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Letter from the Editor

The *Journal of Military and Government Counseling* (*JMGC*) is into its third year of publication! *JMGC* is the official journal of the Association for Counselors and Educators in Government (ACEG). However, this is the last issue under the ACEG banner – July 1 the name of the division becomes the Military and Government Counseling Association (MGCA). The name change moves the focus of the association from who we are as counselors and educators to those we serve. This journal is designed to present current research on military, veteran, and government topics.

This issue is an eclectic collection of articles in practice, theory, and research. The lead article presents a case for the use of online sources for survivors of military sexual trauma. The second article assesses the needs of student veterans and their families as they move into higher education. The next article reviews the barriers to mental health treatment in the military. The final article is a graduate student review of the literature on career counseling veterans as they enter the civilian workforce. 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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Reaching Those Who Are Difficult to Reach: Exploring Online Interventions for Survivors of Military Sexual Trauma

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Abstract

Research suggests that there may be unique barriers to accessing care among women who have experienced military sexual trauma. The intent of the current research was to elucidate potential barriers to successful reintegration following deployment and to identify options for mental health care for women who have experienced military sexual trauma (MST). A secondary goal was to explore the feasibility of internet-based technology as a means of expanding options for counselor outreach, service delivery, and social support for this population. A comprehensive literature review was conducted which revealed several important points. A strong correlation exists between successful reintegration for women who have experienced MST and a) the availability of social support networks and b) the ability of the individual to utilize these supports. Women who have experienced MST were found to experience high levels of organizational distrust, social isolation, and self-perceived stigma, which create significant barriers for participation in treatment services, and for community reintegration. A comprehensive literature review revealed that the use of social media and other internet technologies show promise, not only as effective therapeutic tools, but also as an effective outreach method to identify and connect with those who are difficult to reach. A summary of this research is provided, ethical implications are discussed, and recommendations are made for the use of these technologies within professional counseling practice.

Keywords: Counseling, military sexual trauma, online, social support, women, veterans

Although men continue to make up the majority of the armed forces, women are now the fastest growing cohort of U.S. veterans (Carlson, Stromwall, & Lietz, 2013), serving in record number in combat and non-combat zones in Iraq and Afghanistan. Projections from the National Center for Veterans Analysis and Statistics (DoVA, 2014) imply that the number of women veterans is expected to increase dramatically over the next 10 years. As the number and visibility of women in active service has increased, so have reports of military sexual harassment and trauma incidents. Federal organizations, the public, and service providers are becoming increasingly aware of the emotional cost and burden that the experience of military sexual trauma and its sequelae exerts on women veterans (Washington, Bean-Mayberry, Reopelle & Yano, 2011). Regardless of age or time of service, military sexual trauma (MST) correlates

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strongly with a multitude of difficulties for male and female veterans. Research has found a strong association between MST and difficulties in post deployment reintegration (Carlson, Stromwall & Lietz, 2013; Mattocks et al., 2012; Street, Vogt & Dutra, 2009; Suris & Lind, 2008). A primary contributor to successful reintegration is the availability of social support networks and the ability of the individual to utilize these supports. The capacity to participate in effective interactions with social support networks, referred to as social functioning, is vital to successful reintegration for returning veterans. Unfortunately, it is in this area that many experience the greatest difficulty (DeAndrea & Anthony, 2013; Walker & Bryant, 2013).

Reintegration challenges for women veterans include the unique and disproportionate mental and physical readjustment issues and obstacles they face in their return to civilian life (Carlson, Stromwell & Lietz, 2014; Washington et al., 2011). Women veterans experience psychosocial stressors different from their male counterparts. These stressors include a higher risk of sexual assault or harassment during service that may result in isolating behaviors (Kelly, Skelton, Patel & Bradley, 2011). Compounding these issues is women's minority status in a historically male-oriented military system.

While military membership offers the salience of group reference and economic stability for many who enlist, upon their return this group reference may be lost for women veterans, who are seldom recognized as combat veterans by their communities. Economic stability may also be illusory, as they will not receive combat pay or benefits. Statistics suggest that women veterans are more likely to be unemployed and they have a lower socioeconomic status than male veterans do (SWAN, 2012). As a result, their access to supportive social networks is further limited (Fontana, Rosenheck & Desai, 2010). Combining these factors with MST and its psychological sequelae, contributes to the high correlation between being a woman veteran and being vulnerable for homelessness (Washington et al., 2011).

The Veterans Health Administration (VHA) has made great progress in the past decade in their effort to provide patient-centric care for women veterans. However, statistical data varies pertaining to women's use of VHA medical facilities or services (Kelly et al., 2011). Barriers noted by researchers include women's perception that services are fragmented, that information about eligibility and benefits for women is limited, and that the VA is unwelcoming to women, particularly as it relates to the assurance of safety and privacy (Kimerling et al., 2011; Mattocks et al., 2012; Mengeling, Booth, Torner & Sadler, 2014). Further, some MST survivors who have used these services have reported the experience of a "secondary victimization." Secondary victimization is the re-traumatization of the sexual assault, abuse, or rape victim through the responses of individuals and institutions (Campbell & Raja, 1999). Types of secondary victimization include victim blaming and inappropriate post-assault treatment by medical personnel or others. Women are vulnerable to these behaviors given the evidentiary burden placed upon them when filing claims for disability benefits (Campbell & Raja, 2005; Koo & Maguen, 2014). According to current evidentiary rules (38 C.F.R. § 3.304, 2010), a greater burden of proof is placed on veterans whose mental illness stems from their military sexual trauma than from combat related mental illness. A substantial body of proof (e.g., doctor's records, eyewitness accounts) that the incident occurred must be provided to substantiate MST related claims. For male veterans, participation in combat is considered prima facie evidence for PTSD related claims. Campbell and Raja (2005) found that most MST survivors who sought

help from the legal or medical systems (military or civilian) reported that this contact made them feel guilty, depressed, anxious, distrustful of others, and reluctant to seek further help. Consequently, many women veterans who require medical and mental health services fail to identify, and remain untreated (Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009). Fortunately, new legislation is in process (Civic Impulse, 2014) which would relax the standards of evidence associated with MST claims thereby improving the reporting and claims process.

Availability of trauma related care and geographic barriers also pose considerable problems, as one third of all veterans live in rural or highly rural areas (Pietrzak et al., 2009; Straits-Trostler, 2011). These barriers have an impact on the success of outreach efforts by veteran service agencies and organizations, which are eager to identify women veterans in need of medical and mental health services for referral. Consequently, linking women veterans who have experienced MST with agencies that can help is essential (Gunter-Hunt, Feldman, Gendron, Bonney & Unger, 2013), yet veteran service agencies and organizations have reported that engaging women veterans is a continuing challenge (Burns, Grindlay, Holt, Manski & Grossman, 2014; Giambarbra-Casura, 2010; Gunter-Hunt et al., 2013; O'Brien, 2014; SWAN, 2012). By failing to utilize services, these women place themselves at risk for reduced social support due to increased isolation, which is a common behavioral characteristic of MST (Vogt et al., 2011).

Social support has been established as a potent buffer from the deleterious effects psychosocial sequale of MST including symptoms of mental illness, interpersonal difficulties, vocational difficulties, and homelessness (DeAndrea & Anthony, 2013; Hamilton et al, 2012, O'Brien et al., 2008; Walker & Bryant, 2013). The importance of social support in the trauma recovery process is clear and internet technologies have the potential to improve not only the availability of social support but also to provide access to needed services. Internet based technology is being used successfully to provide counseling services with other populations who experience social isolation as the result of stigma (Rothbaum, Rizzo, & Difede, 2010).

To explore the connection between technology and the needs of women veterans who have experienced MST, a research of available literature from the fields of psychiatry, psychology, counseling, and computer mediated behavior was conducted. The resulting review is therefore exploratory in nature. Nonetheless, it provides a framework for further research pertaining to the very important topic of women veterans, MST, and their post deployment needs. The purpose of the research conducted is fourfold. First, to examine the nature of MST and it's psychosocial charactersitics; second, to idenify factors associated with the psychological sequelae of MST that contribute to reductions in social support; third, to explore the role of technology as a therapeutic tool to improve social support; and finally, to adress the implications of internet technology for counselors interested in serving this population.

Diagnosis and Prevalence

Military Sexual Trauma

The experience of military sexual trauma is defined by Title 38 U.S.C. §1720D (2011) entitled, *Counseling and Treatment for Sexual Trauma*. MST is described as

> …psychological trauma, which in the judgment of a mental health professional employed by the Department, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the veteran was serving on active duty or active duty for training. (38 U.S.C. §1720D, 2011, 1.a.1.)

In section 2(f), sexual harassment is further defined as "repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character."

Reactions to MST will vary, and the features and sequelae of this event are considered distinct from other forms of sexual maltreatment in terms of the individual's relationship to the perpetrator, the power structure concomitant with the military, and the severity of associated psychological distress (Allard, Nunnink, Gregory, Klest, & Platt, 2011). Problems may not surface until months after discharge, and for some veterans the long term deleterious effects of MST may continue to affect their mental and physical health, their work, and their relationships even many years later (Kimerling et al., 2011; Make the Connection, 2013).

Prevalence

Reports of MST have been on a slow and steady rise over the past several years. However, in a recent report, the DoD Sexual Assault Prevention and Response (SAPR) program reported that cases of sexual assaults in the military rose sharply showing a 50 percent increase between fiscal 2012 and 2013 (DoD: SAPR, 2014). Compared to prior time periods this increase is considered unprecedented. More concerning are recent estimates on the number of sexual assault incidents that go unreported. According approximations from the Department of Defense, about 86 percent of MST incidents are never reported (USGAO, 2013). Compounding the issue is the culture of the military, which stigmatizes mental illness (Rivera & Johnson, 2014). Consequently, it can be assumed that MST prevalence rates cited from any era of military service are conservative estimates at best.

Mental Health and Behavioral Sequelae

In the case of persons who have experienced MST, comorbidities are the rule rather than the exception. The most common comorbidities identified among women who have experienced MST include posttraumatic stress disorder (PTSD), depression, and other anxiety disorders (Bean-Mayberry et al, 2011; Hoge, 2013; Kashdan et al., 2006; Kelly, Skelton & Bradley, 2011). Two WWII psychiatrists eloquently described the unequivocal result of trauma on any military member in a war zone. Initially published to describe the experience of male soldiers, in the 21st century the observances clearly apply to women soldiers as well. Appel and Beebe (1946, p. 1470) stated

> There is no such thing as 'getting used to combat'. Each [wo]man up there knows that at any moment [s]he may be killed…Each moment of combat imposes a strain so great that [wo]men will break down in direct relation to the intensity and duration of their exposure. Thus, psychiatric casualties are as inevitable as gunshot and shrapnel wounds in warfare.

While historically assigned to what were considered non-combat roles, women serving in the military have been subjected to the traumas of war in every deployment and in every branch of the United States Armed Forces. As Solaro (2006) notes, women "were, legally and by policy,

banned from going into combat, the military's core function. But combat could not be banned from coming to women" (p. 14). Because women are also at an increased risk for exposure to sexual harassment or assault during deployment, concerns have been raised pertaining to the potential for complex post-traumatic stress disorder (Herman, 2001) among women veterans (Cobb, et al., 2014; LeardMann et al., 2013). Using longitudinal data from the Department of Defense (DoD) Millennium Study, LeardMann et al. analyzed the relationship between deployment and sexual stressors for a large sample of women soldiers over a three-year period. They discovered that women who deployed to operations with combat-like experiences had significantly greater odds of reporting sexual harassment or both sexual harassment and assault, after adjustment. They attributed this to several factors, notably finding themselves in more traditionally male-dominated environments compared with other deployed women.

Not surprisingly, the combination of MST and combat exposure place women veterans at increased risk for emotional distress and readjustment difficulties. Cobb et al. (2014) found a significant interaction between MST and combat exposure in predicting military-related PTSD ($p = .030$). Specifically, under conditions of high combat exposure, female veterans with MST had significantly higher PTSD compared to female veterans without MST. These findings reflect recent trends in PTSD claims among women veterans. The prevalence of PTSD has increased more than twofold in women veterans compared with their civilian counterparts (O'Brien & Sher, 2013; Washington, Bean-Mayberry, Hamilton, Cordasco & Yano, 2013). Iverson et al. (2013) also found a correlation between unwanted sexual experiences during military service and past-year interpersonal violence among women veterans, compared to women veterans who did not report such experiences. Therefore, screening for and addressing interpersonal violence is essential when defining patient centered mental health treatment plans for women veterans (Atkins, 2013).

MST is associated with increased medical illness and functional limitations. The literature suggests that these are primarily pain-related, involving multiple organ systems, including gastrointestinal, neurological, genitourinary, and musculoskeletal systems (Atkins, 2013; O'Brien, Gaher, Pope, & Smiley, 2008; O'Brien & Sher, 2013). In addition, female veterans have historically reported more reproductive and gynecological problems than the general population (Rivera & Johnson, 2014). In a recent study conducted by Turchik et al. (2012) among OIF and OEF veterans, women who reported a history of MST were more likely to report gynecological problems including sexually transmitted infections (STI's) or sexual dysfunction disorders (SDD's) when compared with veterans without a history of MST. The risk increased for those with co-occurring mental health diagnoses.

Trauma associated behaviors include difficulty in the identification and expression of feelings (Cusinato, 2012), detachment (O'Brien et al., 2008), and emotional numbing (Agaibi & Wilson, 2005). Conversely, behaviors such as hypervigilance, agitation, unexpected bouts of anger, violence, and participation in risky behavior have also been reported (Hoge, 2013). While a large portion of the literature has focused on PTSD related symptoms, survivors are also at risk of experiencing a range of other mental health problems. These include substance use disorders (Mengeling, Booth, Torner & Sadler, 2014), mood disorders (Kelly et al, 2011), eating disorders (Mattocks et al., 2012), and other anxiety disorders such as panic disorder and generalized anxiety disorder (Maguen et al., 2012). If these symptoms are left untreated, outcomes include

family problems, unemployment, homelessness (Pavao et al., 2013), self-harm, and suicidality (O'Brien & Sher, 2013). Any or all of these psychological injuries can create significant impairment in social functioning given their influence on emotional connections with others (Demers, 2013; Suris & Lind, 2008).

