Vol 4, Num 3
Sep-Dec 2016

ISSN: 2165-7726

Journal of Military and Government Counseling

THE JOURNAL of MILITARY AND GOVERNMENT COUNSELING

The Journal for Military and Government Counseling (ISSN: 2165-7726) is published tri-annually in April, August, and December by the Military and Government Counseling Association.

December, 2016

Volume 4, Number 3, 2016

Journal of Military and Government Counseling

Letter From the Editor

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

I have decided the journal will start following the capitalization used by the Department of Veteran Affairs and the Department of Defense for the following terms: Veteran, Soldier, Sailor, Marine, and Airmen. I contacted the APA style folks about making this change and was basically told it was my call as Editor. The capitalization of these terms will only apply when the word is related to personnel. So, should you article relate to working with members of the Army the use of Soldier would be appropriate; however, if it is a simple "soldier on," lower case would be appropriate. Likewise, Veteran would refer to former members of the military, while "veteran police officers" would remain lower case.

This issue is an eclectic collection of articles in practice, theory, and research. The lead article examines including emotional intelligence assessment when counseling military clients. The second article reviews the culture of emergency service responders. As is was reading and editing the article, it brought to mind the iconic photo of firefighter Chris Fields holding the dying little Baylee Almon in the aftermath of the Oklahoma City Bombing and Chris Fields struggle with PTSD. The third article presents a pilot study of a substance abuse prevention training program. The fourth article the military success model's use with children. The final article is the first international submission – a graduate student paper from Canada. I maintain the original spelling style to maintain the international flavor of the article.

I have seen an increase in submissions for the JMCG – but could always use more. I could use more reviewers. If the number of articles submitted continues at this rate, the journal maybe able to support four issues per year. The MGCA Board wants reviewers to be members of MGCA. If you have an interest in research – send me your CV.

Benjamin V. Noah, PhD
JMGC Founding Editor

Incorporating Emotional Intelligence Assessment with Counseling Military Clients

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Abstract

Military service members experiencing mental health issues may not seek out a counselor due to distrust of mental health providers or to the stigma attached to attending counseling. Integrating assessment and emotional intelligence into counseling practice may provide a way to reduce stigma and provide quantitative results to military and Veteran clients. The theory of emotional intelligence has been researched for decades; however, the use of emotional intelligence assessment and psychoeducation in a counseling environment with the transitioning military population is lacking. This article describes the specific needs of returning service members and methods for combating these issues by infusing emotional intelligence into counseling practice with military clients.

KEYWORDS: emotional intelligence, military, counseling

Military deployments today have become more frequent and longer in duration than have been experienced at any other time in history. A military member must engage in psychological preparation for deployment, involving thoughts of separation from friends, family, jobs, and a daily routine. While deployed, military members must try to come to terms with the possibility that they may lose their own life or a fellow service member. Throughout their deployment, experiences may result in feelings of shame, guilt, sadness, or anger. For those who have served in the wars in Iraq and Afghanistan, over two million military service members must return home and transition to civilian life (Erbes, Polusny, MacDermid, & Compton, 2008). During this transition, many service members report issues involving interpersonal functioning due to both stressors during deployment, as well as psychological issues which may have resulted from serving their country (Erbes et al., 2008). After returning home, a military member must adjust one's mindset from combat to civilian life. This adjustment may take weeks, months, or years. Reports of mental health misdiagnosis occur with returning military personnel, but may be preventable if clients are able to better express themselves in a counseling setting.

Without this ability to communicate effectively in the civilian world, service members find themselves struggling with homelessness, substance use, interpersonal violence issues,

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depression, and soaring suicide rates (Robertson, 2015). Faced with these issues, many do not turn to mental health counselors due to the stigma associated with attending counseling (Milstein, Manierre, & Yali, 2010). For those who fear this stigma, military chaplains may be identified as better able to assist a service member with mental health needs (Nieuwsma et al., 2013; Nieuwsma et al., 2014) as they provide similar services which are considered outside of the mental health care system (Nieuwsma et al., 2014). As counselors, we must view military clients from this context, working to build trust and rapport with their mental health counselor, while helping these clients rebuild emotional skills and supports to help them effectively communicate and positively transition.

The theory of emotional intelligence was first directly coined by Salovey and Mayer in 1990, sparking both discussion and research regarding the importance of emotional intelligence as compared to the intelligence quotient (IQ). While the IQ of an individual remains relatively fixed from birth, emotional intelligence has the ability to be increased through various strategies and interventions. These strategies and interventions can be employed in a counseling setting but have yet to be researched with the military counseling population. Understanding emotional intelligence as applied to the military and Veteran population may better assist counselors in giving these clients more effective strategies for their transition. The purpose of this article is to increase awareness of how implementation of emotional intelligence strategies will better assist counselors working with military and Veteran clients to create more positive transitions to civilian life.

Specific Needs of this Population

According to the United States Department of Veterans Affairs (2014), there are currently over 21 million Veterans. Since the launch of Operations Enduring Freedom (OEF) and Iraqi Freedom (OIF) in 2001 and 2003, over two million soldiers have been deployed to Iraq and Afghanistan (Iraq and Afghanistan Veterans of America [IAVA], 2016). Since that time, several programs have been made available to Veterans to address mental health needs and other issues associated with their military service and transition to civilian life (e.g., VetsPrevail, Mission Reconnect, Veteran Crisis Line; IAVA, 2016). However, approximately 22 Veterans die each day due to suicide (IAVA, 2016), a number which reaches over 8,000 annually. To put this in perspective, across the United States in 2014 there were 42,773 reported suicides (Suicide Awareness Voices of Education, 2016), of which, almost 19% were Veterans. This further illustrates the dire need to create more effective counseling strategies for military and Veteran clients. While suicide is a specific struggle for this population, it is not the only struggle they face upon returning to civilian life.

