may also assist the mental health professorate when supporting student Veterans.

Finally, it may be important for educators to be able to identify symptoms of PTSD in their students. While mental health professors are likely familiar with the symptoms of PTSD, they may not be considering diagnoses with their students. Dale suggested that professors, "Teach about PTSD and work to recognize the symptoms in students with military service." He and other respondents indicated that student Veterans might also require counseling services as a result of their service. Maria indicated, "I think that Veterans need to recognize that they need to work through their own issues. But many are holding onto some not so good history and experiences." Mental health professors are in unique positions to facilitate such a referral and to normalize the process of counseling. Carl reflected that it was the normalization of counseling that occurred during his masters that enabled him to seek out his own counseling.

Discussion

The present study is both necessary and timely given the increase in student Veterans on campuses today, as well as the anticipated growth in the coming years (Vacchi, 2012). The military is a culture unto itself (DiRamio, Ackerman, & Mitchell, 2008; Strom, et al., 2012) and

this study seeks to educate mental health professors about their students. The findings of the present study depict the experiences of student Veterans in mental health preparation programs.

Many of these student Veteran participants went through a personal process of self-exploration prior to entering the mental health field. This finding was not present in work examining other student Veteran samples (Ackerman, et al., 2009; Wheeler, 2012), which may suggest that this is unique to student Veterans entering the mental health fields. Similar to previous research and scholarship on student Veterans (e.g., Ackerman, et al., 2009; Wheeler, 2012), the respondents required assistance in navigating the adjustment to campuses. There has traditionally been a cultural disconnect between military and academic cultures (Watson, 2007). This disconnect was present in the participants' responses, particularly around their peers. However, there was not necessarily any disconnect with professors or professional values.

The three campus climates, as described by Summerlot, Green, and Parker (2009), were also relevant for the present study. The student Veterans noted the ways in which the institution provided or lacked support for their Veteran students. Most of the reports were negative, which may suggest that the sample was pulled from challenging campus climates. While the campuses might not have been supportive, the professors played an important role in creating a more Veteran-friendly climate. Many student Veterans in the present study cited that the relationships they formed with professors often helped sustain them through their studies.

Education is viewed as "the next step" for many student Veterans, whether during or after their military service (Ryan, Carlstrom, Hughey, & Harris, 2011). Respondents in the present study supported this assertion by highlighting the importance of the G.I. Bill in deciding to whether or not to pursue a degree in a mental health profession. However, even at the masters' level, these students struggled with how the funding process worked. This finding has been depicted in previous research (Ackerman et al., 2009; Wheeler, 2012), which suggested that this particular issue might be universal across disciplines and educational levels.

The present study found that student Veterans in mental health programs may also feel like outsiders, even if the age disparity between student groups might be less in graduate school (Radford, 2011). The finding that the student Veterans felt somewhat disconnected or distanced from their civilian peers has been evidenced elsewhere in the scholarship (e.g., Ackerman, DiRamio, & Mitchell, 2009; DiRamio, Ackerman, & Mitchell, 2008; Rumann & Hamrick, 2010). The divide found in other studies has been attributed to the age difference in student Veteran and civilian populations (Radford, 2011; Wheeler, 2012); however, that might not be as relevant in the present study. Instead, the immaturity observed by the student Veterans might have more to do with the incongruence between military and academic cultures (Watson, 2007). It seems that age may not play as integral role in maturity that has been cited in previous studies (Wheeler, 2012); rather, it may have to do with life experience. The latter was also turned towards the professorate in the present study, as one respondent indicated that his professors lacked real world experience.

The respondents described a connection between their mental health identities and what they had learned in the military. While Petrovich (2012) suggested that a recruit joins a new family when he or she enters the military, it might be said that this military family then marries

into a mental health family. The strong qualities forged through military service (e.g., discipline, confidence, endurance; Petrovich, 2012) seem to blend with the qualities adopted as a mental health professional. Furthermore, the call to serve in the mental health profession was also connected to their military history, as well as the desire to support other veterans dealing with mental health issues. This type of finding has not been reflected in other research on the topic, given that this is the first to focus on student veterans entering a particular profession. The implications of this work relate to the specific profession and also connect to the larger higher educational system.

Implications for Higher Education

The current scholarship on student Veterans in higher education has largely focused on how colleges and universities can support this growing student population (e.g., Vacchi, 2012). The present finding suggest that continued work needs to be done in order to assist student Veterans in transitioning into this new setting and new role. It may behoove colleges and universities to employ specialized administrative staff to work with Veterans, particularly around the G.I. Bill and deployment.

A second implication for colleges and universities is that some student Veterans are not only transitioning into higher education, but may also be transitioning into a brick-and-mortar school. This was the case for Maria, who transitioned to a brick-and-mortar school after completing her bachelors online. This may mean that some seemingly experienced students are actually novices on campus services and procedures. Colleges and universities need to be sensitive to this potentiality and scaffold new student Veterans regardless of educational history.

Finally, the student Veterans entering the mental health field indicated that some form of personal exploration was pivotal in their career decision. This coupled with the proposition that student Veterans seek out counseling, suggests that colleges and universities need to have Veteran-friendly counseling services available on campus. Institutions need to ensure that the clinicians staffing the facility are prepared to assist with Veteran student issues.

Implications for Mental Health Professors

Student Veterans face unique challenges and it is the responsibility of those in higher education to assist in their transition into the academic world (Branker, 2009). As indicated in the results, student Veterans had a number of suggestions for mental health professors. The respondents suggested that simply being acknowledged by their professors as being a Veteran was helpful. However, this population is often very private about their Veteran status (Black, Westwood, & Sorsdal, 2007). It may benefit professors to flag this aspect of students' files in order to maintain awareness of their Veteran status. Furthermore, the manner in which student Veterans prefer to be acknowledged may vary by student. Some may feel comfortable discussing this as a part of the larger class discourse, as was the case with Carl, while others may prefer to address this in one-on-one situations.

There was also an indication that student Veterans thought it was important for mental health professors to address military culture in class. This may require some restructuring of

courses such as multiculturalism, developmental, and grief counseling. It may be helpful to invite a therapist from the VA to speak about Veteran issues in a class. It may also be helpful to create opportunities for student Veterans to integrate military culture into course assignments. A number of respondents indicated that they gave class presentations on military topics, which were enriching for the Veteran and civilian students alike.

Given that many of the student Veterans wanted to work with Veterans, it may be important to discuss issues related to TRICARE benefits and working for the VA. Being able to accept this type of insurance or work in the VA will vary depending on discipline, and accreditation (ACA, 2011). Ensuring that the student Veteran's goals are aligned with the opportunities afforded by the program will be important. Conscientious advisement and mentorship may go a long way to ensure that student Veterans are choosing programs that will help them meet their goals.

Limitations and Future Research

The findings may be limited by researcher biases and sampling issues. Given that I am not a part of the culture under study, there may have been culturally specific nuances to the respondents' narratives that went unnoticed. Additionally, given my outsider status, some respondents may not have felt comfortable fully disclosing their stories. As Ned suggested in his interview, many combat Veterans are weary about sharing their stories with non-combat Veterans and civilians. The lack of differences found between combat and non-combat Veterans may have been due to this weariness. Future research conducted by a scholar combat-Veteran might yield different results.

The sample may also limit the utility of the findings, given that it was both militarily and professionally diverse. While the themes appeared to transcend concentration (i.e., counseling, psychology, social work), there may be field specific experiences that were not detected given the small sample size. All the mental health professions represented in the sample have a direct-practice route; however, it does not mean that the coursework is homogenous. Additionally, the diversity in current professional standing may also impact the findings. Four of the nine respondents were graduates working in the field; they may recall their educational experiences differently given their years of experience. Similarly, the Veterans served in the military at different times and under different conditions. These experiences may have shaped the quality of their experiences. While no differences were detected in the results, research may be warranted with more homogenous samples.

Other areas of future inquiry may include an examination of the implementation of student-Veteran friendly techniques in coursework. While some of the suggestions might produce positive feelings (e.g., integrating military culture into courses), others may be less appreciated (e.g., being acknowledged as a student Veteran). Just because these suggestions came from student Veterans does not necessarily mean that they will be well received in the classroom. Future research might focus on these suggestions and how they are experienced by student Veterans themselves. Similarly, an assumption embedded in the findings is that Veterans are uniquely suited to provide mental health services to Veterans. There is no research in this area, but the accounts were full of supportive anecdotal data from the participants. Further

research in this area may elucidate whether this assumption is true and, if so, what about that pairing is beneficial.

Conclusion

The results from the present study depict a student population with unique needs from the institution and the professorate. If there are insufficient institutional supports, student Veterans may seek out support from their professors. As such, mental health professors need to be prepared to play a number of roles in the lives of student Veterans. While this population is largely self-sufficient, they pose unique challenges for educators in regards to accessing funding, managing deployment, and addressing mental health issues. Professors reaching out to this population may go a long way in terms of helping to facilitate a meaningful educational experience; however, colleges and universities would be well served by creating administrative positions to provide additional supports.

This study situates mental health professors in a position to scaffold student Veterans entering the mental health field. The profession's tradition of inclusion needs to extend to this population and their needs have to be acknowledged in higher education. The challenges that they face in transitioning into a new environment with new norms can be daunting for many student Veterans. By heeding the suggestions from the present study, professors may be better positioned to support student Veterans and improve their success.

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Assessing Mental Illness Stigma and Resilience in the Military

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Abstract

This article explores mental illness stigma and psychological resilience as they relate to military personnel. Given the unique characteristics of military culture, assessment of stigma and psychological resilience offers important information to researchers, clinicians, and military recruiters and leaders who make personnel decisions. Although it is known that stigma and resilience are related and important constructs in military personnel, there is no formal assessment, which measures both concurrently. The authors review the literature on mental illness stigma, psychological resilience, and their assessment in the military. A final conclusion proposes that a measure that assesses the two constructs together is warranted and would be vital in assisting with multiple issues currently experienced within military personnel.

Keywords: mental illness stigma, psychological resilience, military personnel

Mental illness is prevalent in the United States, with one quarter of adults struggling with a diagnosable concern in a given year (National Institute of Mental Health, 2013). Mental illness can influence an individual's life in a number of ways, impacting a person's daily functioning with cognitive, behavioral, and affective difficulties. The stigma of mental illness, however, has been said to be as harmful as any symptoms of the illness (Feldman & Crandall, 2007) with one

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of the largest consequences of stigma being avoidance of mental health treatment (Larkings & Brown, 2012; World Health Organization, 2013). In relation to all other forms of stigma, fact, struggling with mental illness has long been recognized as one of the most powerful (Bathje & Pryor, 2011). Furthermore, multiple aspects of mental illness are susceptible to stigmatization, such as both having a psychological diagnosis and the act of seeking treatment (Bathje & Pryor, 2011; Ben-Porath, 2002).

Various types of stigma exist, each with negative consequences. Public stigma, or the common societal reactions to people who seek help for psychological distress include beliefs such as those with mental illness are dangerous, should be feared, or are annoying. These beliefs result in a lack of sympathy, denial of employment, housing, or social interactions (Bathje & Pryor, 2011; Corrigan & Watson, 2005). Self-stigma describes the internalized negative impact of public stigma (Bathje & Pryor, 2011; Corrigan, Morris, Michaels, Rafacz, & Rusch, 2012; Crowe, 2013), whereas associative stigma, or the discrimination felt by friends and family of someone struggling with the mental health issue, impacts those in contact with the person with the mental illness (World Health Organization, 2013). In turn, a number of negative consequences of stigma related to mental illness exist, both internal and external. These include decreases in self-esteem and increases in shame, fear, and avoidance (Bathje & Pryor, 2011; Corrigan, 2004; Link, Yang, Phelan, & Collins, 2004). External consequences include exclusion, discrimination, prejudice, stereotyping from others, and social distance (Corrigan, 2004; Link et al., 2004; Smith & Cashwell, 2011).