The Role of Social Support

The literature reviewed points to the centrality of social networks to the emotional well-being for women veterans who have experienced MST (Duax, Bohnert, Rauch & Defever, 2014; Hamilton, Poza, Hines & Washington, 2012; Kilbourne, McCarthy, Post, Welsh & Blow, 2007; Price, Gros, Strachan, Ruggiero & Acierno, 2013; Smith, Benight & Cieslak, 2013 ; Vogt et al., 2013). Veterans with strong social bonds seem to suffer less from problems with PTSD and associated disorders like depression and alcohol abuse (Agaibi & Wilson, 2005). External support and resources from others may be able to buffer some of the deleterious effects of PTSD on social functioning. In fact, research has suggested that trauma survivors who have a capacity to mobilize and utilize protective factors such as social and personal support mechanisms have better treatment outcomes (Agaibi & Wilson, 2005). In her qualitative research with women veterans, Demers (2014) elucidated the reintegration challenges female veterans face, including gender identity issues associated with their military service, and the differences in values between civilian society and military society. The expectation of mental toughness, and the fear and shame that are unilaterally attributed to any sexual assault, create significant obstacles for adequate social functioning (Coll, Weiss & Exxum, 2010).

Tsai et al. (2012) conducted a study to identify potential mediators between social functioning among OEF and OIF veterans receiving mental health services, and their risk for increased PTSD symptomatology. They found that veterans who reported less social support from the community, a lack of feeling understood by others, and fewer secure relationships reported lower stress resilience and more social impairment. Other factors included worrying more about unpleasant or unwanted thoughts, and less acceptance of change and availability of secure relationships, which correlated with lower life satisfaction. One general implication of this finding is that individuals with PTSD, who report lower life satisfaction, might benefit from peer support groups. This seems particularly true for veterans, who frequently report that peers constitute the largest part of their social network. This suggests that veteran peers may provide a greater level of emotional support during treatment, than non-veteran friends and family (Chinman, Shoai & Cohen, 2010).

The Role of Technology

In discussions pertaining to the role of technology for counseling purposes, there has been controversy between professionals, encompassing both the legitimacy and the function of technology within the counseling milieu. These debates have generated a large body of literature including multiple meta-analytic studies, all of which inform counseling professionals, educators, and researchers (Barak & Grohol, 2011; Barak & Ray, 2011; Carroll & Rounsaville, 2010; Fenichel et al., 2002; Reamer, 2013; Richards & Vigano, 2013; VanVoorhees, Gollan & Fogel, 2012). Advocates point to the potential that online interventions provide for increased accessibility to mental health services. From this perspective, advocates see online interventions,

as valuable and constructive therapeutic modalities for those clients who live in rural areas, are socially phobic, or hesitant about in person counseling due to anxiety or stigmatization (Daker-White & Rodgers, 2013; Schultz, Stolz & Berger, 2014). On the other hand, skeptics argue that communicating via the internet fails to offer the human interaction that is crucial in the development of a therapeutic alliance, pointing to the absence of facial and verbal cues in online communications (Baker & Ray, 2011). The skeptics foresee opportunities for miscommunication and suggest that the absence of non-verbal's and other behavioral information will lead to inaccurate assessments of the client's stability (Richards & Vigano, 2013). Others have posited that the quality of the therapeutic relationship might be less relevant to treatment outcomes when online therapy is utilized (Knaevelsrud & Maercker, 2006).

Whatever remains to be settled, there is clear evidence that the practice of counseling using online interventions, and the role of technology as a treatment tool is generally accepted. To date, well over 100 different computer-assisted therapy programs have been developed for use with a wide range of mental health disorders and behavioral health problems (Carroll & Rounsaville, 2010). Research suggests that the majority of counselors (95%) who use online resources as part of treatment planning and implementation, believe that these approaches are appropriate for interpersonal and social issues, as well as personal development (Barak & Grohol, 2011). Of most importance is the fact that many clients prefer this option as an avenue for communicating with others (Chung, 2013).

Technology has offered advantages for practitioners in reaching groups whose mental health sequelae creates stigmatizing beliefs and social isolation (e.g., schizophrenia, substance use disorders, physical disabilities and chronic illness; Schultz, Stolz & Berger, 2014). Common intervention components included in the studies reviewed included: a) information sharing and referral, b) cognitive-behavioral therapy, c) peer support, and d) group therapies. Methods for counselor patient interaction included the use of discussion boards, social networking sites, chat rooms, text messaging, synchronous (real-time), and asynchronous computer mediated communication. Online tools and technologies have been investigated for a variety of purposes, from being an avenue for social interaction to a source of information on health issues and treatment options. Highlights from the literature review follows.

New Communities of Practice

Given the absence of empirical studies associated with the intersect between online technology and social support for women veterans, the literature review was broadened to include other populations experiencing similar functional limitations related to mental health and insufficient social support, and the exploration of technology within these studies. The result yielded results that show promise for use with women veterans who have experienced MST in two key areas; engagement in health seeking behaviors and engagement in support group membership.

Engagement in Health Seeking Behaviors

Lamberg (2003) conducted a longitudinal study, gathering data from 103 volunteers who were recruited from websites, online message boards, and email lists for individuals who were

experiencing and receiving treatment for depression. The participants agreed to be monitored for frequency of use of a health related online social support group. Participants were ranked as either high users (5+ hours per week) or low users (<5 hours per week). At the conclusion of the study, the researchers found that 43% of high users reported a resolution of their depression compared to 20 percent of low users. High users also reported their intention to utilize health related social support services in conjunction with their face-to-face (f2f) treatment in the future.

Tsai and Rosencheck (2012) also examined the usefulness of internet online health information to increase veteran engagement, specifically those veterans who utilized mental health services. Using a national sample of 7,215 veterans identified from the 2010 National Survey of Veterans, logistic regression was employed to examine user characteristics, type, and level of engagement with online health information. Seventy one percent of veterans reported using the internet and about a fifth accessed their health records on line. The majority of VA mental health service users had home internet access, but a quarter also accessed the internet in other locations (work, school, library, etc.). The researchers noted that his finding is important because it establishes that VA mental health service users have ready access to the internet. They also discovered that VA mental health services users were no less likely to use the internet than other veterans enrolled or not enrolled to use VA health services. The researchers concluded that the majority of veterans, including mental health service users, use the internet and indicate a willingness to receive and interact with health information online. The fact that more than half (63%) of the responders indicated that they used the internet daily, suggests great potential for the implementation of internet-based mental health interventions.

A study conducted by VanVoorhes et al. (2012) took the exploration of veteran engagement a step further. Their study focused on the feasibility of providing mental health treatment using online therapeutic interventions to create changes in mental health symptoms (depression and PTSD). They focused on a specific subgroup of VA health service users, by identifying 50 Iraq and Afghanistan veterans who were described by primary care staff as "reluctant to seek care." Barriers to engagement in health care identified by participants included geographical, attitudinal, and individual factors. An internet-based program, which included CBT-based coping skills training, mental health information, peer support and coaching, was administered for a 12-week period. Significant correlations were identified between the 12-week intervention and reductions in depression and PTSD symptoms, acceptance of diagnosis, perceived social norms, and a reduction of stigma attached to mental health care via peer support. The study demonstrated that an internet based intervention with features including information, peer support, and coaching could overcome one of the most difficult and critical components of providing mental health services; which is moving people who would benefit from care toward seeking care, engaging them in care, and interacting with others. Clearly this is connected to the needs of women veterans with MST, as social and emotional support are key determinants of the severity of mental health symptomology. This is further supported by the following studies, which explored the therapeutic benefits of online support groups.

Engagement in Support Groups

Online support groups (OSG) for those experiencing mental health symptomology are hugely diverse. Some are connected to organizations, but many exist independently. It is

generally accepted that these support groups attract a variety of group members, more specifically those who have previously avoided peers or other traditional support systems. These groups also vary in format. Many are synchronous offered in real-time (e.g., chat rooms where participants log on at specific times), while others are asynchronous, where the opportunity to participate in discussions is available 24/7 at times most convenient to the group member. While synchronous groups offer more immediate interactions, asynchronicity allows individuals to carefully develop responses at their own speed. Some groups are peer led while others ore therapist moderated. These diverse characteristics of OSG have led to a growing body of research, which explores the impact of these characteristics on mental health symptom management, the potential for inclusion as a component of a comprehensive mental health plan, and questions on patient engagement.

Chung (2013) conducted a study, which focused on current users of health-related OSGs and examined factors leading to preference and engagement in virtual social interaction in OSGs over offline, face-to-face interaction. The study aimed to advance an understanding of how patients use OSG as a health care resource. Chung (2013) surveyed 158 current users of health-related OSG's. Concerning preference, most patients preferred OSG's to offline support (e.g., family and friends) because of the perceived benefits in OSG's. Common benefits included enhanced freedom of expression, optimism, social well-being, being better informed, encountering emotional support, finding recognition, and understanding, in addition to the opportunity to help others. Chung (2013) also found that certain users of OSGs are prone to develop a preference for social interaction in OSGs over offline contacts. Those participants who reported dissatisfaction and low levels of support from offline contacts were more likely to prefer social interaction in OSGs. Not surprisingly, those who believed that they developed deeper relationships in OSG than in off line contacts preferred OSG's. In a later study, Chung (2014) conducted an online survey with current users of OSGs to examine the associations among motivation, use of specific features and support outcomes. Among other results, the study findings suggest that the perceptions of receiving emotional and informational support are associated with the patient's source of motivation. For example, patients with a strong motivation for social interaction use diverse features of OSG and make one-to-one connections with other users (e.g., friending), as compared to those with a strong motivation for information seeking who may limit their use to asynchronous textual connections (e.g., discussion boards). Chung (2014) also found a relationship between OSG features including the sharing of personal stories on blogs, in satisfying participant needs for emotional support. What is important to note is that there is in inherent flexibility in the use of these modalities that is well suited to those whose needs are divers, such as the population of women veterans who have experienced MST.

Oh et al. (2013) explored the supportive benefits of online groups and the characteristics of their users more closely in their study, which addressed a) the relative significance of social networking sites and user's perception of social support, and b) whether social networking sites can serve as an effective venue for health-related social support exchange among users. An analysis of data from online social networking sites was gathered for 291 college undergraduates who used social networking to gather health information. Perceptions of social support fell into four categories; perceived support, esteem, tangible, and emotional supports. Of these four, emotional supports showed the strongest correlation to user participation in health related social support sites, thus highlighting the importance of emotional support as a factor in OSG's.

Further, a positive relationship between perceived social support and health self-efficacy was identified in addition to correlations between having a health concern, seeking health related social support, and perceiving health related social support.

While it appears that online and social networking can be useful for the development of self-efficacy and a support network, there remain ideological, ethical, and procedural debates surrounding the effectiveness of such techniques in counseling and psychology. One study offered the most comprehensive analysis of the research pertaining to online therapeutic effectiveness. Barak, Hen, Boniel-Nissim and Shapira (2008) conducted a meta-analysis across 92 studies examining the effectiveness of multiple online psychotherapeutic interventions for a variety of populations experiencing mental health issues. The study revealed an average effect size of .53, with treatment effects persisting post treatment. A direct comparison between internet therapies and traditional, face-to-face treatment for the same problem, with random assignment to treatment conditions revealed no significant differences between modalities (Barak et al., 2008; Gainsbury & Wood, 2012). The results also suggested that internet interventions allowed individuals with stigmatizing illnesses to engage in mental health support activities while maintaining a degree of emotional and personal distance.

Discussion

In light of the reluctance of women veterans who have experienced MST to seek treatment, the internet may prove to be a useful tool for outreach and the implementation of standardized, empirically supported treatment. Advantages include on demand access (particularly for younger veterans who are working or have children at home, and those who lack transportation), transcendence of geographical boundaries (important for rural veterans), lower costs (for the uninsured), facilitation of linkages to services in the community, and the potential for increased sensitivity to care (Townsend, Gearing, & Polyanskaya, 2012). For the most part, internet interactions allow for individual anonymity when exploring services. Despite these advantages, research pertaining to online interventions for women veterans is slim and slimmer yet when the addition of military sexual trauma was an added factor. Therefore, conclusions must to be drawn from studies of male veterans or those studies of other population with similar psychosocial barriers. The economics of the current health care landscape will likely change this. In the search for solutions to the increasing cost of mental health care, the use of information and communication technologies is gaining increasing attention in psychotherapy and public health research (Kazdin & Blase, 2011). While the technicalities of conducting research and counseling within the bounds of the internet is beyond the scope of this paper, there is an emerging body of research that addresses these methodological issues (Jürgen's, 2012; Wooten et al., 2014). What is evident is that online counseling in its many forms, brings with it new applications for counseling.

Applications

For counselors and those employed outside of the DoD who are interested in providing services to members of the military, advertising via social media platforms has been one way to for agencies outside of the DoD to provide outreach. Well placed ads on social media sites have been used to attract male and female military members and veterans for survey participation,

gathering of demographic data and other project (Wooten et al., 2014). Therefore, researchers interested in working with women who have experienced MST have at their disposal a variety of online recruitment methods for rapid, cost-effective data collection.

For counselors interested in utilization of internet technology in their practice, there exists a growing body of literature and websites offering guidance (see Appendix). For those interested in a better understanding of the lived experience of women veterans who have experienced MST, websites such as Whisper (http://whisper.sh/), which touts that it is, "the best place to express yourself online" anonymously, is a good source. For the purpose of treatment planning, clients may be asked to explore computer-mediated communication using sites such as this. Or, clients could be asked to explore available social media platforms and websites that offer information, groups, and other support resources for women veterans who have experienced MST (see Appendix), and report on their findings. It is likely most are already familiar with social media platforms since Facebook, which accounts for 93% of all social media and is used by 63% of all internet users, is no longer a venue used solely by younger generations (King, O'Rourke, & Delongis, 2014). The benefit of these and similar activities lie in their achievability. Achievable goals encourages proactive involvement on the part of the client despite stigma related fears and anxieties.

Other alternatives include the development of counselor moderated or non-moderated online support groups, chatrooms, or blogs for the provision of therapy and information sharing. These interventions offer options for the participant to connect with others who have had the same experience for the reduction of isolation and normalization of related thoughts and feelings. Other therapeutic interventions that can be transferred to an online format include life skills training, job search skills training or job clubs, wellness behavior tracking, and educational activities. Therapeutic interventions can be offered for the individual or the group in "real time" through video conferencing and Skype, or in an asynchronous fashion through chat rooms and discussion groups.

Researchers and practitioners have also been exploring the interface between human experience and virtual worlds. Work with augmented and virtual reality has been expanding, as research and practice demonstrate efficacy across a range of medical and psychological treatments (Boussard, Bosse, Loranger & Klinger, 2014; Parsons & Rizzo, 2008; Wiederhold & Weiderhold, 2000). Research conducted using virtual reality (VR) and avatar assisted therapies have led to not only to potential treatment for PTSD, depression, and adaptation to injury for veterans, but for social, professional, collaborative, and educational uses among counselors working with military populations.

Advantages and Disadvantages

A specific advantage of online or technology enhanced interventions is that these can extend the reach of specialized treatment centers and thus improve underserved populations' access to mental health care. Other factors include: the increasing acceptability of the internet as a legitimate social tool, improvements in online privacy protection and computer interface, the availability of internet access via mobile networks and smart phones, the establishment of ethical guidelines by various professional organizations (APA, ACA, CRCC), and an increasing

body of research which supports the value of mental health treatment offered via the internet for specific populations (Barak & Grohol, 2011; Barak et. al. 2008; Liang, Duffy & Cummins, 2013; Markham & Baym, 2009; Mo & Coulson, 2013; Richards & Vigano, 2013). As the literature review demonstrates, online interactions and interventions are an effective way to lower the perceived threshold for social interactions and information access for persons who experience anxiety related to social interactions or those who might otherwise be subject to stigma (Haker, Lauber & Rossler, 2005). The potential of maintaining relative anonymity in many online environments and geographical distance theoretically facilitate psychological safety, disinhibition, and increased self-disclosure for this population (Cook & Doyle, 2002; Suler, 2004).

The fact that all of the visual and verbal cues that convey subtle information about another person and their affect are missing in text-based online counseling has been a point of much debate among professionals. For those who have experienced MST, this feature may be one of its primary benefits. It has been hypothesized that one of the positive effects of computer mediated communication is the promotion of psychological safety for the user (Fenichelet al., 2002; Leibert, Archer, Munson, & York, 2006). Referred to as online disinhibition (Suler, 2004) this phenomenon occurs when concerns about the other person's reaction (social signals) to one's narrative and presence are removed. Last, the accessibility of interventions offered online can also overcome barriers to treatment access (mobility, geographical isolation, language barriers, time availability) and economic restraints (Rochlen, Zack, & Speyer, 2004).

Disadvantages or criticisms raised by professionals associated with the use of internet interventions for therapeutic purposes have been associated with the absence of verbal or behavioral cues (Rochlen, Zack, & Speyer, 2004), security and privacy breaches (Buchanan & Hvizdak, 2009; Zack, 2010), the exclusion of those unable to text or use computer applications due to cognitive or verbal fluency limitations (Richards & Vigano, 2013), the potential for the dissemination of inaccurate information among users (Fenichel et al., 2002), the potential for erosion of professional roles (Daker-White & Rodgers, 2013), and the belief in the existence of a digital divide that challenges access and availability to resources available via technological experiences (Norris, 2001). For researchers, despite much discussion, no specific theoretical framework has evolved to support use of the online interventions in mental health counseling in general or for specific populations such as those who have experienced MST (Barak, Hen, Boneile-Nissim & Shapira, 2008).

As a profession, there has been less concern expressed from counselors about treatment frameworks as there has been about the lack of specific ethical guidelines to assure client safety in these environments and counselor compliance with health information laws (Ipsen, Goe, & West–Evans, 2013; Fenichel et al., 2002; LoFrisco, 2013). In response to these concerns, most if not all professional behavioral health licensing and certification associations, have adopted standards of technology ethics over the past five years, which provide the professional with substantial guidance. To further assure that counselors are engaging in safe practices by providing interventions within an internet environment, counselors should receive training related to the application of these interventions (Chung, 2013; Reamer, 2013). A variety of approved training and certification methods are available (see Appendix).

Conclusion

The fact that MST carries with it a great deal of stigma and shame has been identified as a barrier for social support, outreach, and treatment for women veterans. The presence of social media and its growing integration into daily life uniquely positions social media platforms as an outreach tool, particularly for this population. Military service members, including women who have experienced MST, have been utilizing computer technologies for communication on and off the battlefield for some time (Prindle, 2011), and their proficiency in utilizing these tools make them viable for use in the counseling process. The effectiveness of counseling practitioners over time may well lie in their ability to embrace internet technologies to create supportive communities online for their clients, particularly those who prefer to engage in therapeutic activities while maintaining a degree of personal distance.

Social media-online forums such as social networking sites, chatrooms, and other remote communications including telephone, internet, text, and video can improve the ability of advocates for women veterans in reaching this highly mobile, hard to reach population. Military organizations and an increasing number of veterans service organizations use social networking sites, to communicate with military personnel, their families, veterans, government, and community organizations (Mathews-Juarez, Juarez, & Faulkner, 2013). The case has been made for the difficulty in connecting with women veterans who have experienced military sexual trauma due to the stigma related to the event, the failure of some women who have served to identify as veterans, and due to the psychosocial effects of PTSD and related mental illnesses which generally accompany the experience of a traumatic sexual event. Woman veterans who have experienced MST are not a homogenous group; consequently, it is unreasonable to project the same behavioral and mental health symptoms on them. However, based on the literature reviewed it is reasonable for counselors to expect some commonality of consistent problematic behaviors in varying degrees including social isolation and withdrawal among most women veteran who have experienced MST.

For counselors interested in providing services to this or any population who has proven difficult to reach, the answer seems clear. The use of online technologies has been shown to be effective. How those technologies should be best utilized will be dependent on the needs of the client, and the decision of individual practitioners and counseling organizations. The chief professional officer of the American Counseling Association, David Kaplan (n.d.), summarizes this well, “The question counselors should be asking themselves is not ‘is it OK for me to use social media? The question should be ‘is this particular tool the best way to help this specific client with this specific need?’” For women who have experienced MST and its psychological sequelae, the answer should be “yes.”

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Appendix. Websites Offering Guidance

1. Veterans Coalitions

- The Service Women's Action Network
  http://servicewomen.org/
- Women Veterans Rock
  http://www.womenvetsrock.org/
- The f7 Group
  http://www.f7group.com/
- American Women Veterans Organization
  http://americanwomenveterans.org/home/
- Vet WOW
  http://vetwow.com/
- Iraq and Afghanistan Veterans Association
  http://iava.org

2. Support Group Resources

- American Self Help Group Clearinghouse
  http://www.mentalhelp.net/selfhelp/
- National Mental Health Consumers Self Help Clearinghouse
  http://www.mhselfhelp.org/
- Network of Consumer Driven Services
  http://www.cdsdirectory.org/
- Network of Care, State by State Referrals
  http://networkofcare.org/splash.aspx

3. VHA Resources

- eHealth University.
  http://www.vehu.va.gov/ ; https://www.ebenefits.va.gov/ebenefits-portal/ebenefits.portal
- VHA Military Sexual Trauma
  http://www.mentalhealth.va.gov/msthom
- eHealth Rural
  http://www.ruralhealth.va.gov/education/myvehu-training.asp

4. Training Resources

- International Society for Mental Health Online
  http://ismho.org/
- Center for Credentialing and Education
  http://cce-global.org/DC

From Combat to Campus: Assessing the Needs of Student Veterans and Their Families in Higher Education

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Abstract

Universities report an influx of military veterans entering higher education upon return from service (O'Herrin, 2011).These veterans may have recognizable physical wounds; however, many return with unseen moral, emotional, and relational wounds. These invisible wounds can create challenges for the veteran and campus faculty who may not understand the issues unique to veterans. Civilian and university cultures are vastly different from the military environment and campus counselors, administrators, and educators have an obligation to understand this diverse population with their unique needs. This action research study (ARS) presents the perceived needs of student veterans at a southeastern university, discusses implications, and explores future interventions, limitations, and recommendations for future research.

KEYWORDS: student veteran, family, higher education

As the nation approaches the conclusion of a decade of wars in Iraq and Afghanistan, colleges and universities are experiencing vast increases in enrollment of student veterans (O'Herrin, 2011). Recent data on the campus examined in this action research study (ARS) indicates that nearly 80% of student veterans live at home with their family or spouse, and 78% of student veterans are unaware of counseling services available on campus (Stephens, n.d.). As a college counselor, awareness of the unique needs of this diverse population is of utmost importance. But after a few attempts at outreach events, with very little participation, the realization set in that in order to have success with veteran-specific programs, additional research about needs was necessary. One thing is clear: counselors should anticipate this population will increase on campuses over the next several years.

In this ARS, the needs of student veterans and their families at a medium sized university in a southeastern region of the United States are assessed so that these needs may be more

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beneficially met. The implications of meeting those needs within a campus community are discussed and ways to fulfill those needs, if possible, in the realm of university life are proposed. This manuscript begins with a literature review of military veterans and their unique needs in the realm of higher education, and their familial system.

Student Veterans and Their Families in Higher Education

Importance of the Government Issue (GI) Bill

Radford (2009) reports a large influx of military veterans are entering higher education upon their return to civilian life. With the passing of the Post- 9/11 Veterans Educational Assistance Act of 2008, also known as the Post-9/11 GI Bill, many returning veterans are entering higher education as they transition to civilian life. Higher education provides these service men and women more opportunities for employment outside the military. This bill is designed to provide higher education incentives for more than two million service members who have served since September 11, 2001. It covers tuition and fees for in-state public undergraduate higher education for eligible veterans and their families. It also provides a monthly housing stipend and an annual book allowance. In 2010, legislation expanded eligibility for the benefit to an additional 85,000 members of the National Guard and Reserves. In its first year of expanded eligibility, more than half a million veterans applied for certificates of eligibility for the Post-9/11 GI Bill, and more than 300,000 veterans and family members used the benefit to attend classes (Steele, Salcedo, & Coley, 2010).

Characteristics of Student Veterans

Veterans are, by definition, nontraditional students. They are typically older and more likely to be non-white than traditional college students (Radford, 2009). Twenty seven percent of students with military experience are women (O'Herrin, 2011). Many are categorized as "transfer students" because they often bring credits earned through college courses completed while in the military. Some veterans view college as an "obligatory box to be checked to enhance prospects for gainful employment after military service, other veterans embrace the opportunity to immerse themselves in the traditional college experience" (O'Herrin, 2011, p. 15).

A recent RAND Corporation (2008) report states that 18.5% of Operation Enduring Freedom and Operation Iraqi Freedom veterans have developed symptoms of posttraumatic stress disorder (PTSD), traumatic brain injury (TBI), and/or depression. Almost half of military veterans who are enrolled in college contemplated suicide at some point, and 20% had planned to kill themselves (Lipka, 2011). To compare to the overall population, in 2010, veterans accounted for roughly 20% of the estimated 30,000 suicides annually in the United States (Hotakeinen, 2011). Most veterans are hyper-vigilant, and have not had time to "decompress" after returning from the field. With the availability of GI benefits for higher education as a potential source of income for limited expenses, many returning veterans are entering colleges immediately after deployment without this vital "decompression" time (J. Horne, personal communication, October 26, 2011).

Transitional Challenges

Returning veterans have a "come down" period, one of a re-adjustment from detailed, structured life, when civilian life does not give them what they are physically accustomed to (B. Dees, personal communication, September 30, 2011). These "warriors" may come home with physical wounds that are easy to recognize. However, many come home with moral, emotional, and relational wounds that cannot be observed. During a panel discussion of military chaplains at the American Association of Christian Counselors, Major General (Retired) Bob Dees suggested that many returning veterans experience guilt, anger, separation anxiety, infidelity, grief, and loss (personal communication, September 30, 2011). Carrying these wounds from a military structure to a campus environment creates a challenge for both the student veteran and members of campus community who may not understand the world-view or challenges of a veteran. Student veterans do not want to reveal mental health information that could potentially threaten their benefits or possible future in the military. Enrolled student veterans also may not be familiar with disability terminology in a higher education setting. For example, the phrase "having a disability" can be confusing for a veteran who may have a disability, but has not completed the VA's disability rating process. As a result, even though the veteran may have documentation required for accommodation services or assistive devices, the terminology may be unclear, and they may not seek needed assistance (O'Herrin, 2011). Some veterans may arrive on campus with service-connected disabilities such as PTSD, hearing and vision loss, TBI, and depression.

Other challenges include developing an identity and sense of community on campus, apprehensiveness about being singled out as a veteran, and mental health issues as a stigma. The Veterans Administration recently changed their outreach campaign for suicide prevention to "Veterans Crisis Line" in order to help reduce the stigma and encourage help-seeking behavior (C. Domingo, personal communication, November 11, 2011). Managing the transition from a regimented military environment to an independent university lifestyle may frustrate veterans who are used to respecting and following strict rules and regulations (Draper, &Yarrish, 2009).

Family Challenges

The life of one family member has a profound effect on the whole family, as family systems theory explains (Becvar & Becvar, 1999). When a married student returns to school, higher education becomes a "family" task rather than an individual endeavor. The marriage or couple relationship and parenting styles must change to meet the new demands. Life roles also change to meet the mandates placed on the couple and family during the pursuit of higher education (Gold, 2006).

The above dynamics are especially true of veterans. Nearly 80% of student veterans on this ARS campus live at home with their spouse, partner, or family (Stephens, n.d.). With transition comes stress. Student veterans have multiple stressors to deal with (Draper & Yarrish, 2009; Lipka, 2011; O'Herrin, 2011; Radford, 2009; Steele, Salcedo, & Coley, 2010). The stressors of being a college student and juggling major family roles are difficult and with a young military force basic parenting, life, and financial skills are greatly lacking (B. Dees, personal communication, September 30, 2011).