The stigma of mental illness in the military is of such concern that it has recently been named a mental health crisis (Dingfelder, 2009). Given the unique stressors and culture of the military, stigmatization of mental illness may contribute to the avoidance of much needed mental health services. Untreated mental health symptoms can worsen and lead to suicide. Recently, Kuehn (2010) discussed suicide, particularly in Army personnel, and reported that since 2008, the rate of suicide in the Army is greater than the rate found in the general population (20 per 10,000 as compared to 19 per 10,000, respectively). In addition to stigma, psychological resilience is another important topic related to the overall mental health in military personnel. Defined as the ability to successfully change or adapt in the face of adversity (Pietrzak et al., 2010), resilience plays a vital role in protecting individuals against mental health struggles associated with the stress of combat. Although some individuals respond to the traumas of combat without lasting mental distress, many others return home with mental health issues (e.g., post-traumatic stress disorder [PTSD] and depression) and the need for psychiatric treatment. Furthermore, only about half of those returning from combat deployments with symptoms of PTSD or depression seek help (Meredith et al., 2011). In turn, the Department of Defense (DOD) has responded with a call for increased attention to the "invisible wounds" of combat (Meredith et al., 2011).

Resilience is highlighted as a potential explanation as to why some individuals remain as psychologically healthy as they were before traumatic experiences associated with war, whereas others do not (Seligman, 2011). Psychological resilience can include protective factors such as positive emotions, cognitive flexibility, meaning making, social support, and active coping (Pietrzak et al., 2010). Protective factors such as these have the potential to decrease mental health issues such as depression, which meta-analyses have revealed as a significant predictor of

PTSD (Oliver, Harman, Hoover, Hayes, & Pandhi, 1999; Brewin, Andrews, & Valentine, 2000). In sum, researchers (Pietrzak et al., 2010) have investigated and substantiated that resilience has an impact on mental health struggles in military personnel.

This article will examine the stigma of mental illness, the unique characteristics of the military that may impact that stigma, the concept of psychological resilience and how it relates to stigma, with a particular focus on current measures that exist to examine these two constructs. Although there are instruments that measure mental illness stigma, there is no current instrument that measures mental illness stigma in military personnel. Further, while stigma and resilience have been discussed as related constructs, a measure does not exist that measures the two constructs together and in military personnel. We conclude with a call to the profession for a measure that explores these concepts together. Such a measure is necessary, since the two constructs have been reported as related (Boardman et al., 2011; Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009). The measure would add to the existing body of literature related to military mental health.

Military Culture and Stigmatization of Mental Illness

Few would debate that life in the military does not expose a person to a unique culture. Viewing the military as a culture separate from nonmilitary populations is not a new idea (Christian, Stivers, & Sammons, 2009; Reger, Etherage, Reger, & Gahm, 2008) and is supported through research that has demonstrated that U.S. service members share more traits with service members from other nations than with U.S. civilians (Matthews, Eid, Kelly, Bailey, & Peterson, 2006). In order to adequately serve the needs of a military population, it is critical that counselors understand the cultural context involved when working with military clients.

It has been suggested that military culture is created due to the use of specific language, symbols, and hierarchy that exist in the formation of armed forces personnel (Greene, Buckman, Dandeker, & Greenberg, 2010). The U.S. military has developed a culture that values strength, courage, resilience, and personal sacrifice (Bryan & Morrow, 2011). Although it may be suggested that these values are desired in nonmilitary cultures as well, the military is unique in that it demands that individuals be willing to make sacrifices for others, perhaps including giving of their own lives if necessary (Dandeker, 2000). This helps to create a culture where value is placed on a person's ability to conquer fear when faced with extreme danger as well as the ability to make difficult decisions quickly, even though those decisions could cause loss of life (Greene et al., 2010). Emphasizing courage helps to promote resilience, which potentially leads to fewer psychological breakdowns (Baynes, 1967).

Presently, the U.S. has been actively engaged in war, through Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) for 12 years. In support of the war effort, approximately two million members of the U.S. Armed Forces have engaged in combat or combat supporting operations (Osinub et al., 2012). The conflicts in Afghanistan and Iraq not only boast an extensive duration, but also a high operational tempo (i.e., a measure of the frequency and length of deployments; Ryan, 1998). In turn, military personnel are at a high risk of exposure to events that are potentially traumatic (Langston, Gould, & Greenberg, 2007). This exposure makes them vulnerable to experiencing and suffering from mental health issues that

may include depression, family violence, and PTSD (Hoge et al., 2002). In addition to the typical stressors of war, service members are expected to function at peak efficiency when carrying out their duty. Difficulties caused by mental health issues, which potentially interfere with one's ability to function at an expected level could have very serious consequences, both personally and professionally. As such, mental health issues that threaten a service member's occupational functionality are often hidden, and treatment not sought, due to those feared consequences.

Given the extended combat operations in Afghanistan and Iraq for the U.S., the number of military personnel reporting psychological problems upon return from deployment continues to grow, potentially resulting in future veterans at risk for chronic mental health problems (Litz, 2007). Over 1.3 million service members returning from the wars in Afghanistan and Iraq have become eligible for benefits from the Department of Veterans Affairs (VA), with mental health disorders ranking as the second most common diagnosis (Osinubi et al., 2012). Due to these numbers, the DOD and the VA have worked to improve access to mental health services. They have done so by expanding professional mental health staffing within their agencies, as well as facilitating access to outside entities (Bryan & Morrow, 2011). Other helping professionals have also implemented outreach programs to serve the military population; however, the effectiveness of these programs is in question given the fact that mental health problems, in general, continue to rise (Department of the Army, 2010).

One explanation for the limited success of mental health outreach programs is the entrenched mental health stigma among military personnel (Bryan & Morrow, 2011). In fact, the World Health Organization has gone so far as to suggest that effectively dealing with the stigma and discrimination towards persons who suffer from mental and behavioral disorders is the most important barrier to overcome in the military community (World Health Organization, 2001). The development of this stigma has been viewed as a systemic issue, deeply rooted in military traditions (McFarling, D'Angelo, Drain, Gibbs, & Olmsted, 2011). This pervasive stigma inhibits many members of the military from seeking the mental health services that are so desperately needed. This is evidenced by the statistic that less than half of the veterans of OIF who screened positive for depression, anxiety, or acute stress sought help. Furthermore, this was mostly due to concerns that those in leadership positions would treat them differently, that peers would perceive them as being weak and have less confidence in their ability to perform well in their jobs, and that seeking such mental health services would have a negative impact on their career (Capella University, 2008; MHAT-V, 2008; Pietrzak, Johnson, Goldsein, Malley, & Southwick, 2009). This in turn makes the task of providing quality mental health care to military personnel more complicated than simply offering the services.

Offering effective treatment is critical; however, the impact of that care is greatly lessened if the target clients are intentional in avoiding such services. Negative attitudes toward seeking mental health treatment are often dependent on military personnel's perceptions of how others will respond to their treatment status (McFarling et al., 2011). Therefore, being able to provide much needed mental health care to military personnel requires service providers to facilitate change in the perception of both the individual service member in need of care, as well as the culture in which they work (Bryan & Morrow, 2011).

Resilience and the Military

It has been suggested that most people are exposed to at least one violent or life-threatening situation during their lives (Breslau, Davis, Peterson, & Schultz, 2000; Copeland, Keeler, Angold, & Costello, 2007; Ozer, Best, Lipsey, & Weiss, 2003), or the loss of a loved one. Not everyone handles these situations in a similar manner, and some people are seemingly able to deal with various levels of stress more effectively than others. For the military, the identification of persons who are better able to effectively deal with traumatic events is important. The idea is that those persons who best deal with traumatic stressors are best suited to perform effectively within the military profession and specifically, in combat roles. The importance of protective psychological factors in the prevention of illness has been well documented (Taylor, Kemeny, Reed, Bower, & Gruenewald, 2000).

Just as in other occupations, retention of effective personnel is important to the military. The extraordinary costs associated with recruitment, training, and retention of military personnel make it important to identify effective support systems to mitigate the impact of psychological trauma and hopefully avoid the loss of valuable personnel (Keller et al., 2005). It has been suggested that this resilience, or hardiness, operates through social support to increase resistance to PTSD (King, King, Fairbank, Keane, & Adams, 1998). Bonanno (2004) points out that the vast majority of individuals who are exposed to violent or traumatic events do not go on to develop PTSD, and that this should be given more attention.

Earlier models of development assumed that only children with substantial coping abilities could thrive in adverse situations (Bonanno & Mancini, 2010); however, recent studies suggest that resilience is a result of normal human adaptation mechanisms (Masten, 2001). Given the evidence that occupational stressors can physically and mentally impact employee well-being (Barling, Kelloway, & Frone, 2005), it is logical that the military would be interested in the impact such stressors can have on their personnel. The military is aware of the potential consequences related to deployments for extended periods on a repeated basis, as well as the other impacts of combat, and the challenges that these factors pose for military personnel and their families (Meredith et al., 2011). The military community is particularly interested in the concept of resilience in terms of keeping personnel and leaders fit for duty, as well as protecting the health of military families (Meredith et al., 2011). Military members continue to worry about the confidentiality of seeking psychological help, which serves to enhance the pervasive stigma of receiving mental health services among this population. In recent years, the military has worked towards a model emphasizing "building a culture of resilience." Meredith et al. (2011) explains that this model stresses strengths and views the use of psychological services as prevention, and emphasizes that mental health is equally as important as physical health. The idea is that most military personnel will remain at optimal functioning given they receive prevention and intervention through education and training. The military believes that such resilience programs will keep military personnel, leaders, and families mentally healthy and best prepared for duty across all phases of deployment including pre-deployment, in theater, and post-deployment (Meredith et al., 2011).

Resilience and Stigma Assessment

Resilience

Resilience for military personnel has been the subject of much conversation in the last few years, and a number of current assessments that measure resilience in military personnel exist. Despite increased interest in the topic, there has been little consistency regarding the definition and measurement of resilience (Kolar, 2011). This could lead to a variety of issues, such as confusion amongst researchers and the use of measures not validated for a particular population. Researchers have indicated the importance of understanding resilience within the specific culture in which it is observed (Kolar, 2011). Therefore, agreement on what factors combine to describe and explain resilience in the military, and how to measure it, remains vital.

One formal measure of resilience that has been used within the military context is the Deployment Risk and Resilience Inventory (DRRI; Vogt, Proctor, King, & Vasterling, 2008). The DRRI measures deployment-related factors related to health and well-being in the military before, during, and after deployment. Specific to pre-deployment, the scale measures prior stressors and childhood family environment. Ten features of deployment are examined (combat experiences; perceived threat; aftermath of battle; difficult living and working environment; sense of preparedness; nuclear, biological, and chemical exposures; concerns about life and family disruptions; deployment social support; sexual harassment; and general harassment) and two post-deployment factors (post-deployment social support and post-deployment stressors) are included in the scale. Psychometric properties and a full validation study can be found for those wishing to read more about the scale (Vogt et al., 2008). While the scale is comprehensive as it measures resilience before, during, and after combat, there is no inclusion of mental health services and attitudes toward seeking support from professionals related to mental health concerns. Given the notion that military personnel will most likely experience one or more traumatic events, the possibility of needing mental health support to overcome these experiences is likely. The stigma of seeking such help among military personnel oftentimes prevents this from occurring, thus measuring these attitudes as they might relate to resilience seems important.