Veterans, as non-traditional students, have the needs of both typical non-traditional students and the needs of veterans. Research is scarce on the comparison of the needs of student veterans to non-traditional students. This is especially true concerning student veterans in their family contexts. There is definitely a need for research in this area. However, there is much research on attending to the needs of the military and their family throughout the deployment cycle. Michelle Obama and Jill Biden launched "Joining Forces," an initiative to help military families who face a long list of unique challenges (Benac, 2011).

Summary and Conclusions

From these findings, it is evident that in order to ensure success among student veterans and their families in higher education, institutions must become more aware of the current needs of this population and continue to develop and implement programs and collaborations within the campus community to support these students. As the country approaches the conclusion of a decade of wars in Iraq and Afghanistan, as well as a return of military personnel from Operation Iraqi Freedom in 2011, veterans are in need of "the next step" in their career journey. For many, their career journey will include entering higher education. Understanding the uniqueness of student veterans and their families is of utmost importance. Members of campus communities, such as counselors, administration, and educators, have an obligation to understand the various needs this diverse population and serve them accordingly.

Supporting veterans in their transition to the culture of higher education is a university's responsibility. A "veteran friendly" campus will attract veterans, assist them in their career development, and provide a community where they feel empowered and honored. Universities can help them face the challenges of transitioning from military service and navigate the complexities of daily life as student veterans, leading to academic and personal success.

Method

This ARS, a collective, self-reflective inquiry by the participant principal investigator (PI) was conducted in order to improve social justice and cultural understanding of student veterans and their family in higher education. The results give voice to the veterans and provide specific data for informed decision making in funding, student support services, and individualized interventions for academic and personal success.

Role of the Principal Investigator

In both the quantitative and qualitative investigation, it was impossible for the PI to separate herself from the research process maintaining complete objectivity (Davies, & Dodd, 2002). Preconceived notions (bias) about the research process were considered, noted and the PI discussed this consideration with the other member of the research team. The conclusion was made that as a participant researcher it was important for the PI to keep careful field notes for reflection about bias (Mills, 2010). Glesne (2011) suggests the research process is to learn by being involved rather than a distant, separated researcher. Consequently, the PI needed to identify, understand, and become aware of her position as the researcher/counselor throughout the ARS. As coordinator of media and outreach for a suicide prevention grant, the PI reflected on

data with the subjectivity of a counselor. She never served in the military. However, she was raised a family for 10 years in Central Asia and the Middle East. Her relationship with military personnel and their families in deployment was beneficial in understanding similar experiences.

In September, 2011, the PI spent the afternoon with a military panel of chaplains and their families listening to the "need of the hour" for military personnel returning from combat duty (B. Dees, personal communication, September 30, 2011). In November, 2011, the PI coordinated a National Roll Call event on campus and heard stories from student veterans as they volunteered to read the names of fallen comrades. These occasions provided exposure to military culture and individuals who served in the Armed Forces. In February, 2012, at a student veteran's association meeting, the PI learned about concerns and needs. Reactions to her proposed ARS were positive. In addition, the PI recently attended a workshop on trauma among military veterans and presented a program at a 2012 State Conference for College Counselors. These experiences helped her to connect with others in the military and academia who are concerned about the issues of returning veterans.

Before data collection and throughout the ARS process, the PI met with the Veteran Affairs Certifying Official (VACO) on campus for guidance in working with student veterans. Her responsibility is to assist students in applying for educational benefits and act as a liaison between the student and the Department of Veteran Affairs (VA). She also is the "gate keeper" for this study because she controlled the venue for the quantitative data collection: the listserv.

Participants

Participants came from a general listserv of 425 student veterans enrolled using military benefits at the ARS site. However, there is an undocumented number in the general student population who are not part of this listserv. After one week, the listserv yielded only 19 participants. A reminder email was sent that the online survey would terminate soon. The VACO also posted the survey on the University's student portal, which is available to the student veteran population.

Thirty one veterans participated in the online survey. Racial makeup was primarily Caucasian, but other races were represented. The majority of respondents was in their late twenties and ranged from under 20 to over 40. The majority of the participants reported their military status as veteran. There were no active duty respondents. The majority served in the Army, with all services were represented. The time in military service ranges from five years or less to over 20 years. Current living situation found the majority lived off campus with their partner/spouse/family, the range extended to living on campus or some other situation (Table 1).

Purposeful sampling strategies were used for interview selection allowing the PI to intentionally choose participants for perspectives on needs within this campus community. Three veterans and their families completed taped interviews. Family interview demographics and interview items are found in Table 2.

Table 1. *Survey Participant Demographic Information*

Characteristics	**Number** (N=31)	**Percent**	
Gender			
Male	19	61.3%	
Female	12	38.7%	
Race			
African-American	4	12.9%	
Caucasian	22	71%	
Hispanic	3	9.7%	
Multi-Racial	2	6.5%	
Decline to Respond	3	9.7%	
Age			
18-24	8	25.8%	
25-29	12	38.7%	
30-34	2	6.5%	
35-39	2	6.5%	
40+	7	22.6%	
Military Status			
Veteran	16	51.6%	
Retired	3	9.7%	
Reserves	4	12.9%	
Guard	4	12.9%	
Spouse or child of veteran	4	12.9%	
Active duty	0	0%	
Branch of Service			
Army	21	67.7%	
Navy	4	12.9%	
Air Force	1	3.2%	
Marine	4	12.9%	
National Guard	1	3.2%	
Years in Military			
0-5	11	35.5%	
6-10	10	32.3%	
11-15	3	9.7%	
16-20	2	6.5%	
More than 20 years	5	16.1%	
Current Living Situation			
On campus	2	6.5%	
Off campus with partner/spouse/family	18	58.1%	
Off campus by self or with roommates	6	19.4%	
Off campus with parents or relatives	4	12.9%	

Table 2. *Family Interview Demographics and Interview Items*

Family Interview Participant Information

Family A. Single Mom (student vet) living with parents until finished with higher education.	Race: Caucasian Age: 25-29 Military Status: Guard	Branch: Army Years in Service: 6-10 years Utilizing the GI Bill: Yes
Family B. Engaged couple living in nearby city while husband (student vet) completes higher education.	Race: Caucasian Age: 25-29 Military Status: Veteran	Branch: Navy Years in Service: 6-10 years Utilizing the GI Bill: Yes
Family C. Married couple of 3 years living 70 miles off campus while husband (student vet) completes higher education.	Race: Caucasian Age: 30-35 Military Status: Veteran	Branch: Army Years in Service: 6-10 Utilizing the GI Bill: Yes

Student Veteran Family Survey Questions (Semi-structured)

Describe your adjustments to life as a university student.
What was your greatest challenge as a family through these adjustments?
How would you describe the "need of the hour" for your fellow UWG student veterans?
Has anyone in your family thought about suicide within the past 6 months?
If you are currently having thoughts of suicide, please contact the Veterans Crisis Line at 1-800-273-8255 and press 1. You can also have a confidential chat at VeteransCrisisLine.net, or visit your local hospital.

Data Collection

A triangulation method was utilized in collecting data because it was felt that relying on multiple methods of obtaining data would validate the information reflected by the veterans and allow the PI more confidence in presenting the data (Glesne, 2011). Items for the quantitative survey were gathered from the literature and discussions with key stakeholders. The online survey sent through surveygizmo.com contained 24 items: seven were demographic in nature, two requested multiple preferences, five were Likert scale items ranging from 1 (strongly disagree) to 5 (strongly agree), sic dichotomous choices, three qualitative responses, and a directive for suicide prevention.

On the survey, the participant could volunteer for a semi-structured family interview. Eight indicated a preference for the family interview; however, after contacting the eight respondents, only three scheduled the interview. The interviews were held at the Counseling and Career Development (CCD) on campus. Both the survey and interview had an item concerning suicidal ideation for the veteran and their family. As a safety procedure, the Veteran's Crisis Line phone number and live chat website were presented following the survey item, as well as during the interview. Interview questions focused on adjustments, challenges, and immediate needs for a rich, thick description, and convergent validation. As an incentive to participate in the

survey, participants could enter a drawing to receive $20.00 gift certificate to a local coffee shop. This protocol was approved by IRB through the appropriate request and review process.

Analysis and Results

Data were interpreted using descriptive statistics. Frequencies, means, and standard deviations were determined through the use of SPSS. Family interviews and field notes were coded for thematic material as noted in the literature. The technique of organizing the data by themes seen in the literature helped create categories/types of responses. Mills (2010) suggests a literature matrix that displays the content as themes a valuable component in the organization of themes brought forth within the ARS.

Items 1-4 and 20-22 on the survey collected demographic information. In items 5-6, participants were asked about participation in orientation or Preview Day prior to enrollment. Over 54% attended orientation, but 77% of participants did not attend Preview Day. When asked about a preference for an orientation specifically designed for student veterans, over 77% indicated favorably. During interviews, however, a theme of integration of the veteran into higher education was strong. The interviewees did not want a separate orientation, but rather a time during the orientation that was specific to the needs of the veteran, and perhaps peer to peer. Items 7 and 8 focused on the knowledge and utilization of the CCD; 63% stated that they were aware of counseling services, yet 84% indicated they had not utilized the services available at the CCD.

Student veterans were asked to rate whether or not the university site offered everything the veteran needs to succeed at a high scholastic level; over 67% responded favorably. However, nearly 55% of participants disagreed that the information regarding current services offered to veterans at this university were easily accessible. And in item 11, over 74% of participants indicated they would attend a training group for military families if available. The interest in training opportunities from item 17 is displayed in Figure 1. The strongest choices for training were in career development (82.1%), finances on a tight budget (53.6%), and study/ test taking skills (46.4%). Items 12-14 assessed anger (M=2.7, *SD* = 1.36), flashbacks (M=2.5, *SD* = 1.06), and suicidal ideation (84% indicated no S/I in past 6 months). Post-traumatic stress disorder (56.3%), multiple injuries (31.3%), combat stress reaction (18.8%), and spinal cord injury (18.8%) are the most prominent adjustments along with “other” (43.8%). Unfortunately, there was not adequate text space on the survey for participants to indicate all “other” adjustments (Figure 2). Table 3 presents Likert scale items 9-13.

Item 19 was an open-ended item on the “need of the hour” for fellow student vets on campus. Themes encompassed access of information, knowledge unique to veterans (benefits, GI process, transfer of training skills), need for community, reintegration, and adjustment to civilian life (Appendix A). Interviews of 3 veteran families were conducted for convergent validation as shown in Appendix E Items 1 and 2.

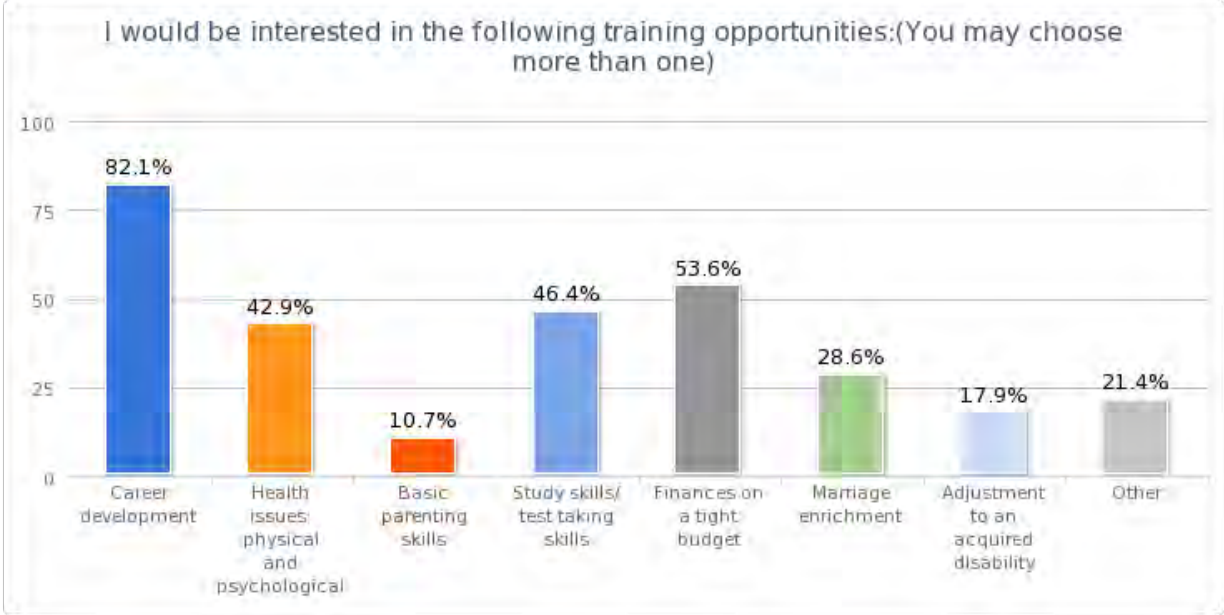

Figure 1. Student Veteran Interest in Training Opportunities

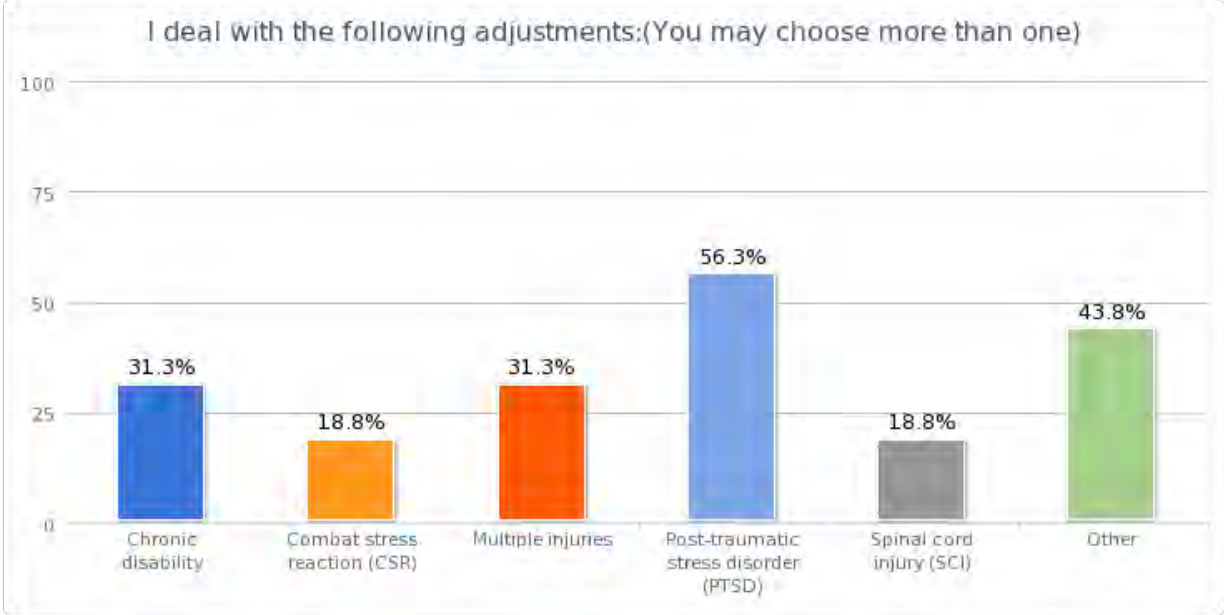

Figure 2. Physical and Psychological Adjustments of the Student Veteran

Table 3.
Likert Scale Demographic Results

Question	Respondents	Agree/ Strongly Agree	Disagree/Strongly Disagree	Neutral
Q9: This University offers everything I need to succeed at a high scholastic level	31	21	5	5
Q10: Information regarding current services offered to veterans at this University is easily accessible.	31	5	17	9
Q11: I would attend a training group designed for military families.	31	23	3	5
Q12: I find myself getting angry easily.	31	10	15	6
Q13: I have frequent flashbacks from my combat experiences.	31	5	14	12