Another assessment, the Global Assessment Tool (GAT; Peterson, Park, & Castro, 2011) provides military personnel with a baseline score on five dimensions of resilience – emotional, spiritual, family, social, and organizational context, which includes items that measure unit cohesion and leadership. The following is a brief description of items for each dimension. For emotional fitness, subscales include but are not limited to adaptability, good/bad coping, depression, positive affect, and optimism. An example of an item is "I usually keep my emotions to myself" (bad coping). An example of an item that measures spiritual fitness reads, "My life has lasting meaning." Social fitness includes but is not limited to friendships, engagement, and organizational trust. An example item is "I have someone to talk to when I feel down." Family fitness includes family satisfaction and family support. A sample item includes "My family supports my decision to serve in the Army." Related to the organizational context subscale, an example of an item is "Soldiers in this unit have enough skills that I would trust them with my life in combat" (unit cohesion). The scale has been adopted by the United States Army as part of a program entitled the Comprehensive Soldier Fitness, and is offered not only to soldiers but to military families. There is an opportunity to track development and growth over time, and results

are not shared with others or diagnostic in nature. Military personnel are able to enhance resilience after learning their areas of strength and improvement. Soldiers take the GAT every two years or 120 days after deployments. A benefit to this test is that the military has validated it over time, and these reports are available online. The most recent update on the instrument's psychometric properties can be found online and was completed in April 2013. Reliability estimates for the GAT range from .66 to .99. Similar to the DRRI, the GAT does not include attitudes toward help seeking or mental illness within the dimensions of resilience. The emotional fitness subscale, in particular, seems to be an opportunity to measure attitudes towards seeking mental health support, since this is a healthy coping skill.

Mental Illness Stigma

Unlike resilience, mental illness stigma has not been measured in a military-specific assessment tool. There are, however, assessments that measure general mental illness stigma. The Opinions of Mental Illness Scale (OMI; Cohen & Struening, 1962), the oldest scale to measure stigma, is still being used in current research (Hinkelman & Haag, 2003; Lauber et al., 2004; Link et al., 2004; Penny, Kasar, & Sinay, 2001; Wallach, 2004). Although the OMI is used to understand stigma, inform the literature, and present findings to the public, significant weaknesses exist with the instrument, namely its outdated language and low internal validity due to weak psychometric properties. Specifically, the lowest alpha levels of the OMI scales range from .29 to .39 for the Mental Hygiene subscale and the highest alpha levels range from .77 to .80 for the Authoritarian subscale (Cohen & Struening, 1962; Ng & Chan, 2000). Outdated language such as "mental patients" is used on the instrument (Cohen & Struening, 1962, p.351). Although scholars (Ng & Chan, 2000) have attempted to strengthen and reanalyze the factor structure of the OMI, little psychometric improvement was found. Despite this, authors (Pitre, Stewart, Adams, Bedard, & Landry, 2007) have used the updated factor structure to measure mental illness stigma.

Others have attempted to develop a more current measure to assess mental illness stigma, the Community Attitudes Toward the Mentally Ill (CAMI; Taylor & Dear, 1981). Similar to the OMI, outdated and pejorative terms such as "mental patients" and "the mentally ill" are used on the CAMI. For example, one item on the measure states "Mental patients should be encouraged to assume the responsibilities of normal life." Such language is problematic because the item itself reflects aspects of stigma. Although the CAMI boasts stronger inter-item reliability than the OMI (α = .68 to .88 on subscales), there are significant threats to the validity to this measure. Researchers have found that two of the four subscales may not be distinct constructs. The Authoritarianism and Social Restrictiveness were found to almost equally correlated with the Community Mental Health Ideology scale (r = .73 and r = .72, respectively), and similarly correlated with the Benevolence subscale (r = .51 and r = .46, respectively), suggesting that the Authoritarianism and Social Restrictiveness scales represent a single dimension (Taylor & Dear, 1981). The authors, however, treated them as two separate subscales. Despite the psychometric limitations of the CAMI, researchers continue to utilize the CAMI as a measure of mental illness stigma (e.g., Hinkelman & Haag, 2003; Lauber et al., 2004; Smith, 2008).

Most recently, researchers (Michaels & Corrigan, 2013), have created measures that examine stigma toward mental illness in ways other than self-report. Through the use of implicit

measures of prejudice, researchers are able to assess attitudes that are stigmatizing and would otherwise be subject to social desirability bias. A validity study indicated fair to good (.50-.70) test-retest reliability. A full validity and reliability report can be found for authors wishing to see more information (see Michaels & Corrigan, 2013). Since self-report assessments are subject to social desirability, this latest development is an important one.

Resilience and Stigma

Although there are formal measures that measure mental illness stigma and resilience separately, there is not a current instrument that measures the two together in military personnel. Completely missing is a measure examining mental illness stigma in military personnel. The capacity of military personnel to withstand stress is directly linked to both resilience and willingness to seek professional help when faced with mental health issues (Boardman et al., 2011; Pietrzak et al., 2009). However, the stigma found in the military when seeking treatment prevents many individuals from getting the help they need. In fact, such fears have fueled what researchers and military officers alike are calling a mental health crisis. This is demonstrated by the amount of personnel returning home from the wars in Iraq and Afghanistan reporting symptoms of PTSD or major depression. Further contributing to its conception as a mental health crisis, only half of returning military personnel who report such symptoms seeks treatment (Dingfelder, 2009). Although resilience and stigma have been discussed separately as they exist in military personnel, research supports that stigma and resilience are related (Boardman et al., 2011). Specifically, low resilience can predict an increase in mental illness stigma in such a way that as a person's resilience is diminished he/she is less likely to seek support (Pietrzak et al., 2009). Therefore, the capacity to measure both stigma and resilience is important to preserving and addressing the mental health needs of military personnel. We propose that they be examined together so that researchers and clinicians alike might understand more fully the relationship between the two as they relate to military personnel.

An assessment that adequately measures stigma and resilience together could better assist the military population identify personnel who are at risk for experiencing mental distress. Specifically, the existence of such measures can have impactful results on current issues experienced within the military. For example, in regard to resilience, as Meredith et al. (2011) note, in recent years the DOD has implemented a series of interventions that address psychological resilience within service members. However, very few of these programs empirically investigate their effectiveness (Meredith et al., 2011). In fact, only five of the 23 programs examined by Meredith et al. (2011) had any type of formal effectiveness assessment. As the awareness of stigma within the military becomes more prevalent, it is conceivable that the DOD will respond with a similar variety of interventions as those seen with resilience. Furthermore, it can be expected that assessment of such interventions will be conducted with equal or less rigor as observed in resilience programs.

In turn, an assessment that measures stigma and resilience could prove to be a valuable tool in the review of military intervention programs. In addition to this intervention-focused use, a large amount of individual benefit is expected from such a measurement tool. Specifically, when used on an individual level, groups within the military of various sizes (e.g., task element, platoon, and squadron) can evaluate and assess the level of stigma and psychological resilience

within their personnel. This may be facilitated in a variety of ways. First, it may be possible to contract the services of professional counselors to administer the instrument to military personnel. An alternative approach would be to design an instrument that can be easily and effectively administered by chain of command. Future research in the area will assist in determining the best method of dissemination for such an instrument. Nevertheless, once administered, individual stigma and resilience scores can be shared with the individual, as well as discussed on a group level in aggregate fashion. This will help facilitate a variety of benefits. For example, individual scores can be used to help direct individuals who may need mental health services to the proper entities or simply increase an individual's level of awareness regarding the concepts. Furthermore, discussing scores on a group level aids in opening the conversation to the topics of stigma and psychological resilience. Such conversation potentially eases feelings of hesitation in asking for mental health services or reducing negative feelings towards others seeking help.

Until an assessment measures stigma and resilience together, the field is missing an important piece of the puzzle concerning mental wellbeing in the military. Although researchers have begun to examine the topics in the military (Vogt et al., 2008), there have not been efforts to look at the two constructs together in order to explore their relationship and how they might predict outcomes, such as lower levels of mental distress or longer military tenure. Psychological and environmental resources and how these predict stigma and resilience can be explored with an instrument that includes both variables. Until then, these factors will go unexamined as they exist in the lives of military personnel.

Conclusion

The need for an assessment that adequately measures stigma and resilience together is necessary to better predict mental distress among the military population. This type of instrument could be useful in helping military leaders recruit personnel who would be more resilient, and therefore better suited for certain specialized roles. Such an instrument could potentially identify those persons who are more at risk for mental health issues, which could factor in decision making regarding deployments or responsibilities. In addition, such an instrument might help connect military personnel with much needed clinical mental health services, and more adequately deal with the stigma and reluctance to receive psychological services. The possible benefits are numerous, and assist with making mental health care more targeted, responsive, and effective for a population that is in desperate need for such services.

In conclusion, an instrument that measures stigma and resilience is envisioned as a multi-faceted tool for assessing and identifying mental health concerns within military personnel. Although the use of such a measure can help to guide individuals to seeking mental health services, its direct purpose would not be to serve as the intervention itself. Scores could be used to determine optimal career pathways for military personnel, functioning as an early detection and prevention tool. Finally, a stigma and resilience instrument can be used to help guide the design of intervention programs to ensure that they adequately address the factors of stigma and resilience, as they currently exist in the military.

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Treating Veterans with Complex Traumagenic Disorders: When Childhood Traumas and Current Traumas Collide

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Abstract

A proposed working approach is delineated as a methodology for treating persons with complex traumagenic disorders. It provides a format and a system of treatment, in order to help reduce the symptom clusters which occur in people who have experienced a combination of childhood trauma, as well as adult trauma, whether as a result of exposure to natural disasters, combat or war. It is argued that traumagenic resolution therapy needs to occur first, before cognitive behavior therapy can be effective. In addition a systems approach is needed to assist the person within the context of their environment, and then tasks such as parenting and other relational interactions will greatly improve. Symptom reduction will then occur, and be maintained, as the feedback loop of positive behaviors is reinforced.

KEYWORDS: traumagenic, traumagenic resolution therapy

Introduction and Historical Considerations

Cognitive-Behavior Therapy (CBT) is framed by the representational models of worldviews for clients (Lazarus, 1978). Lazarus, an early progenitor of CBT, also stated that CBT came about in a time when the social and political forces seemed to be encouraging people to avoid personal responsibility for their actions. Strict behaviorism flourished in America from the 1950's through the 1970's. CBT came about in the 1970's and 1980's and continues to flourish worldwide at the present time (Panzano & Herman, 2005). As opposed to strict behaviorism, CBT made the assumption that the environment was given too much emphasis and that many people were blaming the environment for their own personal behaviors and choices.