Discussion

Because the ARS examines the researcher's own program, the power of the study is the relevance of the findings to improve the researcher's work. The results did reveal helpful information concerning needs of veterans and their families on this campus; yet, because of the limitation of a small participant pool, the results are limited. These results can only be interpreted within the context of this university and the returning veteran population; however, the quantitative data clearly demonstrates the need for intervention. Additionally, qualitative inquiry can be difficult as with this ARS because it delves into the personal lives of the participants and some people are cautious about the inquiry (Glesne, 2011). Glesne (2011) also notes that the study may end up someplace other than where the outcome was expected yet the data that is gathered is useful because it allows us to take steps to understand and improve our work.

In the survey, over half attended orientation, and less than one-third attended Preview Day. As stated in the results section, an orientation that met the unique need of the veteran would be preferable for the majority of respondents. Yet, as noted during the interviews, at least one interviewee would prefer an additional time period during the usual orientation that is devoted to the needs of veterans. Access of information and knowledge unique to the veterans are recurring themes in the responses. Over half of the participants indicated that information regarding veteran services were not easily accessible. One veteran stated feeling overwhelmed with the lack of help to find information.

> When I came here I had no idea about registration or orientation, and everyone assumed that I knew that. I tried to wade through things on my own – it was a little overwhelming. Most colleges are very proactive with their veterans in outreach.

Another veteran indicated the importance of integration into the student body through information gathered during orientation.

> It would be most helpful if there was a briefing hour, or a couple hours [of] question[s] and answer[s] to get to know your GI Bill and walk people through it. Not a separate orientation, because they need to integrate into the student body and orientation is a great place to do that. Just a separate briefing for information session would be good.

Based on a previous needs assessment (Stephens, 2010), there was a 173% increase in awareness of counseling services on campus, and a slight (0.1%) decrease in veterans utilizing counseling services. The awareness statistic is encouraging given the outreach conducted by the CCD campus-wide, as well as information about the physical and psychological adjustment needs of the student veteran. With a high indication of post-traumatic stress and combat stress disorders, student veterans are in need of counseling services provided in an individual or group setting. The assessment of anger outbursts, flashbacks, and suicidal ideation indicate proactive attention. Other physical adjustments such as multiple injuries and spinal cord injury can receive disability counseling and accommodations through CCD. These demonstrate the seen and unseen wounds of war these warriors bring to the campus community.

The need for community and understanding are also recurring themes throughout the survey results and interviews. One veteran stated, “I think it would be awesome to have others around me that could relate to my past lifestyle and are familiar with the challenges of adjusting to civilian life.” There is language and connection only a veteran community can experience. Understanding as a recurring theme is revealed several ways. Understanding by the university staff about VA processes as pertaining to enrollment, and fees is vital. For example, it may take a full semester before the University is paid by the government for the veteran’s classes. As a result, veterans may have a hold on their registration process until the VA pays tuition: a situation in which the student veteran has no control. Also, understanding by professors is needed. Sudden deployment would interrupt the schedule of a student veteran, and require the professor to offer understanding of this unique situation and collaborate accordingly. Hiding one’s identity as a veteran is common on college campuses due to fear of being called out by students or professors who express their anti-war political views in class. One veteran stated, “that is really rough [to hear], what I did in the Army has nothing to do with politics.”

The adjustment back to civilian life was also noted. Overwhelming emotions surrounding freedom from military culture, or dealing with people who are not in the military is a huge adjustment. Settling back into family life after being gone or in combat for a few years is difficult. There is a sense of disconnection upon return. One veteran indicated that there is a time in your life that does not relate to your family, and readjusting requires intentionality. Balancing the demands of life, making ends meet every day, going to school full-time and working to support family also require adjustment. According to several veterans who described university life, they quickly become aware of the need for social adjustments (Appendix B, Item 2). Learning to ignore the awkward questions of “life in the military” by younger students is also a challenge.

Future Intervention

Changes that a university counseling program might offer to better meet the needs of student veterans should be geared to the perceived needs of this population. Augmented orientations for new student veterans that provide clear information needed at the beginning of their education is essential. Offering early registration to veterans who are farther along in their education would ensure they receive their diploma utilizing full GI funding before their eligibility expires. Establishing a peer to peer student veteran mentoring program would ensure that these students remain on track for graduation and progress academically, and professionally. Career development specific to student veterans could be offered in group settings to accommodate greater numbers of veterans and create a community of learners. And finally, as part of the process of becoming a "veteran friendly campus," staff at the CCD should be trained in the unique needs of the student veteran. This training could be part of an in-service after a Needs Assessment of the student veterans on campus has been administrated, analyzed, interpreted and presented to appropriate stakeholders for funding.

Limitations to the ARS

There are limitations to the ARS study. The participants represented only 6.8% of the student veterans which limits its applicability to the entire veteran population on campus. In addition, the goal of ARS is not meant to be generalizable but has a set purpose to improve the program of the action researcher (Hendricks, 2006). The assessments used were researcher developed and not standardized; therefore, are lacking in validity and reliability. However, the use of triangulation, data collection, and analysis provided a chance for convergent validation lending credibility to the outcome. Finally, the number of participants (N=34) was low.

Recommendations for a Future ARS

While the Needs Assessment seemed to reveal areas in need of intentional purpose, an assessment of additional student veterans would provide a more accurate picture. The researcher should note and employ the suggestions made by participants in a future study. The use of a longitudinal study of veterans in higher education examining increasing progression, retention, and graduation rates would be beneficial. The use of a formal standardized instrument would ensure validity and reliability.

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Appendix A. The "Need of the Hour" for Fellow University Student Veterans

Responses from Online Survey

Easy access to veterans services at all campuses both for day and night students.

Have an orientation or information session for enrolling veterans about the GI bill process.

Orientation session for Veterans, and/or non-traditional students which many of us are!

Orientation session geared specifically to veterans and family members.

Understanding

Understanding the whole benefits process

A veteran social group

Having nicer people to explain our benefits and such

Understanding the transfer of military training skills and understanding all of the benefits that can be accessed on campus. Most of the veterans are young and need more guidance in adjusting to a new life. Learning how to fit in takes a great deal of time as well.

Making needs that surround the process of enrolling and paying for classes more streamlined. If I hadn't taken an active role in following my paperwork from office to office I wouldn't have been allowed to take classes this semester. A process that I believe should have been more straight forward and assisted.

I think that it would be awesome to have others around me that could relate to my past lifestyle and are familiar with the challenges of adjusting to civilian life.

People to talk to that can relate to us, not some counselor who doesn't have a clue of what we're talking about

Acceptance requirements into fields. Example: Nursing Dept. requirements are off the chart HIGH!!! My husband 20yr military Retired & graduate of Penn.State - wanted to go into Nursing at UWG but some of his pass classes did not line up with today's UWG requirements. So he dropped the search to get into nursing program. Because the department did not want to take the time to help him. A.) The department Head should have taken his information, research for him to see if the courses did line up, and made a personal interview with him after research came back. B) Military personal and spouses with long term ties to military life - have a greater understanding of how the world works. No they don't ask for special treatment and never will. They do however deserve special (bend over backward) treatment.

Camaraderie. The acknowledgement that our service was really appreciated, rather than simply being told.

I have no clue what other students on campus are also serving our country. More events should be held on campus, so that we can introduce ourselves to each other.

Sessions/orientation to provide information on veteran's benefits and resources including GI Bill benefits, scholarships for veterans, etc.

Appendix B. Family Responses

Item 1: The "Need of the Hour" for fellow university student veterans

Family A Response - I can't imagine someone who has never been to college and who has never had any briefing about their GI benefits. It was overwhelming for me and I had a GI bill class before I left Ft. Hood. Having that more readily available would be a great help. I am glad the SVA started back up to help people coming in and kind of point them in the right direction of who to talk to- kind of a stair-step down between the military and college- the Veterans Association can bridge the gap.
Family B Response - Show more gratitude than what they [University administration] give. Something simple like at a football game, honor the veteran community. Or offering early registration for vets at the end of their education to help get classes before the GI and housing benefits expire. This would reduce the stressors the vet faces in college balancing class schedule, jobs and finances. Also vets got out of the military to go to school- they want to make the most of those years. Providing information/ direction for scholarships, disabilities, registration, programs available is important.
Family C Response - I had a hard time registering for classes. As a commuter student, I want to finish school and be done with college. Registering early would alleviate many problems of drop/add, getting the paperwork, finding the classes I need. The percentages are low of those veterans who finish their education. If there could be an avenue when a new vet comes in to talk with someone to help them wade through the classes, etc. that would be very beneficial. Understanding of how the VA works is important for faculty and staff.

Item 2: Adjustments as a family to life in higher education

Family A Response - Mine is just figuring out how to juggle doing the National Guard, school, and 2 days a week in public school. Doing all that and then be a single mom at the same time. Mine is just wearing all the same hats. Coming out of the military since I'm doing the National Guard, it wasn't a clean break, maybe stair-stepping it down for me. It actually is harder for me now with the national guard than with active duty just because I am trying to do so many other things. It seems like one weekend a month I miss something important.
Family B Response - Social adjustments- trying to "fit in" while experiencing college life, not getting asked questions daily about my military experience on a ship; great need for community; balancing school, work, finances is difficult; going to school full time, working, and trying to "make ends meet every day" as military experience did not count toward hiring/worth at work.
Family C Response - There is a disconnect when you come home. I wanted to tell my story to my family, but no one would ask me about my time at war. My family felt that part of my life was fragile. There is a long period of time in my life that does not relate to my family. It's strange. Adjusting back to civilian life was an emotional one, the freedom was overwhelming, and dealing with people who aren't military was difficult. I've been back a few years and I still deal with survivor's guilt.

Barriers to Mental Health Treatment in the Military

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Abstract

Military services members are applauded for their willingness to fight, selfless sacrifice, and desire to serve their country. Although their battle takes place overseas, members struggle with a personal battle that takes place at home; their fight for sound mental health and a better quality of life. This article explores counseling practice methods for working with service members who experience barriers to mental health treatment. Four areas that are barriers to mental health treatment are described: a) knowledge of military culture, b) assisting with military career concerns, c) addressing mental health stigma, and d) evaluating mental health concerns. To assess the four areas, a short Assessment Checklist for the Military Population is provided for counselors working with military members and a discussion of how to use the checklist in practice is provided.

Keywords: mental illness treatment, treatment barriers, military personnel, Assessment Checklist for the Military Population

Men and women of our Armed Forces are applauded for their willingness to fight, selfless sacrifice, and desire to serve their country. Most often their service takes place overseas, away from American soil and the people they know. Many service members fight an inner battle every day, both at home and overseas. Their fight is for mental health. Recent crisis situations at Ft. Hood in 2009 and 2014 indicate a rise in active shootings that involve service members (Rhodan, 2014). Also, members are diagnosed with posttraumatic stress disorder (PTSD), six times more than they were a decade ago (Xenakis, 2014), and sexual assault in the military has increased (Burns, Grindlay, Kelsey, Masnki, & Grossman, 2014). These crises highlight just a few examples of why service members fight for physical as well as psychological wellness.

Weekly, service members' struggles are reported in the news and more research is being conducted to assess their mental health needs (Bray et al., 2010). In 2010, research indicated that 20 to 44% of members returning from Iraq and Afghanistan met criteria for a mental health

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diagnosis and 19% of those members were diagnosed with traumatic brain injury (Kim, Thomas, Wilk, Castro, & Hoge, 2010). From 2010 to 2012, adjustment disorder was commonly diagnosed in members (Israelashvili, 2012) and was a contributing factor in 82% of active duty suicides (Fielden, 2012). Also, gender differences were found. Approximately 60% of females reported emotional issues after returning from deployment while 35% of males reported similar concerns (Katz, Bloor, Cojucar, & Draper, 2007). And, 38 to 45% of service members reported an interest in receiving treatment (Greene-Shortridge, Britt, & Andrew, 2007), with 13 to 50% of members needing services actually receiving services (Hoge, Auchterlonie, & Milliken, 2006). All of these are examples of members' need for mental health services and may point to the fact that either counseling resources are unavailable or the utilization of resources is not occurring for members.

The purpose of this article is to provide a framework for counselors to understand the possible barriers to military service members seeking mental health services and how counselors can assess and work with military clients dealing with these barriers. Assessment barriers will be described so that counselors can collaborate on treatment approaches for service members in the hope that members can engage and remain engaged in therapy. We used an outline for the presentation of this article based on Falco and MCarthy's (2013) recommendations for practice articles that includes the introduction and purpose of the article followed by a review of the literature (i.e., specific to members' perceptions of barriers to mental health), the methods of practice (i.e., four areas of treatment), the results of practice (i.e., how counselors can work with members using a checklist), and the discussion of limitations and future research.