Many theoreticians wrote that a balance needed to occur between the self and the environment, which included taking responsibility for one's own actions, as well as pursuing the ability to change the self without changing the environment (Lazarus, 1978). Also, clinicians and researchers seemed to be countering strict behaviorism, which stated that humans were simply

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S>R (stimulus-response) organisms. CBT researchers emphasized that humans have intermediate thoughts/cognitions and devised the model S>C>R (stimulus-cognition-response). Therefore, the premise came about that changing the thought would change the action. This was met with hostility by those who said the only way to change the action was to either to change the gene (nature) or to change the environment (nurture). CBT advocates responded with the idea that limiting the options to only those two extremes was a cognitive error; what needed to take place was to change *both/and* rather than *either/or* and to even find additional options for changing thoughts.

Do our thoughts determine or influence our behaviors? Do the antecedents of an event determine the thoughts that precede the actions people take? Compelling evidence would indicate yes on both accounts (Medin, Ross, & Markman, 2005; Rapp & Goscha, 2005). Consider the example that someone is tailgating you. Two urges emerge. Slam on the brakes to make him back-off or slow down so he will pass. Which choice you take depends upon the thoughts you have about the event itself, as well as what has happened to you in about the last three hours before the event (Berkowitz, 1993). If it has been a relatively good three hours, then you may have the thought that the other driver needs to get to the hospital, or has some other emergency, so you will slow down so he can pass. If it has been a stressful, tense, and conflicted three hours, you may have the thought that the driver tailgating you is a jerk, and so you slam on the brakes to jolt some sense into him. The second option is what defensive driving taught you not to do, but you still think it would feel better to do so. The idea is that we all want the adrenaline spike from the option of more conflict (Berkowitz, 1993). Shaler, Hathaway, Sells, and Youngstedt (2013) found this to be the case with Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans with problematic anger.

In fact, in agitated depression, it turns out that people will pick fights or bully other people in order to get that adrenaline spike (Pruitt & Kim, 2004). One can still change the environment or genes or chemicals to change the action, but many times in life, the environment is what it is and is not able to be readily altered. While chemical alterations may work, they are temporary. Genetic alterations are unethical at this time and in this author's opinion, need to remain unethical. Hence, helping people focus on what can be changed, for example internal thoughts, will help them to devise ways to be responsible and perform positive actions (Medin, Ross, & Markman, 2005). The early researchers like Ellis, Beck, Meichenbaum, and Lazarus, to name a few, were very research-driven and extremely prolific. Some of them still remain to be so. Charles Figley has led the way in helping us to understand veterans and to reduce compassion fatigue since 1989 (Figley, 1989). He was certainly a pioneer in his research regarding treating Vietnam veterans with complex trauma histories.

Traumagenic Resolution Therapy, Cognitive Behavior Therapy, and Systems Approaches in Treating Complex Traumagenic Disorders

Celano, Hazzard, Campbell, and Lang (2002) stated that traumagenic resolution therapy (TRT) was a set of techniques, developed in the 1990's, used with children who had been sexually abused, in which the therapy countered the effects of attribution and self-blame. These children had a set of mental images and representations that were pre-cognitive and seemed to resist treatments. Further, Houston, Shevlin, Adamson, and Murphy (2011) noted that co-

occurring traumas tend to cluster symptoms to an inexpressive realm, and thus, for effective TRT, the individual would need an expressive person-centered approach in therapy, prior to the use of cognitive behavior therapy (CBT). The individual would then deal with that which is inexpressive first, helping it to emerge, then finding words for it, and then finally dealing with that which has become expressed. Hansen (2005) issued a strong plea for counselors to again note and treat inner subjective experiences (ISEs) as much as the cognitive experiences. I would argue that it is especially important to treat the ISEs prior to the cognitions in people with complicated traumas (Sarno, 2009). Resolution of the childhood traumas needs to occur, prior to using the approach of cognitive behavioral treatment, as well as resolution of current traumas in adults. TRT employs a wide range of expressive therapies including the use of projectives, drawing, sculpting with materials, family of origin sculpting, and play therapy with adults, all with the aim of resolving childhood traumas.

The idea that how one thinks will influence how one acts is not new. There are proverbs and admonitions in the Old and New Testaments of the Judeo-Christian Scriptures (which are about 2000 to 3500 years old) that advise the readers of that truth. We are cautioned of how to think and about with whom we associate, because of the thoughts they can speak into our lives. It would seem then, that Cognitive Behavior Therapy (CBT) is based upon time-tested principles, which are now being tested again in a more scientific fashion by those of a philosophical Western mindset and worldview. Thus, it is quite beneficial for those of us who are Christian counselors or chaplains, to use both our familiarity with the Scriptures, as well as the present day scientific literature, when working with Veterans and combat stress survivors. It would seem that there is a great deal of benefit in helping our Veterans to recapture inner subjective experiences (ISE's) as well (Dees, 2011; Hansen, 2005).

Hence, CBT is based upon solid research and evidence-based practices, which are important for the counselor/educator and counselor as well as others in the field of human services (Panzano & Herman, 2005; Rapp & Goscha, 2005). The client has beliefs that shape the actions and behaviors which are desired. Conversely, other beliefs produce actions and behaviors that are undesirable. Helping the Veteran client who has seen combat to look out a new belief window or representational model of life will change the undesirable behaviors into productive ones (Dees, 2011; Jones, 1986). The theory of cognition is complex and by no means unified. For fullest efficacy of treatments, any childhood traumas need to be resolved prior to utilizing another therapeutic approach. The paradigm that this author has adopted will be discussed later in this paper.

But first, the question that needs to be asked is: Does TRT or CBT work the same for women as for men? Paludi (1998) stated yes, despite differences in communication styles between genders. Women seem to ask more tag questions and qualifiers, make longer requests, and use more fillers in their speech. This is noted internal and external dialogue. Women seem to use more words to get across their feelings and men tend to suppress feelings. Therefore, the intermediary thoughts of women may have more uncertainty than those in men, as women are more flexible than men. Women smile more than men, but women also have more negative self-talk than men. That could be why women suffer from depression more readily than men, in addition to the fact that men mistreat women more often than men mistreat men.

Paludi (1998) pointed out that successful cognitive readjustment of beliefs needs to include coping, learning, adapting, self-confidence, honesty, and strength. There is a way to teach all people relational intimacy with the self, which includes those cognitive corrections from the old cognitions. Furthermore, the cognitive distortions of magnification of the negative, using imperatives, all-or-nothing thinking, mind reading, and negative forecasting need to cease and be replaced with cognitive corrections.

Both genders are at risk of using the distortions, so corrections are best accomplished by using the theory of thought substitution (Fredrickson, Tugade, Waugh, & Larkin, 2003). The replacements for the distortions listed above are: realistic strategizing, permission from self to relax, both-and thinking, asking from and clarifying to others, and positive creative realistic visioning. Greenberger and Padesky (1995) wrote about how these negative cognitive automatic thoughts keep us from coping. We need to understand the negative automatic thoughts in order to help us to cope. People need to think about the negative, not to believe the negative, but to change it. Coping, according to CBT theory, is thinking about the negative in a framework of how to change it and not believe it (Seligman, 2006). Thinking about negative thoughts in order to change them and not to believe them, is a strategy that is most effective. Journaling and thought logs are important tools in the theory which drive CBT.

Systematic desensitization is one means to overcome fear (Seligman, 2006). All fears are worth overcoming, but for the purposes of this paper, we are focusing on the fear of failure and the fear of success. CBT is considered a treatment system requiring goal-setting and action. One criticism of CBT is that it accomplishes only superficial and temporary gains, but many will attest that the gains are long-lasting (Fredrickson, Tugade, Waugh, & Larkin, 2003). Positive emotions which replace negative emotions, in a type of build and broaden theory, are indicative of rather permanent resiliency and long-term change. Build upon the small amount of positives which the person states to already possess, and broaden the positive emotions from a type of funnel model, into a cylinder. The person's range of emotions was meant to be a cylinder, yet due to childhood abuse, a funnel of protection and survival occurs, in which the same negative emotive response is given for many situations. Thus, TRT and CBT can be used in multiple settings, and can also be considered treatment in one context, and education in another; it can be utilized with veterans, as well as with their family members, or in various social support settings. It might be used theoretically when teaching students about overcoming their fears, or when supervising practicum students or soon-to-be-licensed interns regarding their fears, or clients over their fears, or even me in overcoming mine. Fear of success is a nasty cognitive construct that gets in the way for so many of us, often just as much as the fear of failure. Processing trauma with TRT is important in the process of finding safety and acceptance before launching into CBT in order to reduce the symptoms.

A fear which was quite familiar to me as a kid was the fear of, "being in trouble." As an adult, when I have not been in trouble, dread can still overtake me with the thought that something bad will happen any second. I might as well be afraid to succeed. For me, it is really a fear of getting in trouble before I succeed; this is often seen in survivors of childhood abuse. Putting that into a cognitive construct sounds like this, "I'm going to get into trouble any second, so let me do the bashing for you." The thought occurs and a self-degrading statement is made. People seldom like someone putting themselves down. So the success is averted since negative

reactions from others follow the self-degrading statement. And, yes, once again, success eludes me.

In CBT theory, the thought, "I'm going to get into trouble any second, so let me do the bashing for you," is replaced with a positive thought. This can be done in a systematic manner, so as to desensitize the behavior. This works just like the concept of self-rating cards which are used to help someone with public speaking, for example. For a month, I would think, "I'm going to get into trouble any second or maybe not." The next month, it is replaced with, "I don't think I will get into trouble today." The next month, "I think I will get a reward for great work today." Intermediate thoughts need to gradually get to the goal. Someone can't skip the steps in the process, as the brain will reject it as being beyond reality. A series of successful approximations towards the truth must be unveiled and also accepted in steps. Then the fear of success or failure in public speaking, or whatever the fear is about, will be abated.

That is another important part of the theory as well. When you deal with one area, all of the surrounding areas are improved upon as well. This brings us to this author's application of the theory. Generally, there are four old beliefs that form at various ages of development that need changing. At age five, "I'm no good" develops. When working with children, it is interesting to note that many around that age often stop bringing drawings home to be put up on the fridge, as the child will often report that his drawing is not as good as "others." At age eight, the "I can't trust anyone, not even my parents, not even myself" belief develops, due to broken promises made by parents, as well as those made to oneself. At age 10, mechanistic thinking develops, and the, "I get what I deserve" complex ensues. When bad things happen, that proves three of the old beliefs. At age 12, most children have a great deal of stored up anger which hasn't been discharged with healthy anger management skills, so the belief, "anger is bad" appears on the old belief window (Berkowitz, 1993). So by age 14, most people have addictions and relational problems as a result (Brendtro & Shahbazin, 2004; Kirby, Baucom, & Peterman, 2005).

A new belief window or representational model of life will have four new beliefs that can be viewed when events occur. For our Veterans and families in treatment, Dees (2011) referred to this as deploying with the right mindset. Teaching people to look out of the new window is vital, since the old window is there. It should be pointed out here that whatever we learn before age 12 is the hardest to change. The old window does not go away. The new window is constructed alongside it and then the client is taught to look out the new window for reality. Wolin and Wolin (1993) noted that the internal image of the survivor as one who prevails, is a key component in resiliency for those from troubled families, also known as toxic families, or as those with child abuse and neglect present. Many Veterans are from troubled families (Figley, 1989). Combat Veterans quickly lose the sense of war's certitude (Bradley & Powers, 2000). Perhaps, combat stress gets them looking out the old window again and no longer as one who prevails. Treatment needs to assist combat Veterans and their families in looking out the "I will prevail" window again. We perceive reality through one of the windows, and thus our actions correspond. When an event occurs, look out the old window and a negative action will follow. With the same event, look out the new window and a desirable behavior will follow (Pruitt & Kim, 2004). Resiliency can be seen as changing the view from, "victim to victor, trash to treasure, from survivor to thriver."

One way this author expresses the new window to clients with complex traumas is to say that it contains the four corresponding, counteracting new beliefs of "I like me," "I can trust myself and some people," "I do have powerful influence over outcomes" and "anger is good." Clients are to journal a cognitive log that shows what thoughts led to a behavior set after an antecedent event. The client is to then journal the level of desirability of the outcome. Next, the new cognitive beliefs are journaled to produce a new behavior set, if needed. When a positive outcome occurs, the client journals positive compliments about the way the event sequence was handled. Helping people to be complimentary of self is difficult to achieve and at times that is the target set of behaviors to first explore. It is quite rewarding when achieved and quite an invigorating process to use. Success rates in excess of 75% are often reported (Panzano & Herman, 2005; Pruitt & Kim, 2004).

One theory about human behavior which has been disproven by the empiricism of logical positivism is that human beings cannot change. The old school postulated about humans that, "you can't teach an old dog new tricks." Now we know that anything we learn before age 12 is the hardest to change but it can be changed! Childhood trauma complicated by combat stress/trauma will leave one feeling empty and despairing of life (Figley, 1989). Whether in teaching students or in counseling people, this author benefits from the advances of science and technology in the process of helping people change. What helps combat Veterans the most depends on their age, the context of treatment and the condition of their childhood. Logical positivism looks at those variables within specific settings to inform the clinician which techniques to employ, including when and where (Tebes, 2005).

Creswell (2003) and Crotty (2005) promote logical positivism as a means of knowing what we know and why we need to know it. Dees (2011) and Koenig (2006) use a religious response approach of spiritual understanding with Veterans who have a spiritual paradigm or are seeking one. We do not really need to know why, nor can we really know why. It is interesting that in CBT, we steer people away from asking why. In the classroom, we teach the humility that we cannot really know why. After all, we cannot really 'explain' anything, we can only "describe." We can label and we can relate what we label to our experiences (Thomas, 1997). As soon as other experiences enter in, we need to change the label.

Underwood and Lee (2004) proposed using logical positivism as a means to finding the best practices for the social sciences and within educational settings. When there is so much diversity to what we do, narrow science is not applicable. We can use diverse methods to find out approximations of the truth which can be applied to diverse populations, including combat Veterans and their families/social support systems. Elmes, Kantowitz, and Roediger (2003) elucidated relational research as ex post facto (after the fact) with results that were related and happened because of naturally occurring events. The assumptions of logical positivism permit this type of science, whereas if scientific manipulation of all the variables is required, the educator or social scientist is at a loss. For example, it is widely agreed upon that there are over 150 chemicals which make up the brain. We can only measure about 20 of them in a living person. It is just as scientific to have someone describe their anger for a definition of anger, as it is to base the definition of anger on certain chemical levels. The operational definition sets the parameters of the scientific technique. One is not better than the other.

Hence, there is a need for traumagenic resolution therapy (TRT) for childhood and present trauma to occur in the treatment of combat Veterans before utilizing CBT in the treatment of present traumagenic disorders. When the patient's conclusions are revealed, this may assist in the cessation of the behaviors. The conclusions based upon traumas need to be processed in a different fashion than those based upon learning and recitation in daily developmental living and process. Similarly, Antonovsky's sense of coherence theory (as cited in Joachim, Lyon, & Farrell, 2003) described people's behaviors as purposefully maintained coping mechanisms in an attempt to achieve balance and coherence in their lives. I argued in my dissertation (Sarno, 2009), that if harmful coping skills are utilized due to the patient's distorted conclusions, traumagenic compulsions may become life-threatening, but the purpose of the behaviors need to be explored before the behaviors can be gradually decreased. Thus, Joachim, Lyon, and Farrell stated that treatment which is research-based needed to go beyond what most modalities provide, in order to help patients find coherence using non-compulsive coping mechanisms, and to achieve traumagenic resolution with relief by expressive modalities. In fact, they found that some treatments may leave the patients with other problems to contend with and that is not considered to be successful treatment.

BEST IDEAS

The following is a TRT /CBT and systems approach that this author has used since 1985 (adopted, expanded, and modified from Lazarus, 1978) and most recently with combat Veterans and their families/social support system, for the last ten years. It allows for flexibility, with the content being modified and updated throughout those years. It is especially helpful as a journaling guide for persons new to journaling or for long-term journalers as well. It has been used in a wide variety of settings and with a wide diagnostic spectrum, and especially for those with complex traumagenic disorders.

B.E.S.T. I.D.E.A.S.

B	**E**	**S**	**T**
BEHAVIORS	**EMOTIONS**	**SPIRITUALITY**	**THOUGHTS**
What observable behaviors do you want to change?	How do you want to feel about the new behaviors?	What spiritual principle will help you?	What new thoughts do you want to think?

I	**D**	**E**	**A**	**S**
INTERPERSONAL RELATIONS & INTER-DEPENDENCY	**DRUGS/DIET**	**ENVIRONMENT**	**ATTITUDE**	**SUPPORT**
Who can help you in this process?	What changes do you need to make in what you "take in"?	What do you want from those around you to help you?	What will be your "attitude saying"?	Will you stay positively and actively involved in your support systems?

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PART I

Generally, this author advises people, like combat Veterans and their families, to start with three behaviors and no more. One of those behaviors needs to be to increase humor in order to release endorphins and to help the brain change, since anything we learn before age 12 is the hardest to change. Next, we need to tell the self how to feel about each behavior change, while being under the influence of emotions. Then, we address what spiritual component will assist in the process. For some who avoid spiritual issues, I will have them use moral or ethical principles instead. Next, the individual will state and journal what new thoughts will be thought to replace each of the old thoughts.

The next area to address is interpersonal relations and who can help in an interdependent fashion. The longer the list, the better. The core of this is relational intimacy and spending time with people in self-disclosure, while at the same time learning to compliment and enjoy the mystery of relationships. Giving and receiving compl*i*ments (with an i) is an important pro-social tool. Overcoming the fear of relating is a key component here. Also, learning to compl*e*ment (with an e) people with differences is a crucial pro-social tool as well. Our attention then turns to drugs/diet. Drugs that are addressed are both exogenous drugs/chemicals and endogenous drugs/chemicals. Humans have 52 diets in terms of what we "take in" which is the Latin meaning of diet. We look at food, but also work, play, music, touch, compliments, love, sex, creativity, money, sex, communication, language… and throughout the entire menu of 52 diets. What needs to be increased and what needs to be decreased? Next, we deal with the environment and what we want from others around us. We talk about how to prompt people when we want them to listen and to prompt them when we want advice. This avoids the mind reading cognitive error game of making people guess at what we want and when. Then, I help them adopt a personal, "attitude saying" that fits them individually (like a bumper sticker) which will encourage them along the way. They are to journal this and put signs up in many places to help them in this task. Finally, the question: Will you stay positively and actively involved in your support systems? If they say yes, or even maybe, the behavior changes will occur, if they say no, then the changes will not occur. But, asking them this question last is important, as then they know what is involved, so they can answer a well-informed question.

PART II

Developmental counseling and therapy (DCT), developed by Allen Ivey, Sandra Riagazio-DiGilio, and their associates, is a type of traumagenic resolution therapy and is a type of integrated and eclectic phenomenology (as cited in Seligman, 2006). It is philosophically rooted in Plato and Hegel, in that people understand and operate in the world helped and hindered by levels of cognitive development with social units and systems. Four cognitive developmental orientations emerge over time, though some may never reach the third or fourth level. The levels are respectively: sensorimotor, concrete, formal operations and dialectic/systemic. Therapy is to help the person arrive at the fourth level.

Hansen (2005) and Hage (2006) both agreed that it is important to help clients develop to the fullest potential, and for families as well as societies to play a role in positive change. Further, change is experienced in developmental increments in the phenomenologic perspective

as seen in Vygotsky (1978) and Polanyi (1967). It is important to move victims to victors and survivors to thrivers.

This is different than the developmental hermeneutic of Oyama (1985), Buber (1970), and Fromm (1956). We grow towards love and change by saying we will. We grow from self-centeredness towards other-centeredness. It occurs as we say it. The difference of phenomenology with the philosophical orientation of hermeneutics is that perhaps hermeneutics is assisting the client in saying that they will get there is success in and of itself. Rather, to get the client to the point of change, it is sufficed and change will occur simply by getting a client to contextually say they will get to the point of change. Saying it will occur is as significant a change event as it actually occurring is a change event (Leff, 2005). Behavior will follow what has been said, and that is quite important for a hermeneutical understanding of behavior change (Elmes, Kantowitz, & Roediger, 2006; Creswell, 2003; Crotty, 2005). Many therapists will say that awareness of a problem and admission of the problem is half of the battle. Insight therapists are of the same thought, in that insight does produce change. Hence, they would be taking more of a hermeneutic position than a phenomenological one, as the latter means one has to get there to change. The former states that the statement is a sufficient change in and of the context spoken.

Narrative talk is the coding of a language connection for intrapersonal and interpersonal communication. Whether the talk is in pictures or in words, thinking is a complex task that leads to metacognition. When the metacognition phenomenon becomes distorted, all of the relationships within and outside of the self become impaired. This hermeneutic reality is an event that historically has been conveyed for over 6000 years of recorded history. Humans do not endure impaired relating for very long (Fromm, 1956; Hage, 2006). Hansen (2005) and Leff (2005) are quite explicitly rigorous in coding and rating inner subjective experiences (ISE's). The reasons for the coding and ratings are to give objective descriptions to subjective events. The objectivity does not validate the subjective experiences, but rather provides a type of narrative communication which is equal to other types of communication. The depths to which a person loves someone or the behaviors of love are shown are all equally important in the narrative that describes love (Buber, 1970; Polanyi, 1967).

Oyama (1985) provided a conceptual tool for describing the experiences of love in an informational manner of narration in order to convey meaning and truth. Human experience relies on love for survival, as well as for the essence of living life at every level. Love is a narrative tool in living life, just as food is a physical tool in living life. Survival depends upon having both among many other facets of meaningful events. Could it be that meaning has escaped the combat veteran and now the veteran needs to recapture meaning in life? Love is an ongoing event, just as eating is an ongoing event. Events can be observed and measured in qualitative, quantitative, or mixed methods (Creswell, 2003; Crotty, 2005; Elmes, Kantowitz, & Roediger, 2006). Any means to scientifically study a phenomenon as an event is conducive to the most scientific rigor.

Seligman (2006) described the events of love of self and love of others as crucial in rigorous, present, integrative and eclectic therapies, and when considered are being shown as highly effective in treating all of the disorders in the DSM-IV-TR. Vygotsky (1978) described

the events of love in the organic learning that all humans exhibit. These events scaffold in an unfolding process that is evident in all living organisms. The unfolding itself is a narrative that is meaningful. If an organism is not unfolding or scaffolding, the organism is dying. Events of love fuel the unfolding process that connects humanity within interdependent survival.