Literature Review

Military Culture

Bryan et al. (2012) described military culture as a collectivist culture, where the collectivist culture defines themselves in terms of group membership and place group goals ahead of personal goals. In the military culture, valued attitudes such as self-reliance and self-sacrifice are promoted, and in fact, demanded of service members to best fit the needs of the collective. Emphasis is on mental and physical toughness, and a focus on the mission to promote group protection (Dickstein, Vogt, Handa, & Litz, 2010). With these values and attitudes, a distinct and collective belief system is cultivated within its service members, which includes the belief that strong individuals can handle or tough out anything and that seeking help for a problem is a sign of weakness thus a possible weakness in the group (Zinzow et al., 2013). Military training promotes a psychological habituation in its members through importance of strength, courage, heroism, and sacrifice through adversity. Military members take on these values as part of their personal identities (Bryan et al., 2012). The collective perspective of the military culture also has a plethora of positive attitudes and beliefs surrounding strength and resiliency; but, these positive aspects can also work from an opposite perspective demanding extreme requirements of service members with negative impacts on mental health.

In Johnson, Rosenstein, Buhrke, and Haldeman's (2013) article on the repeal of the *Don't Ask Don't Tell Policy*, they described the social dominance orientation present in military culture. Members of the dominant group stigmatize members of the out-group based on issues

such as heterosexism, racism, and gender. Individuals who do not align with the dominant group are shamed by the larger group (Bryan et al., 2012). This dominant culture perpetuates the belief that service members in the out-group should be able to take care of their own problems and should conform to the in-group mentality, which leads many members to eschew mental health treatment for numerous reasons. One key example of the out-group mentality occurred in the 1980s, when 17,000 military members experienced discrimination when they were separated from the military based on their sexual orientation (Johnson et al., 2013). Reactions to this discrimination forced the military to institute the Don't Ask Don't Tell Policy (1993-2011), which it viewed as a compromise. At that time, the dominant belief was that homosexuality was incompatible with service because homosexual members could jeopardize the military mission; degrade unit cohesion; and increase risks to security. With the repeal of that policy in 2011, homosexuality of members was accepted; however, the dominant heterosexist orientation is still evident today in restrictions placed on the queer, lesbian, gay, bisexual, and transgendered (QLGBT) population's access to base housing, partners as dependents, and other issues not as identifiable (Rich, Schutten, & Rogers, 2012).

Military Career Concerns

A primary reason military members reported they would not seek mental health treatment was the negative effect it might have on their careers (Zinzow et al., 2013). In a study of four infantry units in the Army and Marine Corps, service members reported concerns that leaders would treat them differently if leaders were aware of their mental health issues (Hoge et al., 2008). A major related concern of most military members is that they could be discharged from the military, or they may be barred from advanced rank. Mental health issues could also restrict their ability to obtain a security clearance. Or, they may be denied/unable to accept certain assignments if a duty location does not have resources to support members with mental health issues (Straits-Tröster et al., 2011). Service members also feared that treatment of mental health issues would result in lower evaluations or denial in certain billets.

Confidentiality. Influencing service members' career concerns are the limits to confidentiality in which mental health information is dispersed on a need to know basis in the military. Policies allow for commanders to be informed about service members' fitness for duty, including mental health or related concerns (Zinzow et al., 2013). In some circumstances, mental health providers are required to communicate and make recommendations to commanders (Christensen & Yaffe, 2012). For example, the Air Force confidentiality policy requires mental health providers to communicate to the commander any necessary restrictions when an Airman's mental health status becomes a risk of harm to self, others, property, security, or accomplishment of the mission. Other circumstances, such as domestic violence, are handled differently in the military and with more immediate effect such as required reporting and dismissal from the military. Thus, lack of true confidentiality is a very real concern for service members.

Mental Health Stigma

Just as the stigma of mental health is found in the civilian population, it is also present in the military and can serve as a barrier to mental health treatment. Movies and television depict mentally ill characters as dangerous, incompetent, and often times responsible for their mental

health illness (Dickstein et al., 2010). Zinzow et al. (2013) identified two types of mental health stigmas that carry negative connotations and prejudices known as (a) public stigma and (b) self-stigma. Public stigma occurs when a negative reaction from others is directed toward someone with a mental illness. Self-stigma occurs when an individual internalizes negative views of mental illness. The unique aspects of military culture outlined previously can contribute to both types of stigmas against service members seeking mental health treatment (Vogt et al., 2013). The military culture places a high value on individual competence, confidence, and emotional toughness, which increases the public stigma of service members who have mental health concerns by opposing members' struggle for stability of thoughts and emotions and need to seek treatment (Nash, Silva, & Litz, 2009). Recent research indicated service members reported that use of mental health services would be perceived by others as a personal weakness (Dickstein et al., 2010), and within conducted military focus groups, mental health stigma was a greater concern for enlisted service members compared to officers (Zinzow et al., 2013). Thus, rank may have an effect on members' concerns about a stigma, with higher rank members perceiving mental health as less of a stigma.

In a study on the relationship between morale and PTSD, researchers hypothesized that self-stigma about mental health lowers service members' self-esteem resulting in service members being less likely to seek mental health treatment (Britt, Adler, Bliese, & Moore, 2013). Unfortunately, the result of a self-stigma is that many service members live with conditions that are treatable. Instead of having a negative label attached to them, service members would rather not seek services (Dickstein et al., 2010). Thus, some of the military population suffers from illnesses that go undetected (Zenakis, 2014) or treatment tends to focus on one specific goal like PTSD and the larger context of what service members are struggling with and trying to cope with on a daily basis is lost in therapy (Britt et al., 2013).

A growing problem related to mental health stigma within the military is military sexual trauma (MST); a "sexual assault or repeated, threatening sexual harassment during military service" (Burns et al., 2014, p. 345). In the *Department of Defense Health Related Behaviors Survey of Active Duty Military Personnel* conducted in 2011, 21.7% of women and 3.3% of men reported an occurrence of MST since joining the military (as cited in Burns et al., 2014). In a qualitative study, service members reported contributing factors to the prevalence of MST as the military culture, lack of consequences, and blaming women. Low reporting of MST was attributed to the negative reactions from peers or supervisors, concerns about confidentiality, and stigma associated with MST. Burns et al. (2014) stated that the occurrence of MST places members in further need of services and increased risk for developing PTSD.

Mental Health Concerns

Dickstein et al. (2010) found a relationship between mental health disorders and perceptions regarding individual control over a disorder. When others perceive that individuals should have control over their mental disorders, the public is more likely to blame them for having the disorders and view them as having weak characters. Examples of disorders perceived as self-inflicted are addictions, eating disorders, and PTSD; while disorders like schizophrenia are not linked to character traits because of its perceived biological basis. These individuals may not be perceived as lacking in character, but as having a physical illness.

Britt et al. (2013) found that individuals are more reluctant to seek mental health treatment if they believe they are responsible for their mental health disorder. For example, because PTSD is event-based, a common misperception among service members is that they brought PTSD upon themselves by choosing military service; as many of the events that triggered PTSD occurred while service members were on deployment. Prior to returning from deployment all service members complete a Department of Defense Post-Deployment Health Assessment (PDHA; Straits-Tröster et al., 2011). In a study on the timing of completion of the PDHA, Bliese, Wright, Adler, Thomas, and Hoge (2007) found that service members reported answering the PDHA with what they believed mental health therapists were looking for fearing that returning home may be delayed if mental health concerns were reported. Zinzow et al. (2013) agreed that service members' underreported mental health symptoms could be attributed to their desire for a quicker return home following deployment.

Other research indicated that, rather than seeking help themselves, service members often receive treatment only after mental health symptoms are exhibited to others through the *identify and refer method* (Bryan et al., 2012). This method describes a situation when a service member is observed displaying mental health symptoms by others who then refer the service member for treatment. In most of these cases, symptoms are related to suicide. In 2012, when 154 suicides occurred in 155 days, the military addressed the problem with training emphasizing the signs and symptoms of suicide (Bryan et al., 2012). Thus, recognizing and reporting symptoms of mental health issues other than suicide and how to seek counseling services relies on troubled service members' knowledge of mental health concerns and resources. As a result, service members do not seek treatment because they are unable to identify symptoms and fail to understand the benefits of counseling, thus reinforcing the barriers to treatment (Straits-Tröster et al., 2011).

While on deployment, a lack of resources for military members (Spira, 2010) poses an additional barrier to treatment. Lindstrom et al. (2006) concluded that service members needs go untreated due to lack of services and availability of mental health personnel when deployed. For example, women in combat support occupations involving infantry and armor units are significantly less likely to be hospitalized for a mental disorder than women in other military occupations (Lindstrom et al., 2006). Lower percentages of members' treatment when deployed can be attributed to lack of resources and the necessity of members "toughing it out."

Other barriers to mental health services outside of deployment include difficulty getting time off for appointments or scheduling appointments, financial concerns because of the cost, and proximity to services (Zinzow et al., 2013). With the highest concentration of veterans living in rural and nonmetropolitan areas (U.S. Census Bureau, 2003), their access to care is limited (Straits-Tröster et al., 2011). An additional barrier to services is members' perceptions that therapists will not understand their stressors or the dynamics of the military culture.

Methods of Practice

In 2010, the National Alliance on Mental Health stated that military members "cannot depend solely on the Department of Defense (DOD) and Veteran's Affairs (VA) for mental health care" (p. 1). Members' needs extend beyond military resources; thus counselors practicing in various health care settings can serve the military population.

Knowledge of Military Culture

Considering the widespread need for mental health care and the barriers faced by service members, it is important that counselors have knowledge of the military culture to provide useful services. An important area of focus when working effectively with military clients is the cultural competencies mandated by the American Counseling Association (ACA, 2014). A core competency for counselors should include understanding the context of the military culture (Arredondo, & Toporek, 2004). A failure to understand the impact of the social context and worldview of military clients will limit counselors' ability to provide effective treatment.

As mentioned earlier, values like self-reliance, self-sacrifice, resilience, and courage dominate military culture (Bryan et al., 2012; Zinzow et al., 2013). While they can provide core values that assist service members in the military, these values can also hinder service members' self-care needs making their choice to seek or participate in therapy a challenge. As military clients seek services, counselors need to assess what these values mean to clients, as well as how these values may impact participation in therapy. In many situations, service members show a courageous face, but many may struggle internally. They may not know what therapy is or how it can assist them. Therapists can help service members in normalizing their experiences by explaining the effect that social dominance can have within the military culture and how the culture can prohibit or restrict its members from seeking help (Bryan et al., 2012). As a result of perceived social restrictions or group dominance, service members may experience common stressors such as physical illnesses, family/marital problems, work issues, financial concerns, and trauma (Fielden, 2012) that counselors can help alleviate.

Assisting with Military Career Concerns

Zinzow et al. (2013) indicated that the primary reason military members give for not seeking mental health services is the concern that therapy will have a negative impact on their careers. Counselors' knowledge about possible career paths for military men and women may help when counseling service members. Service members' careers can be broken down into several decisions points; when to enter or exit the military, how to attain certain assignments within the military, how to attain a certain quality of life, and how to provide for their family. Most service members who enter the military did not choose the military as a long term career goal. A study conducted by Ford, Gibson, DeCesare, Marsh, and Griepentrog (2013) found that out of 1,587 military members, over 50% of them did not originally plan to join the military. Their study also indicated service members who intended to join the military in youth were found to have longer military careers than those who did not intend military service. The average time of military service was 70.8 months - almost seven years. Thus, many service members are unsure when their commitment may end. Military clients may seek therapy to discuss their choice to stay or leave the military and how that choice will impact them or their family.

Service members also join the military for internal and external reasons. Internal reasons include a wish to continue a family history, similar values as other family members, as well as expected enjoyment gained from a military career. External reasons for joining the military include employment security and material benefits that assist service members in maintaining quality of life. Members who join for external reasons may feel less in control of their jobs

within the military, as internal factors are not the motivation. This loss of control can translate into fear about a future career (Ford et al., 2013) and mental health issues can contribute to the loss of control members feel.

Another career concern service members experience is the change in billet assignments that may alternate between deployment and non-deployment status. Gambardella (2008) described the five stages of the deployment cycle that are parallel to an emotional cycle service members experience during each of the stages. First, in the pre-deployment stage, members anticipate a loss will occur with separation from family, friends, or identity within their environment. Next, in the deployment stage, members experience emotional disorganization resulting from detachment from family and friends and transition to their new environment. In the third stage, sustainment, the disorganization that members experienced from the previous stages reaches a period of stabilization. In the fourth stage, re-deployment, members learn about the next deployment cycle when they also anticipate the return home. Finally, in the post-deployment phase, members reintegrate into home, family, and friends. Within a three-year time frame, the full deployment cycle can be repeated two or even three times for some members.

Another career concern may include the choice to transition back to civilian life. Service members are familiar with their work identity as a member of the military. Transitioning to a new, public-sector workplace, without the same type of recognition as received as a military person, can feel foreign leaving members unsure of their status or identity in the public sector (Robertson, 2013). During this transition time, a military member may also experience financial stressors; the financial security or stability experienced in the military may not be replaced.

Contrary to service members' expectation of negative career effects of mental health counseling, Christensen and Yaffe (2012) found that self-referred treatment for mental health often does not impact service members' careers within the military. In cases where communication was initiated between mental health providers and commanders, 75% of that communication about service members was positive or supportive in nature. The same research indicated that only 3% of counselors' communication to leadership had negative impacts on members' careers, ranging from separation from military service to change in duty assignment (Christensen & Yaffe, 2012). Counselors can assist service members in understanding various approaches to counseling and how they might benefit.