The forte of this argument is that if the highest aesthetic and ideal of love is scientifically verifiable, then so is everything else. Without succumbing to reductionism, Vygotsky (1978) noted that there are brilliant researchers who give love an elevated place in existence, yet also provide a framework for human experience to be studied. By so doing, life can be enriched and the therapeutic processes can be compared, so the best approach can be paired with each recipient. The resulting matrix and rubric of events to study and compare within this context yield rich valid results that the participants can readily understand, as well as the researchers. That is a very important distinction in this methodology. Participants are the informal researchers and as equal and important to the formal researchers. Narratives have been here longer than science and perhaps narratives contain valid information in a different way than science. Perhaps, both are necessary, side by side, in order to advance the human race, which sometimes seems to be bent upon self-destruction due to the absence of love. It is important to move "victims to victors, trash to treasure, and survivors to thrivers."

Two Case Studies

James (a pseudonym), once an Army medic, now in his thirties, served two extended deployments, one in Iraq (OIF) and one in Afghanistan (OEF). During both deployments, he experienced combat and related traumas, as well as trauma from treating other warriors. When he sought out my services, his symptoms were quite debilitating. He carried a diagnosis of posttraumatic stress disorder (PTSD), with which I concurred. He had difficulty concentrating and intrusive thoughts, as well as thoughts of impending doom always present. With gentle probing and expressive work, and after talking with him about my approach, childhood physical and sexual abuse surfaced, both of which he had never disclosed to anyone. He had thoughts of these events with considerable downrange. He commented that he probably had enlisted out of anger over his past abuse, but had never given it much thought. He did not have any childhood therapy, to his recollection.

Thus, TRT and systems approaches helped to resolve some of those childhood traumas. We had earlier completed the BEST IDEAS chart. He stated that not knowing how to proceed, the BEST IDEAS format assisted him greatly. The first of his three behaviors was improved upon significantly within 90 days, with only one day a month at the local pub, as opposed to the previous daily stays. The second behavior was to spend more time with his family, which he did as well. The third behavior was to become enrolled in and complete college courses, thus making progress towards his goal of getting a degree in a helping profession. He began to enjoy tranquility and serenity as emotions. He made self-directed improvements in each of the areas and enjoyed journaling in each area. Thoughts of impending doom, as well as other intrusive thoughts subsided significantly. He stated he was being faithful to his wife as well. His improvements continued as noted one year later in a follow-up.

Sanchez (a pseudonym), a female in her thirties, once an Airman, sought my services for complicated traumas, which included pervasive childhood sexual abuse, and later in her late teens, as she had experienced two separate date rape incidents by different perpetrators, and as well as having OIF combat trauma as an adult. She also carried a diagnosis of PTSD. She had not received treatment for the childhood or adolescent traumas. As treatment with me unfolded, she told me "things I have not said or talked about to anyone else." Using TRT and systems approaches we treated her childhood and adolescent traumas and family of origin abuse issues. Her symptoms of PTSD were also pervasive and complicated. Concomitantly, her BEST IDEAS behaviors were to make it in to work for at least three weeks, without missing a day. She was then in her fifth job in a year. Next, she wanted to laugh more in life each day. Third, she wanted to take better care of herself, which we narrowed down to specific behaviors. As she journaled her BEST IDEAS for 90 days, her PTSD symptoms greatly subsided and her progress was still present at the one year follow up session. She was in a job/career she thoroughly enjoyed, not missing any work days for "a long, long time." She reported she is dating "carefully." Her laughter is now contagious.

Proposed Future Research

The combination of traumagenic resolution therapy (TRT) and cognitive behavior therapy (CBT) with systems approaches (ST) requires future research with the use of the BEST IDEAS format. It will, no doubt, describe how the use of externalizing behaviors (EXT) will be reduced to an occurrence rate of less than 10% of the time in persons who have received traumagenic resolution therapy (TRT), systems therapy (ST), cognitive-behavior therapy (CBT), or all three. By the end of the study, persons will receive TRT, ST, and CBT, but measurements will be taken at different times and the therapies will be done in differing orders. This is an approach much like the one proposed by Figley (1989). The most notable limitation is that multiple or multimodal approaches are difficult to research.

The proposed initial sample could be 20 persons who have a high rate of EXT based upon the same type of measures used by Verona and Sachs-Ericsson (2005). Pre-test measures will be obtained as to verify the high rate of EXT. Randomly, the 20 persons will be assigned to four groups of five persons each. Group A will receive four sessions of ST, EXT will be measured, and then four sessions of TRT then CBT, after which EXT will be measured. Group B will receive four sessions of CBT, EXT will be measured, then four sessions of ST, and then CBT will be measured. Group C will receive alternating ST and TRT/CBT sessions, with only one post EXT measure at the end. This will be done to hopefully rule out any test effects elevating the EXT scores in Groups A and B. Group D will receive alternating CBT first, then TRT, and then ST sessions with only one post EXT measure to see if the order of initial type of therapy might produce any extraneous or spurious data.

In addition, a six-month measure of EXT would be accomplished to test for maintenance of the hopeful changes in the reduction of EXT behaviors. Further, narrative information would be collected and rated to see what the participants would say about the process and to help with future research directions. In the situation of any persons not showing any improvement in the reduction of EXT scores, future therapy would be available to help them in the process. All therapy would be free and the participants could not receive a fee for their involvement since that

could skew the data. Perhaps, it may be found that all treatments have equal efficacy, because ST can be construed as a type of TRT/CBT, especially when dealing with changes in role behaviors. Combat Veterans need to think of themselves differently, as being in different roles moving towards optimal balance which produces change. The key phrase I have used repeatedly in counseling, and in this article, is assisting our combat Veterans in "moving from trash to treasure, from victim to victor, from survivor to thriver." And in so doing, they will treat their families better as a result and get the social support they need as do we all.

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Efficacy of Group Treatment for Veterans with PTSD: A Review of the Literature

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Abstract

Posttraumatic Stress Disorder (PTSD) among veterans has been prevalent and often difficult to treat for mental health clinicians. Significant gains in research have been made with regards to evidence-based treatments for combat veterans and the reduction of PTSD symptoms. However, most of these gains have occurred within an individual therapy context; therefore, gaps in the literature exist regarding the efficacy of group treatment among this population. This review sought to explore the effectiveness of group treatment among combat Veterans with PTSD. Several group treatment approaches emerged. While the majority of studies demonstrated promising results for the reduction of PTSD symptoms, there were a few concerns. Therefore, future research with more rigorous methodology is recommended before drawing final conclusions.

KEYWORDS: Group therapy, PTSD, Veterans, Military

Current estimates of posttraumatic stress disorder (PTSD) among the Veteran population are reported to be as high as 20% (Kracen, Mastnak, Loaiza, & Matthieu, 2013). However, some clinicians and researchers believe that the prevalence may be understated due to the continuing stigma that exists within the military culture regarding mental health issues and Veterans who continue to refuse treatment. Given the significant prevalence of PTSD among the Veteran population, there is an increased demand for evidence-based treatments for PTSD. The Department of Veterans Affairs (VA) and Department of Defense (DOD) released an update regarding clinical practice guidelines for the management of traumatic stress among military members (Sloan, Bovin, & Schnurr, 2012). These guidelines offer three "A+ treatments" for the treatment of PTSD, two of which are only offered within the context of individual therapy. Unfortunately, group therapy is not currently formally recognized as a first-line evidence-based treatment of PTSD by the VA/DOD guidelines. Furthermore, the VA/DOD practice guidelines recommend that clinicians should "consider" using group treatment for PTSD among Veterans as it has demonstrated "some benefit." Some clinicians note that this mixed review of group therapy

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by the VA/DOD is because Veterans often struggle with vulnerability and admitting their weaknesses in front of others. Therefore, the guidelines claim that significant evidence was found that group therapy has the potential to improve health outcomes, but "the balance of benefits and harms is too close to justify a general recommendation" (Sloan et al., 2012, p. 692). Despite this formal acknowledgement by the VA/DOD, the group treatment modality is often used in various healthcare settings among the Veteran population, particularly in the VA setting where the prevalence of PTSD is relatively high.

Another respected professional association for the treatment of traumatic stress and PTSD is the International Society for Traumatic Stress Studies (ISTSS). ISTSS has published their guidelines for PTSD treatment in *Effective Treatments of PTSD: Second Edition* (Foa, Keane, Friedman, & Cohen, 2009). Within that work, they examine the evidence for group therapy as an efficacious treatment for PTSD. ISTSS guidelines have been mixed regarding the effectiveness of group therapy for PTSD treatment. The guidelines cite that group therapy is recommended as a "useful component" with regards to different traumatic experiences and treatment for PTSD. However, the ISTSS guidelines further cite the limited rigorous evidence that exists for group therapy as a treatment for PTSD while stating that no one particular group modality has demonstrated as superior over another group therapy treatment although the cognitive-behavioral model has received the most empirical support (Foa et al., 2009).

Both VA/DOD and ISTSS sets of guidelines offer minimal or mixed support for group therapy as a recommended evidence-based treatment for PTSD, particularly among the Veteran population. Overall, research about group therapy treatment for PTSD has advanced over the past 20 years but not at the same rate as individual treatment (Sloan et al., 2012). Is group therapy an efficacious treatment for Veterans with PTSD? Given that PTSD is such a prevalent mental health issue among the Veteran population, the question deserves to be examined. The aim of this literature review is to address this important question while exploring various group treatment approaches and other themes that appear in the literature.

Group Therapy Treatment Approaches

A review of the literature revealed some common group therapy treatment approaches in various peer-reviewed and academic journals when exploring the efficacy of group treatment among Veterans with PTSD. These common group treatment approaches involved some combination of the following broad categories: (a) psychodynamic and/or interpersonal, (b) cognitive-behavioral, (c) exposure-based or trauma-focused, and (d) multimodal approaches.

Psychodynamic/Interpersonal Approaches

Key components of psychodynamic and interpersonal groups focus on increasing interpersonal and intrapersonal awareness about internal conflicts and defense mechanisms. Psychodynamic group approaches may also explore insight about how the traumatic event(s) impacts the patient's sense of self, interpersonal functioning, and affective experience (Sloan et al., 2012). Three individual studies emerged among the review regarding this group treatment approach. One particular study by Britvić, Radelić, and Urlić (2006) examined 59 combat Veterans and assessed the effectiveness of long-term dynamically-oriented group therapy for the treatment

of PTSD, associated neurotic symptoms, and adopted models of defense mechanisms. Results seemed promising as long-term dynamic group therapy (i.e., five years) significantly reduced the intensity of PTSD symptoms in the patients. However, none of the defense mechanisms or neurotic symptoms changed significantly after two or five years of treatment. The authors concluded that group therapy can reduce the intensity of PTSD symptoms among combat Veterans, but the personalities of the population with PTSD are deeply rooted and do not appear to be affected by group therapy treatment. For the purpose of this review and the reduction of PTSD symptoms, this study produced significant outcomes.

A second study utilized group-based interpersonal psychotherapy (IPT-G) and was provided to nine male Vietnam Veterans with PTSD with the purpose of reducing interpersonal difficulties. Results showed improvements in interpersonal and global functioning (not maintained at follow-up), as well as for PTSD and depressive symptoms (maintained at follow-up). Qualitative feedback from group members indicated reduced levels of anger and stress as well as improved significant relationships. Ray and Webster (2010) concluded that interpersonal group therapy could be effective for Veterans in the reduction of PTSD and depressive symptoms. However, the small sample size and lack of more rigorous methodology (i.e., randomized controls) may limit the generalizability of the results to the larger Veteran population.

The third nonrandomized study was to evaluate the efficacy of interpersonal therapy in a group format (IPT-G) among patients who had PTSD. The patients (n=33) of this study had received conventional psychopharmacological treatment for at least 12 weeks and failed to have an adequate clinical response. Of the 33 patients who completed the trial, all had significant reduction in PTSD symptoms in addition to reduction of symptoms of depression and anxiety (Campinini, 2010). While this study did not sample the Veteran population, it was included in the review because there may be similarities between these participants and the Veteran population with regards to being nonresponsive to psychopharmological treatment as stated in the literature. Some Veterans are known as having negligible treatment response to psychotropic medications for PTSD symptoms. However, further research would need to be conducted to explore the efficacy of this mode of group treatment among this population.

Cognitive-Behavioral Approaches

Cognitive-behavioral group therapy approaches often include skills training that target specific problem areas that are common for patients. Some of these groups primarily focus on cognitive therapy that involves cognitive restructuring as a key intervention within the group context that is often present-focused (Sloan et al., 2012). For instance, this cognitive element is a core focus of cognitive processing therapy (CPT), which was first developed as a group approach but later expanded into an evidence-based individual therapy for Veterans per the VA/DOD clinical guidelines for treatment of PTSD. One nonrandomized study included the examination of group CPT relative to trauma-focused group treatment as usual (TAU) in the context of a VA PTSD residential rehabilitation program. Participants were two cohorts of male patients in the same rehabilitation program treated with either group CPT (n=104) or TAU trauma-focused group treatment (n=93) prior to the implementation of CPT. Cohorts completed the PTSD Checklist (PCL) and other measures of symptoms and functioning. CPT participants evidenced

more symptom improvement at discharge than TAU participants on the PCL and other measures. Given the clinically significant reduction in PTSD symptoms for Veterans, Alvarez et al. (2011) concluded that group-based CPT could be an evidence-based treatment for combat veterans while being superior to group-based trauma-focused TAU in VA clinical settings. These results have significant implications for the implementation of evidence-based manualized treatment packages in existing VA clinical settings. This study represents some of the first data indicating that evidence-based treatments for PTSD can be disseminated and sustained effectively using a group format. However, one limitation of this study was that it did not include any measures of treatment fidelity or therapist competency that is often demonstrated in randomized clinical trials.

Another significant study was a randomized controlled trial that utilized a CBT group-based intervention. This was the only randomized controlled study that emerged among the CBT approaches. Dunn et al. (2007) reasoned that effective treatment for depression might enhance the treatment responsiveness of comorbid PTSD by removing an obstacle leading to progress. The authors of this randomized trial further suspected that because PTSD and depression shared certain similar core psychological features (i.e., helplessness, low self-esteem, social withdrawal, anhedonia) the effective treatment of depression might also directly benefit PTSD. The authors selected a depression treatment with established efficacy: self-management therapy (SMT), a CBT group model developed from the self-control model of depression. Group-based SMT attempts to change behavioral elements of depression by teaching relatively simple cognitive-behavioral principles for self-evaluation, self-reinforcement, and self-monitoring to promote self-esteem. Prior to this randomized controlled trial, the authors conducted a small, uncontrolled pilot study that indicated the Veteran patients with comorbid depression and PTSD enjoyed SMT and reported significant symptom improvement. The methods conducted within the study included randomization of 101 male veterans with combat-related PTSD and depressive disorder to either the SMT group (n=51) or active-control group therapy (n=50). Main outcome measures administered involved both objective and subjective depression and PTSD scales at pretest, posttest, and 3-month, 6-month, 12-month follow-up. SMT demonstrated a modest greater improvement on depressive symptoms at treatment completion; however, these improvements disappeared at follow-up intervals. PTSD symptoms or any other psychiatric symptoms were improved by either group therapy intervention. No other differences on functional symptoms appeared, even though psychiatric outpatient utilization and overall outpatient costs were lower with SMT. The authors concluded, "despite SMT's success in other depressive populations, SMT produced no clinically significant effect in depression with chronic PTSD" (Dunn et al., 2007, p. 236). One of the significant limitations of this randomized study included the substantial number of potential participants who met inclusion criteria, but refused to participate in the study. Losing these individuals may have produced a biased sample.

Other nonrandomized studies utilizing a group CBT approach included various models that targeted specific symptoms of PTSD. King et al. (2013) completed a pilot study attempting to measure the efficacy of group mindfulness-based cognitive therapy (G-MBCT). The authors stated that MBCT has been noted to provide relief across various psychiatric conditions including depression and anxiety. Based on this promising evidence, the authors believed that mindfulness-based interventions may also be useful in the treatment of PTSD, and combat-related PTSD in particular. The results of this study showed clinically significant improvement in

PTSD symptom severity on post-treatment assessment outcome measures, and also reduced PTSD-relevant cognitions. Another CBT-based study aimed at targeting two key PTSD symptoms – insomnia and nightmares – among 10 combat Veterans with PTSD. The participants engaged in a 10-session CBT group treatment model that involved various elements such as nightmare rescripting and relaxation therapy. Furthermore, Swanson, Favorite, Horin, and Arnedt (2009) reported in this study that participants reported significant improvements in sleep and nightmares upon completion of treatment. Although this study did not measure the overall reduction of PTSD symptoms, it was included due to its examination of two predominant symptoms of PTSD. Kibler and Lyons (2008) conducted a study of 14 combat Veterans who seemed to be treatment-resistant regarding PTSD treatment. All participants in the study had previously received trauma-focused therapy but achieved no significant change in symptoms. A brief CBT emotion-management group model with a present focus was utilized. For 14 participants with completed data, the treatment showed partial improvement in cognitive appraisals and improvement in depressive symptoms. Some of the limitations involved in these nonrandomized studies were either lack of follow-up (i.e., at 3-month, 6-month, or 12-momonth intervals) or not measuring the overall reduction in PTSD severity rather than only targeting a couple of significant PTSD symptoms.

Exposure-Based or Trauma-Focused Approaches

Groups with exposure and trauma-focused elements often include imaginal exposure to the traumatic memory (or memories) through writing or verbalizing within the group treatment setting. Exposure-based approaches normally involve a homework aspect, such as listening to session tapes. Groups could also include in vivo exposure to feared stimuli associated with the trauma. For these exercises, a hierarchy of feared stimuli is developed within the group setting, and members often complete in vivo exposures as assignments outside of the group (Sloan et al., 2012). Although a large body of empirical evidence supports the efficacy of individually-based exposure therapy for PTSD, the research available for group-based exposure approaches is not as plentiful (Sutherland et al., 2012). A few studies emerged within this review among exposure-based approaches.

Schnurr et al. (2012) conducted the largest treatment trial to date testing a group exposure protocol while utilizing randomized controls (Sutherland et al., 2012). The randomized study used a method of exposure-based treatment - trauma-focused group therapy (TFGT) - that was devised for Veteran patients who might not otherwise comply with or tolerate individual exposure therapy. The treatment embedded exposure in a group setting that includes psychoeduation, cognitive restructuring, coping skills, and relapse prevention training. The group setting was used to create a feeling of safety and to increase each patient's capacity to tolerate exposure. A present-centered group treatment (PCGT) that avoided trauma-focused references, cognitive restructuring, and other TFGT components served as the comparison condition in this randomized trial. Of the 325 Vietnam Veteran men who participated, dropout rates were significantly higher among the TFGT than the PCGT men (22.8% versus 8.6%). There were overall reductions in PTSD symptoms as demonstrated by scores on the Clinician-Administered PTSD Scale, PTSD Checklist, and General Health Questionnaire. However, in both groups, the average amount of change in PTSD symptoms was not clinically significant. The treatments did not differ with respect to clinical effectiveness at both 7-month and 12-month follow-up.

Schnurr et al. (2012) concluded, "the short answer to the question of whether the VA should promote system wide use of TFGT for Vietnam Veterans seems to be no, but it could be a yes if we can learn more about who will stay in treatment…" (Schnurr et al., 2003, p. 488). The authors concluded that further evidence was needed before firm conclusions about the treatment can be drawn, especially due to the significant amount of potential participants who refused to enter the study. However, it does appear that this study provides an overall discouragement for the dissemination of group-based exposure treatment for PTSD among the Veteran population within the VA setting (Sutherland et al., 2012).

Another study explored the group-based exposure therapy (GBET) model. GBET is a manualized protocol that includes psychoeducation, coping and psychosocial skills training, guided imagery exercises, and both imaginal and in vivo exposure. The GBET protocol has three distinct phases: phase one (three weeks) involves psychoeducation and group-building exercises; phase two (seven weeks) focuses on triggers and exposure to traumatic memories; and phase three (two weeks) emphasizes acceptance and closure through visual imagery and discussion of grief and guilt. Of the Veterans (n=20) that received the GBET treatment, most participants tolerated the treatment and experienced a significant reduction in PTSD symptoms. Qualitative themes included Veterans' perceptions about the effectiveness of GBET. The members perceived that the support/feedback from other group members on imaginal exposures was the single most helpful component of the therapy. One major limitation of this study was that it did not examine therapeutic mechanisms, and it is not known whether observed improvements can be attributed to exposure techniques or to other nonspecific treatment factors. Further research should investigate which treatment components actively contribute to changes in PTSD symptoms over the course of treatment (Mott et al., 2013). The previous study is one of only two in this review to explore patient perspectives on group therapy for PTSD and provides valuable insights into the population that could help inform further research.

One particular study that deserved attention involved one that examined the effects of group exposure therapy on PTSD among female Veterans. Castillo, de Baca, Qualls, and Bornovalova (2012) reported that one purpose of this study was to describe the course of PTSD symptoms across the different group sessions while the ultimate goal was to expand options for therapy utilization. Of the remaining treatment sample of 55 participants, 22% (n=12) no longer met clinical significance for PTSD, 40% (n=22) achieved significant clinical change (10 points or more reduction on the PCL), and 13% (n=7) were in complete remission at the completion of the group-based exposure therapy treatment. While the results of this study seemed promising, one concern is that there was no follow-up after the completion of treatment to verify if treatment effects persisted. Another limitation was that the study relied on a single self-report outcome measure (PCL) versus multiple measures (i.e., Clinician-Administered PTSD Scale, BDI, etc.) used in more rigorous studies.

Another pilot study that emerged focused on a hybrid model for group-based exposure therapy (GBET) that included a modified 12-week duration group therapy model (from the manualized 16-week GBET treatment) and also inserted six individual prolonged exposure (PE) sessions as a part of the overall treatment. This study combined core elements of GBET with components of PE in an effort to increase the effectiveness of a group-based treatment while reducing length and maintaining low attrition. Vietnam Veterans (n=8) with PTSD were treated

for 12 weeks, with interventions including within-group war trauma presentations, six PE style individual imaginal exposure sessions per participant, daily in vivo exposure exercises, and daily listening to recorded exposure sessions. All Veterans completed treatment and demonstrated clinically significant reductions of PTSD symptoms with larger effect sizes. Seven of the eight participants no longer met criteria for PTSD. Most gains were maintained at 6-month follow-up. Ready, Vega, Worley, and Bradley (2012) acknowledged that therapist bias was involved since the clinicians conducting the sessions also administered the assessments. Also, during the screening process, the majority of Veterans declined participations in the treatment, limiting generalizability. This is a common issue with Veterans rejecting trauma-focused or exposure-based treatments that could have significant implications for future research. One major limitation from this study is that the study did not directly compare to another group therapy treatment approach. Also, due to small sample size, the generalizability of this study across the Vietnam Veteran population is questioned.