Addressing Mental Health Stigma

Another aspect military members give for not seeking mental health services is perceptions of mental health stigma when treatment is sought. Dickstein et al. (2010) proposed five areas that could reduce negative stigma and change perceptions within the military, which include: a) stereotypes about mental health, b) self-blame for mental illness, c) uncertainty about signs of mental health, d) treatment as a sign of weakness, and e) uncertainty about what mental health treatment looks like. They recommended counselors examine military clients' negative beliefs about counseling in an effort to reduce the stigma surrounding mental health. For example, counselors could examine clients' belief that seeking mental health services shows weakness, and assist clients in reframing perceived weakness as courage in the face of ridicule.

Also, in reducing stigma about mental health services and helping service members to feel comfortable seeking out services, practitioners can use multiple modes of counseling (Dickstein et al., 2010). One approach that Valaitis (2005) suggested is using the internet and computer-based strategies to reduce stigmas about mental health. Computer-based methods might include web-based videos specific to topics with which military members struggle (i.e., combat fatigue, concerns about family/friends while on deployment, etc.). Internet sources can be effectively used to make counseling services more available to service members through the anonymity associated with online methods. Web-based educational sources and videos are cost-effective and easier for counselors to disseminate to clients who are away on deployment. Counselors can also provide information to chaplains, unit staff, and family support groups who can then disseminate the information to service members. When addressing mental health stigma, face-to-face contact may not be effective or possible especially when service members are resistant or cannot access services in a traditional way (Valaitis, 2005).

Another approach to combat service members' negative perceptions of counseling is the use of bibliotherapy. Counselors can use bibliotherapy as a means for clients to self-examine their belief systems and reflect on their understanding about the counseling process and what it means to see a counselor. Through bilbiotherapy, counselors can address any self-blame service members experience for having a mental illness (i.e., volunteering to join the service, choosing a particular job, or accepting a particular assignment). For example, counselors can have members read about what is counseling and journal between sessions about their understanding of counseling without fear of retribution or judgment.

Because female service members are at higher risk of exposure to MST than their male counterparts (Burns et al., 2014), MST can be a key component of mental health stigma. Within a culture of self-sacrifice, strength, and courage; military members may experience complex trauma from MST as well as PTSD (Landes, Garovoy, & Burkman, 2013). While confidentiality is a major concern of members in general, it is a vital concern more specifically to stigma of MST. Additionally, survivors of MST often blame themselves for the assault (Burns et al., 2014), a fact counselors need to be aware of in treatment. Counselors should assess whether they need additional training in MST and other traumas specific to the military population through mentoring programs such as *Understanding Military Culture* (Bernardy, Hamblen, Friedman, Ruzek, & McFall, 2011). Alternatively, counselors could determine whether they should refer military clients to counselors trained in trauma work.

Evaluating Mental Health Concerns

Britt et al. (2013) found that individuals who believe they are responsible for their mental health issues are less likely to seek treatment. In the military, PTSD is a mental health disorder that service members may feel they brought upon themselves through their choice to serve in the military. If members do enter treatment, they may not fully participate in therapy due to a lack of knowledge about mental health issues related to PTSD or other symptoms such as insomnia, lack of or over eating, frequent nightmares, or substance abuse issues. Bryan et al. (2012) suggested that military members may be referred to treatment only after a greater problem is recognized. An important component to evaluation of mental health treatment for members is to assist members in how to recognize their symptoms and how they can be related to mental health

issues. Counselors can assess for symptoms and use psychoeducation regarding symptoms to help service members stay in treatment and learn how to manage or eliminate symptoms. Counselors may also want to explore members' ideas about responsibility and to recognize the choices they do have. Counselors can use psychoeducational goals "to increase [members'] understanding of stress reactions, readjustment difficulties, and recovery, as well as to normalize experiences, and assist in the early identification of symptoms that may reflect the development or exacerbation of a mental disorder" (Niles et al., 2012, p. 539).

Fielden (2012) reported that while service members are on deployment a lack of mental health resources exists. Just as alternate methods of treatment discussed earlier can help reduce stigma about mental health, these methods can also increase availability of services for service members. Counselors may want to consider discussing things such as email or phone contact, self-help books, long-term homework, and workbooks that can facilitate change in clients while away from their mental health provider. Further, when members do receive services while away, it is important for therapists to evaluate possible alternative options for counseling services and collaborate with providers to facilitate continuity between service members' deployment and returning home (Engel et al., 2008).

Counselors can also become familiar with resources available to service members as well as their families. For example, support groups for family members are built into the military structure (Weiss, Coll, Gerbauer, Smiley, & Carillo, 2010), such as the *Army's Family Readiness Groups* (FRG, n.d.) for spouses when service members are deployed. Their mission is to support one another including things such as babysitting, cutting the lawn, assisting with home repairs, or other daily needs. Counselors can consider doing pro-bono work, or offer services at a discounted rate through programs like the *Returning Veterans Project* (n.d.).

Results of Practice

In the previous sections, barriers to mental health treatment for service members were outlined, as well as how counselors can work with military clients dealing with these barriers. A challenge of working with members is that "those that avail themselves of counseling services only do so when their problems have reached a critical and often incurable stage" (Gomulka, 2010, p. 115). Assessment of barriers can help military clients and counselors collaborate on approaches to treatment in the hope that clients engage and remain engaged in counseling prior to reaching a critical point by providing positive results from therapy. The authors have developed a short Assessment Checklist for the Military Population (ACMP) for counselors working with members during initial sessions and as needed in later sessions (see Appendix).

As noted in the ACMP, it can be used to assess four areas that create barriers to clients obtaining and continuing therapy: military culture, career concerns, mental health stigma, and mental health concerns. Using the first section, Military Culture counselors can begin with a general question to a military client about what brought the client to treatment, and whether counseling is mandatory or voluntary. Counselors can discuss with a client, "What values does the client have?" and what they mean to the client. Also in this section, counselors are encouraged to discuss which values will be helpful to the client and which values may not be helpful. For example, a client might describe a time he or she exhibited courage on deployment

when others were fearful. The counselor can ask how that courage can also be useful in counseling sessions. Additionally, counselors can ask about any negative aspect of chosen values, such as how self-reliance can contribute to ongoing problems as clients attempts to handle problems on their own.

The second section of the ACMP is about Career Concerns of service members. Members are asked about concerns related to seeking treatment for mental health issues. "What concerns does the client have related to his or her career?" Counselors can evaluate concerns that are listed in the ACMP, such as confidentiality and other concerns that service members fear and are related to their command's awareness of service members' choice to seek treatment. Therapists can ask "are you concerned about confidentiality" and "what do you think would happen if your command found out you were coming to counseling?" Other fears may include not being able to maintain a security clearance, moving to a different duty location, or ranking on yearly evaluations. The military is currently rewriting the security clearance question related to mental health to include an explanation of how seeking mental health services is not evidence of a condition that would disqualify a member from receiving a clearance (Maze, 2013).

Once military members concerns are evaluated, counselors can ask, "What transition period is the client in at this time?" General related questions to a client could be "do you have any concerns that working through a mental health issue might impact your career," or "how do you think treatment will impact your career?" At this point, members may describe some of the cycles they have experienced such as predeployment, deployment, or the other three cycles.

In the next section, Mental Health Stigma, counselors can assess "What stigma(s) does the client have about counseling?" Counselors could use this time for psychoeducation to assist clients in understanding "public" or "self" stigmas. They might ask questions such as "are you worried about what others may say if they know you are seeking treatment?" or "how do you feel about working on a mental health issue?" Counselors can also ask "have you seen other military members with a mental health issue?" and "what was it like for them?" Assessment can also include "What type of trauma has the client experienced in the military?" If a member does disclose information related to a trauma another question might be "what was the client's experience in how that trauma was handled?"

In the final section of the ACMP, counselors can assess for Mental Health Concerns. To start that discussion, counselors can ask, "What hurdles to treatment does the client have?" For example, clients may be able to discuss a specific situation or may give indications of self-blame. Or, asking clients about what they know in general about mental health and symptoms related to mental health. Assessment about practical concerns for getting treatment is also important to evaluate. For example, a client that is going to be leaving on multiple week long work-ups prior to deployment may be open to reading books or journaling. Counselors may want to consider a shift in approach to using resources like the internet to make sure the treatment modality fits clients' needs. This is a great time for counselors and clients to collaborate on what will work best in terms of treatment for the client.

Discussion

Too often military members live with a substandard quality of life due to mental health issues that go untreated (Xenakis, 2014). Service members lose the belief and hope that things can and will get better. Counselors can help military clients work towards a higher quality of life. This article provided details regarding four barriers that prevent military members from receiving mental health treatment when needed. Barriers include the impact of the military culture on help-seeking behaviors, concerns about military careers, perceptions about mental health stigma, and practical concerns that affect members receiving treatment. Counselors can assess these barriers using the ACMP and discuss with clients effective treatment options.

One limitation of this approach is that not every service member requiring mental health services will seek treatment. While this is troubling, counselors can concentrate on providing counseling services to those who do seek services. Counselors can address stigmas and fears of service members and possibly these members who do seek treatment will share their positive experiences with others who are hesitant to seek services. Addressing specific barriers that service members have to counseling can facilitate effective treatment, better therapeutic relationships, and engagement in the therapeutic process.

A second limitation is that this article does not exhaust all areas that may be barriers to the military population needing counseling. However, information is provided on four core areas for assessing military members who seek care. In an effort to reach service members and provide counseling services, therapists can consider offering pro-bono services by posting fliers on military bases and in base newspapers along with posts on counselors' LinkedIn sites, webpages, or other advertisement sources that they provide services to the military. *Give an Hour* (www.giveanhour.org) is an example of a national organization focused on organizing mental health providers where counselors can provide pro-bono services to members and their families.

For future research, assessment of the efficacy of addressing barriers to counseling is needed. Also, the four important areas in the ACMP could be assessed by asking therapists how many areas therapists assessed, what areas were more important to military clients, and what other areas might be considered when working with military members. Also, qualitative research could assess the efficacy of addressing barriers with military clients and which barriers is a theme for each client. Finally, future research could also focus on counseling modalities that are effective in reaching this population in the four areas of the ACMP.

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Appendix. Assessment Checklist for the Military Population

Military Culture

- What brought the client into counseling?

☐ Mandatory ☐ Voluntary ☐ Referred

Presenting Issue: _____
_____

- What values does the client have?

☐ Self-reliance/sacrifice ☐ Courage ☐ Resilience ☐ Strength
☐ Bravery ☐ Valor ☐ Heroism ☐ Other: _____

Which values might help or hinder the client in the counseling process? _____
_____

Career Concerns

- What concerns does the client have related to his or her career?

☐ Fitness for duty ☐ Assignment ☐ Advancement
☐ Evaluations ☐ Denial of billets ☐ Security clearance
☐ Confidentiality ☐ Access to care ☐ None
☐ Other: _____

- What transition period is the client in at this time?

☐ Pre-deployment ☐ Deployment ☐ Sustainment
☐ Re-deployment ☐ Post-deployment ☐ Other: _____

Mental Health Stigma

- What stigma(s) does the client have about counseling?

☐ Public stigma (negative reaction from others) ☐ Self-stigma (internal negative reaction)
☐ Observed stigma during the military ☐ None
☐ Other: _____

- What type of trauma has the client experienced in the military?

☐ Sexual trauma ☐ Combat trauma
☐ None reported ☐ Other: _____

Mental Health Concerns

- What hurdles to treatment does the client have?

☐ Blame self for the current problem ☐ Negative perceptions about mental health
☐ Recognition of signs/symptoms of problems ☐ Practical concerns for getting treatment

Veterans and the Civilian Workforce

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Abstract

This paper will examine the methods career counselors could use to assist veterans in finding adequate employment after they return from deployment using the veterans' skills and abilities. The areas that will be addressed are career concerns, clinical and demographic factors, mental health diagnosis, occupational functioning, economic concerns, re-adjustment concerns, attitude towards finding adequate guidance to employment, and environmental concerns preventing them from finding adequate employment. This research will explore current and proposed veteran programs designed to assist in finding adequate civilian employment and options to reduce or eliminate barriers to successful transition.

KEYWORDS: deployment, employment, veterans, veteran programs

Introduction

Veterans, returning from deployment, are having difficulty finding adequate employment due to the lack of skills and ability to re-join the civilian workforce. This is especially true of homeless veterans. Research by Burnett-Zeigler, Valenstein, Marcia, Ilgen, Blow, Gorman, and Zivin (2011) suggest "Active duty service members enter the civilian workforce only upon separation from the military, which occurs at the end of their enlistment period sometime after they return to the United States and at a time of their discretion" (p. 639). The full military veteran population includes both active duty and their subsequent reserve component. Burnett-Zeigler et al. (2011) state, "In contrast, National Guard service members face earlier entry into the civilian workforce either 14 days (for service of 31–180 days) or 90 days (for service of 181 days or more) following their return to the United States" (p. 639). A holistic approach to serving the veteran population should provide the best outcome due to the myriad of potential career needs and developmental issues. Burnett-Zeigler et al. (2011) suggest, "Early outreach and supportive employment counseling for younger Veterans may be important in this critical transition period to civilian employment" (p. 645). Career and personal interventions can be varied to ensure that all of the issues are covered in the best way possible.

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Career Concerns

The veteran population is usually met with unemployment stemming from specific physical disabilities, psychological issues, and a lack of advanced skills due to the specific job or career field they worked in while serving in the military. When returning from a deployment or being discharged from the military many, benefits and financial compensation earned while serving are sometimes delayed and cause unforeseen concerns, most prevalent being homelessness resulting from rising housing costs as a result of the falling economy which has added additional barriers to employment (Bullock, Braud, Andrews, & Phillips, 2007). The barriers that are occasionally noticed with the homeless veteran population are the lack of self-respect, low self-esteem, and a stigma of lacking the ability to help them in the career search. Bullock et al. (2007) report, "because society determines an individual's worth by his or her monetary value or job status, lack of employment or chronic unemployment is devastating to one's feelings of self-worth and self-efficacy" (p. 172). The homeless veteran population has certain characteristics and developmental issues which come from being unable to sustain a regular life without the assistance of others. This also includes career issues. Ludwikowski, Vogel, and Armstrong (2009) suggest "in the case of career issues, individuals who have difficulty crystallizing their career paths may be viewed as indecisive, unmotivated, less intelligent, and unsuccessful, and individuals may avoid career services to avoid being linked to these negative labels" (p. 409). Clinical and demographic factors could have an impact on how well this special population transitions back into the civilian workforce.