A final study that appeared in this review utilizing a group-based exposure therapy (GBET) approach involved a modified GBET model. The purpose of this study was to assess the acceptability and feasibility of a modified 12-week course of GBET and to examine the effectiveness in reducing PTSD symptoms among combat Veterans. Participants included 10 male OIF (Operation Iraqi Freedom) and Vietnam Veterans recruited from a PTSD specialty clinic at a large VA Medical Center. All participants (n=10) were retained for group treatment and showed a clinically significant reduction in PTSD symptoms comparable to the standard GBET protocol of 16 weeks. Also, findings were consistent at 3-month follow-up. The authors concluded that the findings indicate that the 12-week GBET protocol is potentially effective treatment for PTSD (Sutherland et al., 2012). Further research with more rigorous methods is needed before drawing firm conclusions about the efficacy of the modified GBET treatment.

Multimodal Approaches

Multimodal approaches can include any combination of the following elements: psychoeducation, coping skills training, discussion of ongoing stressors, problem-solving skills, and overall emotional support and interpersonal feedback by the group members (Sloan et al., 2012). These approaches can offer a present-day focus that avoids addressing the traumatic experience itself but consist of a here-and-now emphasis. On the other hand, sometimes these approaches have a blend of focusing on the traumatic event(s), present-day triggers and stressors. One significant study among the multimodal approaches was reviewed. Britvić et al. (2006) attempted to measure the efficacy of a multimodal approach that utilized psychoeducation training, sociotherapeutic factors, and a dynamically-oriented trauma focus. The authors created a 20-week multimodal group-based psychotherapy program for 158 Croatian war veterans that included psychoeducation, addressing daily life issues, and the working through of the traumatic experience. They were interested in assessing the effectiveness of this therapeutic program on a variety of dimensions, namely PTSD symptoms, depression, neurotic symptoms, coping skills, and quality of life for three years. Patients attended three types of groups: psychoeduation, sociotherapeutic, and dynamically oriented trauma focused. Overall, the results of this study were mixed. Regarding PTSD symptoms, the majority of participants experienced a significant decrease by the end of treatment. However, the reduction in PTSD symptoms from pretreatment to termination was not maintained at the one-year and three-year follow-ups. Furthermore, at one

and three years following termination of treatment, the PTSD symptom scores were significantly higher than they had been at completion of the program and did not differ from pretreatment scores. Concerning the depressive symptoms, the significant decrease that occurred by termination did not persist at the one-year and three-year follow-ups. However, the results of coping skills showed significant differences on all three coping elements: problem-oriented coping, emotion-oriented coping, and coping by avoidance. All three coping factors showed clinically significant increases and were maintained at the one-year and three-year follow-ups. The authors concluded that the overall mixed results were promising but presented a complex clinical picture and emphasized the need for further research to sort out under which conditions and for whom a multimodal group-based treatment would be effective in reducing PTSD and depressive symptoms among combat veterans (Britvić et al., 2006).

Another multimodal approach study attempted to examine the relationships among the symptoms of PTSD, anxiety, and dissociation with self-disclosure among Veterans with PTSD who were attending an eight-week group therapy treatment program. This multimodal model consisted of various components – psychoeducation, interpersonal feedback, coping skills, and a focus on the traumatic event(s). The primary aim of this study was to explore the association among disclosure and dissociation among PTSD patients undertaking an outpatient group therapy setting. Participants included 72 male combat Veterans and were administered various self-report measures (i.e., Clinician-Administered PTSD Scale, Dissociation measure, Hospital Anxiety and Depression Scale, assessment of disclosure, previous PTSD diagnosis). Based on this study's findings, Bowen, Shelley, Helmes, and Landman (2010) concluded that the frequency and severity of dissociation reported by participants decreased over time. It was also found that high self-disclosers had higher levels of dissociation when compared to low self-disclosers at baseline and program end, but showed a greater decline in levels of dissociation at three-month follow-up. The lower frequency and severity of dissociation at the three-month follow-up suggested a delayed treatment effect among those who more frequently disclosed aspects of the traumatic event during treatment. One major limitation of this study was that the overall PTSD symptoms were not reported and/or measured at the end of treatment or follow-up. Also, no measure was given as to whether the participants wanted to disclose their trauma or not. This study was included in this review due to dissociation being a symptom within the continuum of PTSD even though the overall PTSD symptoms themselves were not measured upon termination of treatment.

Perceived Benefits and Barriers of Group Therapy

In order to fully examine the efficacy of group therapy among Veterans with PTSD, it is helpful to also consider possible benefits and barriers of group therapy among the population. Perspectives among clinicians as well as among Veterans could provide additional insight. Clinicians often assume that group treatment involves a number of mechanisms that offer benefit beyond those provided by the individual therapy setting. First, Veterans with PTSD are often socially isolated and have difficulty trusting others. Group treatment provides a safe environment for Veterans with PTSD to become more socially connected with others and the opportunity to build trust (Sloan et al., 2012). Meeting and sharing with other members of a similar trauma (i.e., combat) can promote a sense of acceptance and belonging (Ruzek, Young, & Walser, 2003). Yalom and Leszcz (2005) regard the social component (i.e., cohesion, interpersonal learning) of

group treatment as a central therapeutic mechanism through which change occurs. Second, Veterans with PTSD frequently feel that their PTSD symptoms are unique to them and that others will never understand their experience. The group setting allows Veterans to normalize PTSD symptoms and engage with each other. This process is referred to as universality. Third, outpatient treatment settings are often understaffed and unable to provide individual treatment for each patient. Group treatment can maximize limited resources (Sloan et al., 2012). While there are many assumptions among clinicians regarding perceived benefits of group treatment, very little research has been conducted to examine the accuracy of these perceptions.

However, from the Veterans' perspective, one study emerged in this review that attempted to measure Veterans' perceived barriers and benefits regarding group therapy treatment. The aim of this pilot study was to assess Veterans who served in either Operation Enduring Freedom (OEF - Afghanistan conflict) or Operation Iraqi Freedom (OIF - Iraq conflict). Also, Kracen et al. (2013) intended to measure the Veterans' utilization of previous mental health treatment and their perceived barriers to and interest in group therapy for PTSD. This is one of the first studies to examine barriers to group mental health treatment from the perspective of OEF/OIF Veterans. Of the Veterans studied (n=110), 79% reported favorable experiences in individual therapy versus 32% reported favorable experiences in group therapy. Fifty-seven percent of the sample was not interested in participating in group therapy. When they were asked to rank their preferences for PTSD treatment, 83% identified individual therapy as most desirable; in contrast, 13% of participants identified group therapy as most desirable, whereas 57% of the sample ranked group therapy at least desirable. From these findings, the authors suspected that a clear preference of individual therapy over group therapy may be related to hallmark avoidance and arousal symptoms. Also, the authors stated that the most frequently endorsed barriers were items derived from clinical observations and not currently addressed in the existing literature. One major limitation of this study was that the survey presented to Veterans had not been subject to psychometric testing. Also, review of the authors' literature did not yield an evidence-based instrument that fully assessed mental health treatment utilization, perceived barriers to group therapy, and treatment preferences (Kracen et al., 2013). Ongoing research is needed to better understand barriers to mental health care, especially the treatment of veterans in group therapy settings.

Another study attempted to identify certain perspectives of Veterans included measuring potential predictors related to seeking treatment and continuing treatment instead of avoiding mental health services. Analysis of clinical data from 197 male veterans was evaluated in a VA Medical Center outpatient PTSD clinic. The results of the study indicated only two significant predictors. Among the symptom and life satisfaction measures administered during initial assessment, only depression and PTSD hyperarousal symptoms predicted enrollment in treatment. Kutter, Wolf, and McKeever (2004) discussed that further research might consider other potential predictors of enrolling and continuing in treatment, such as locus of control, perceived self-efficacy, motivation for change, readiness for change, previous therapy experiences, expectations for therapy, and social support for therapy.

Discussion

While various group therapy approaches appear to offer some reduction in PTSD symptoms among combat Veterans, the literature appears to be somewhat mixed with regards to group therapy being a well-established evidence-based treatment for this population. Concerns exist regarding the lack of rigorous research methodology as this review only revealed two randomized controlled trials when measuring the efficacy of certain group therapy approaches. The VA/DOD guidelines list group therapy as having "some benefit" but do not formally endorse it as being efficacious for combat Veterans. The limited amount of research that exists regarding perceived benefits and barriers among Veterans seeking treatment calls for additional research to be conducted. If clinicians are to determine which group therapy approach is appropriate for a particular group of Veterans, then would it not be helpful to know more about what the population believes about group therapy? From this review it also seems to be that there are several key assumptions by clinicians about why Veterans would benefit from group therapy. However, these assumptions have had very little evidence to verify those beliefs by clinicians. For example, the assumption that group therapy is a more economical method of treating Veterans than individual therapy does not appear to have been measured by empirical evidence. Also, the assumption that Veterans would benefit from the universality of group members is also rarely a factor in various studies among this population. Another missing gap in the literature seems to involve the examination of the therapeutic factors within the group setting among this population and how those factors might affect PTSD symptoms. More studies need to be conducted on comparing the efficacy between individual therapy versus group therapy while also comparing the efficacy between various models of group therapy. Furthermore, another research question to explore could involve the following: what might be the added benefits of conjoint group therapy when used in addition to individual therapy versus individual therapy utilized on its own? Many of the nonrandomized studies reviewed seemed to provide some benefit in reducing PTSD symptoms among the population; however, some of those same studies did not provide the necessary follow-up element to verify if the reduction in symptoms continued after treatment ended. Therefore, further studies with follow-up elements (i.e., 3-month, 6-month, 12-month) are needed to help verify if group treatment effects will continue. Cognitive processing therapy in its group format (CPT-G) seems promising for the reduction of PTSD symptoms but additional randomized controlled trials would be helpful in the future before definite conclusions can be made about its treatment efficacy. Therefore, a possible future study would include a randomized controlled trial comparing CPT-G against another evidence-based group treatment (i.e., CBT) and its effect on reducing PTSD symptoms. Another aspect for future research might include a study on Veterans' perspectives concerning the refusal of group therapy participation. Is it related to the theme of avoidance of not wanting to disclose traumatic memories since that can be present among the population in general, or is it due to other factors? Some clinicians believe that the avoidance plays a significant role in the reluctance of group therapy. More studies on Veterans' perceived obstacles and benefits of group therapy treatment might provide additional insight regarding the dropout rate among the population. Many clinicians and researchers seem to identify that group therapy treatment provides a needed increase in social functioning among the population, but there is very little research measuring this as a possible outcome among veterans. From a multicultural perspective, it is noticeable that all but one of the studies examined only male veterans. Would certain group approaches work better among

female Veterans or other minority groups? These are some of the observable gaps in the literature that need to be further examined.

Conclusion

Group therapy treatment revealed in the literature appears to be superior to no treatment and wait-list controls among Veterans with PTSD symptoms. Some evidence indicates that certain group therapy approaches (i.e., CPT-G) have a clinically significant effect on the reduction of PTSD symptoms. However, a portion of those promising results are mixed due to the absence of any follow-up element within several studies. Unfortunately, current standardized guidelines for clinicians do not exist with regards to which group approach works best for this population and when certain groups should be used and/or avoided for the effective treatment of PTSD. Is group therapy effective for the treatment of PTSD among Veterans? Although some of the research shows significant potential to reduce PTSD symptoms, further research with more rigorous methodology is needed to fully answer this question.

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