Clinical and Demographic Factors

Career counselors need to be aware of which clinical and demographic factors determine employment status in returning veterans. Research by Cohen, Suri, Amick, and Yan, (2013) suggest "since 2001, over 1.5 million US soldiers have been deployed to Iraq or Afghanistan. Individuals with combat exposure in prior conflicts are known to have had a greater than two-fold increase in the prevalence of unemployment" (p. 213). Life stressors for veterans can be roadblocks to successful career interventions due to the clinical and demographic factors evolving from medical issues developed during their enlistment.

Many factors lead to these high numbers of veterans without employment including being diagnosed with a mental disorder received during combat, which can prevent them from ever returning to work after a deployment. Demographic factors play a role in the equation due to the many different places these men and women have been ordered to travel. The ability to readjust to their surroundings in a war time situation can also lead to mental health issues. Cohen et al. (2013) find, "mental health problems are an important factor associated with employment. Posttraumatic stress disorder (PTSD), observed in 13 to 17% of active duty soldiers following return from Iraq, has been found to triple the odds of unemployment" (p. 214).

Depression is a mental disorder that could cause undue stressors for the veteran and might impact the veteran's employment opportunities when he/she returns from deployment. Cohen et al. (2013) suggest "depression has been shown to have a dramatic negative effect on employment status, and when co-occurring with PTSD, there is a 5 to 6 fold higher risk of

unemployment" (p. 214). Holistic intervention is needed to reduce the effects of depression and PTSD for veterans.

Mental Health Diagnosis

Career counselors should be aware of the connection between the military and civilian environment when working with veterans. Understanding the differences in how daily life activities affect their skills and abilities to perform career functions will provide a positive base for building a cohesive relationship with clients. When the veteran provides proof of a mental health diagnosis from a professional, it should be investigated as to the best interventions to utilize for maximum positive outcomes for the transition back into the civilian workforce. This is especially true for the diagnosis of PTSD. Erbes, Kaler, Schult, Polusny, and Arbisi (2011) suggest "service members with a diagnosis of PTSD reported greater rates of deterioration in work role functioning over time" (p. 1159). Many barriers prevent the veteran from a seamless re-entry back into the civilian workforce with this diagnosis.

The career counselor and veteran will need to discuss how the symptoms of PTSD can negatively impact the re-entry into the civilian workforce. Symptoms such as fatigue, impaired concentration, loss of interest in activities, disrupted sleep, irritability, social withdrawal, vigilance, and behavioral avoidance (Erbes et al. 2011). The positive effort the career counselor and veteran do in the counseling sessions to reduce these symptoms could increase job opportunities for a successful transition.

Economic Concerns

Educated counselors or counselors with experience working with military clients should be able to provide input on why recent veterans have such high unemployment rates relative to the rest of the labor force. The economic concerns brought on by being unemployed has a direct impact on the rest of society. Research by Faberman and Foster (2013) suggests "evidence that deployments during wartime have a strong negative effect on the subsequent labor market outcomes of recent veterans" (p. 12). Veterans suffer negative aspects of deployments leading to veteran unemployment, which could be physical or psychological trauma. This may lead to difficulty finding work caused by factors having less to do with the recession and more with wartime deployments producing higher unemployment (Faberman & Foster, 2013). Veterans who possess military specific skills which do not transfer into a civilian occupation might have a more difficult time during the transition into the civilian workforce. Faberman and Foster (2013) suggest "if the skills and abilities of these individuals were better suited to military life, such a switch may result in a 'mismatch' between their skills and the skills required for available civilian jobs" (p. 2). Career counselors should research the military experience and job history of each client to better provide a career action plan set up to match the past military career experiences and allow the client the opportunity to share his/her ideas on what second career path they would like to pursue.

Another concern is the impact on family during the transition. This can be a trying time for all concerned due to the adjustment from how life was without the veteran to the re-entry back into the family. The re-adjustment period can help or hinder the civilian job search process.

Re-adjustment Concerns

Career counselors working with the veteran population might not understand the adjustment issues preventing them from being able to comprehend the information provided due to barriers or roadblocks from their current family or living situation. Adjustment concerns include PTSD symptoms, family, marital, or parenting issues. Career counselors could collaborate with professionals in their community to provide a holistic view of interventions for the client. Furthermore, the client might not be able to move forward in the career counseling sessions or complete the career development action plan if he/she does not remove the barriers stemming from the military to civilian transition. Feist and Freeman (2011) suggest "behavioral and emotional changes in soldiers may include violence and abuse, emotional hardening and numbing, an increased likelihood for drugs and alcohol abuse, legal problems, difficulty in obtaining and maintaining work, and chronic physical problems"(p. 14). The re-adjustment might cause the veteran to have a negative attitude towards gaining assistance or counseling from a professional outside of their comfort zone.

Attitude

Attitude is vital for a successful counseling experience and if the client has a negative outlook on the overall process then adjustments for a more useful career counseling experience and possible dynamic outcome should be discussed. The veteran population has certain characteristics and developmental issues which come from being unable to sustain a regular life without the assistance of others. Ludwikowski et al. (2011) suggest "in the case of career issues, individuals who have difficulty crystallizing their career paths may be viewed as indecisive, unmotivated, less intelligent, and unsuccessful, and individuals may avoid career services to avoid being linked to these negative labels" (p. 409). The barriers that are occasionally noticed with veteran population are the lack of self-respect, low self-esteem, and a stigma of lacking the ability to help them in the career search. They do not want to be a burden to society or their particular community. Direct interventions coupled with individual career counseling might be able to help the veteran adjust his/her attitude toward finding adequate employment.

Career counselors working with veterans on interventions to decrease the stigma from accepting career assistance and focusing on a productive career plan includes environmental factors. Environmental factors that could prevent a successful transition back into the civilian workforce include; traumatic brain injury, PTSD, substance use disorders, suicide, problems with emotional control, family violence, mental health problems of military children, and family disruption.

Environmental Concerns

Career counselors and other social services professionals want to be knowledgeable about their client's environmental challenges. This can help veterans find answers to eliminate barriers to a successful job search. Research by Rubin (2012) suggests "most social work professionals who will be assisting military personnel, veterans and their families know very little about this population" (p. 294). Counselors will need to understand the importance of environmental

concerns on the returning veteran's ability to find adequate civilian employment. Rubin (2012) suggests:

> This includes preventing homelessness and rehabilitating those who are homeless; helping veterans and their families navigate through complex systems of care; helping veterans secure employment, adequate housing, and veteran benefits related to education and health care; and helping transitioning service members offset the loss of camaraderie and cohesion by becoming involved in community activities and, thus, finding a new "mission." (p. 295)

Career counselors can do justice for the veteran when they are knowledgeable and want to assist them in finding adequate civilian employment.

Occupational Functioning

Career counselors can assist veterans transitioning back into the civilian workforce who suffer from mental health disorders find gainful employment through occupational therapy. Occupational functioning is how well the veteran maintains daily living and work skills. Interventions focus on adapting the environment, modifying the task, teaching the skill, and educating the client/family in order to increase participation in and performance of daily activities, particularly those that are meaningful to the client. Erbes, Kaler, Schult, Polusny, and Arbisi (2011) suggest "occupational functioning represents both an important outcome for military service members return from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) and a predictor for long-term mental health functioning" (p. 1159). Career counselors continue to work with veterans afflicted by mental health disorders on occupational functioning in order to increase the skill level and build the confidence of the veteran. Erbes et.al (2011) reports "the present findings also highlight the importance of continuing to evaluate veteran occupational functioning over time" (p. 1166). When career counselors and social service professionals collaborate to assist veterans with occupational functioning it might improve the opportunities to gain civilian employment after they return from deployment. Erbes et.al (2011) report, "as OIF/OEF continues and the potential for other military operations persists, attending to the broader levels of interpersonal and occupational functioning may serve as an important means of promoting the mental health and well-being of the large population of those who continue to serve the nation abroad" (p. 1167).

Discussion

Veterans, returning from deployment, are having difficulty finding adequate employment due to the lack of skills and ability to re-join the civilian workforce. This is especially true of homeless veterans. This also includes barriers to successful re-employment. Career counselors choosing to work with this population have to be aware of other disadvantages the veteran might have in reference to finding employment. Negative labels such as being indecisive, unmotivated, less intelligent, and unsuccessful can be evident in individuals who have difficulty crystallizing their career paths (Ludwikowski, Vogel, & Armstrong, 2009). These issues can be apparent in career counseling settings when working with the veteran recently returning from Iraq or Afghanistan.

A holistic approach to serving the veteran population would provide the best outcome due to the myriad of potential career needs and developmental issues. Intervention and collaboration are important aspects of the veteran's career development which should be written into the overall career transition plan. Career and personal interventions can be varied to ensure that all of the issues are covered in the best way possible. Research by Burnett-Zeigler, Valenstein, Marcia, Ilgen, Blow, Gorman, and Zivin (2011) suggest "early outreach and supportive employment counseling for younger veterans may be important in this critical transition period to civilian employment" (p. 645). Early outreach with returning veterans includes an overview of the individualized career plan for ease of understanding while maintaining multicultural sensitivity and ethics.

Ethical and Multicultural Considerations

Career counselors need to understand the ethical and multicultural impact when working with veterans having difficulty finding adequate employment due to the lack the skills and ability to re-join the civilian workforce after returning from deployment. The American Counseling Association (ACA) provides ethical guidelines for professional counselors working with clients to ensure they maintain a continuum of care. The ethical and multicultural implications of counseling these populations are spelled out in the *ACA Code of Ethics*. ACA provides specific instructions on how to proceed with all counselees who require counseling. The American Counseling Association (2014) addresses this issue:

> A.1.c. Counseling Plans; Counselors and their clients work jointly in devising counseling plans that offer reasonable promise of success and are consistent with the abilities, temperament, developmental level, and circumstances of clients. Counselors and clients regularly review and revise counseling plans to assess their continued viability and effectiveness, respecting clients' freedom of choice.

In addition to understanding the ethical concerns written by the American Counseling Association, career counselors are also provided guidelines on building career service plans from the National Career Development Association (NCDA). The NCDA *Ethical Standards* (2013) states:

> A.1.d. Career Services Plans; Career professionals and their clients work jointly in devising integrated career services plans (in writing or orally) that offer reasonable promise of success and are consistent with the abilities and circumstances of clients. Career professionals and clients regularly review career plans to assess their continued viability and effectiveness, respecting the freedom of choice of clients.

Career counselors provide opportunities for the veteran to build a career plan which includes addressing career concerns, clinical and demographic factors, mental health diagnosis, occupational functioning, economic concerns, re-adjustment concerns, attitude towards finding adequate guidance to employment, and environmental concerns preventing them from finding adequate employment.

Career Counselors provide career guidance and use strategies that match the client. When working with veterans the holistic approach should be a major consideration. Veterans have specific issues that can hinder the progress of the career service plan if not included in the process.

Strategies

Career counselors understand how theory can be applied to specific counseling situations. A theory that can be applied to working with veterans in transition is Krumboltz's happenstance learning theory (HLT). Krumboltz's HLT contains four propositions; to take action to do more than just make a single career decision, stimulate learning through assessments, explore ways to benefit from unplanned events, explore personal accomplishments outside of the counseling sessions (Krumboltz, Foley, & Cotter 2013). The veteran population will need to work through more than a single career decision, take assessments to learn of current interests, abilities, and values, benefit from unplanned events, and take action to accomplish given tasks outside of the counseling sessions. HLT will assist in developing a usable plan to join forces with career interventions to provide a client the veteran population an opportunity to remove barriers and find suitable employment.

New or Improved Strategies

The veteran population is usually met with unemployment stemming from specific physical disabilities, psychological issues, and a lack of advanced skills due to the specific job or career field they worked in while serving in the military. Additionally, the career counselor should be assisting veterans on a holistic level to empower them to overcome the roadblocks to successful career opportunities. They can do this by building an action plan with them that is positive and includes positive self-talk and positive steps. The transitioning veteran can only take action to accomplish given tasks outside of the counseling sessions if they can locate and navigate career resources. Another concern of these veterans is accessibility due to lack of transportation or technology. The U.S. Department of Veterans Affairs provides veteran centers through-out the country and also provides transportation for accessing the services. The National Veterans Technical Assistance Center (NVTAC) is an employment resource for homeless veterans. Collaboration has been a key in identifying the career resources for homeless veterans as many corporations have started foundations to build houses and provide grants for re-training of homeless veterans.

Recommendations

Research is needed to find positive methods career counselors can utilize when working with veterans returning from wartime deployments to remove roadblocks to gaining civilian employment. Research by Faberman and Foster (2013) recommends "further research on the relationship between wartime deployments and the labor market outcomes of new veterans can shed light on why such an adverse effect exists" (p. 12). Career counselors can add labor market research for their specific geographical location to the overall individualized career plan for the veteran.

Additionally, unemployment in America can vary depending on the amount of job openings in specific metro areas. Rappaport (2012) suggests "long-run metro unemployment rates may follow from characteristics intrinsic to the metro area itself rather than from the characteristics of its workers" (p. 15). Long term unemployment may be higher in specific metro areas from different causes either from the metro environmental influences or from the

unemployed population. Career counselors research the community to build a network of employment opportunities specific to the veteran population.

Advocacy is also important to give veterans the opportunity to get the same choices as their civilian counterparts. Career counselors can work with community partners and also work to pass legislation to provide funds to achieve the goals veterans have of finding adequate civilian employment after deployment. Another recommendation that could assist the veteran is to provide services for this special population by other veterans who have the formal knowledge, skills, and training in the career counseling field. A career center specifically focused to assist this population could help to alleviate the roadblocks and ease the stress the veteran has towards counseling and asking for help in the transition.

Conclusion

Veterans have transferable skills which can be used in the civilian community but have been in a specialized working environment and might not understand how to re-enter the civilian workforce. Career counselors are competent in their field and provide holistic career intervention to each client especially if they are in a special population. Career counselors work with veterans on ways to remove roadblocks and barriers preventing them from finding adequate civilian employment after returning from wartime deployments.

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