For those deployed and those remaining stateside, military training itself can impact the emotional functioning of a soldier. Avoidance behaviors (e.g., distancing self, excessive involvement in productive or non-productive activities to cope with stress, emotional numbing) may develop and be maintained throughout their service in an effort to distract from the feelings associated with the tasks at hand (Erbes et al, 2008). Soldiers, who are unaccustomed to the communication style of a drill sergeant, the physical demands of basic or combat trainings, or the plight of being away from loved ones, may use avoidance techniques in order to distance themselves from these stressors. Unfortunately, while this coping strategy may be helpful within

certain parameters, chronic avoidance has been shown to lead to both increased distress and impairment over time (Marx & Sloan, 2005). Chronic avoidance can have deleterious effects, but perhaps not as extensive as the effects of chronic arousal.

Chronic activation of the stress response in the body can occur when an individual remains in a "fight or flight" situation (Mayo Clinic, 2016). In normal stressful situations, the fight or flight response is fleeting, providing additional adrenaline, cortisol, and other stress hormones to the body in order to combat the perceived attack. During combat or other stressful military situations, these stress hormones remain active. The body of a military member with a consistently activated stress-response system does not have the opportunity to return blood pressure, heart rate, or stress hormone levels to normal (Mayo Clinic, 2016). Effects of this chronic response include depression, anxiety, memory and concentration impairment, sleep issues, weight gain, and other health concerns (i.e., digestive problems, heart disease; Mayo Clinic, 2016). Subsequently, a Veteran may not receive help for these stress related concerns or other issues, leading to the creation of problems of daily living.

In addition to the emotional and physical strain created by deployment, Veterans face struggles regarding finding employment, entering school through the use of government financial assistance (e.g., the G.I. Bill), legal or financial problems which may or may not be caused by the deployment, and physical problems which also may be due to their service (Graf, Miller, Feist & Freeman, 2011; Mellencamp, 2015). Encountering these obstacles can create added stress for these individuals, with research showing the rates of excessive alcohol use to cost the military $1.2 billion per year (Schumm & Chard, 2012). Additional stressors may result in marijuana use or divorce. Additionally, this population reports high rates of interpersonal violence within their marriages (i.e., 13.5%-58%; Marshall, Panuzio, & Taft, 2005). For Veterans struggling with issues associated with avoidance and chronic stress activation, the occurrence of these additional stressors is both high and uniquely difficult.

The military currently provides a wide range of counseling services and programs for transitioning Veterans (e.g., Mental Health Treatment Coordinators and Family and Couples Services; U.S. Department of Veterans Affairs, 2016); however, many Veterans choose not to utilize these services. The choice to forego counseling services provided by the military can be rooted in many issues: lack of trust in the military, anger towards the military, fear of the consequences associated with certain mental health diagnoses (Robson, 2012), distance from the nearest facility, pride, guilt, or other reasons. Veterans diagnosed with posttraumatic stress disorder (PTSD) may exhibit distrust or anxiety related to the diagnosis, further increasing their negative feelings towards counseling (Robson, 2012). Transitioning Veterans may wish to seek out civilian counseling due to their feelings regarding government provided therapy, but research shows they feel misunderstood by civilian counselors (Kime, 2014). In order to better serve this population, civilian counselors must increase their multicultural competence and work to provide effective practice to the military population. The use of emotional intelligence may be a way to increase Veteran confidence in the civilian counseling community, while helping them with the myriad issues they face during the transition back to civilian life.

Emotional Intelligence

The following information provides an overview of emotional intelligence. The construct has been defined differently by other researchers (i.e., Gardner's interpersonal intelligence); however, the basis for this article will be grounded in Mayer and Salovey's description of emotional intelligence which includes four areas of emotional ability (Mayer & Salovey, 1997; Salovey & Grewal, 2005; Salovey & Mayer, 1990).

Theoretical Basis

Salovey and Mayer (1990) originally proposed the model of emotional intelligence in an effort to better organize the differences in the way individuals related to their emotions. Perhaps best described by the original authors, the definition of emotional intelligence is, "the ability to monitor one's own and others' feelings, to discriminate among them, and to use this information to guide one's thinking and action" (Salovey & Mayer, 1990, p. 189). Since the original definition, Salovey and Mayer have introduced four abilities which further define emotional intelligence: *perceiving, using, understanding,* and *managing emotions* (Mayer & Salovey, 1997). Understanding these four hierarchically challenging constructs is imperative to begin learning ways to increase abilities in each area, beginning with perceiving.

Perceiving involves the multiple ways an individual recognizes emotions – both in themselves as well as in others (Salovey & Grewal, 2005). Nonverbal expression of emotion is an intricate way individuals externally demonstrate their internal feelings. This nonverbal expression may be either intentional or unintentional, yet communicates a message regardless (Argyle, 2013). The timing, emphasis on particular words or phrases, and pitch of the voice may communicate an emotional response which either matches or varies from the spoken word (Argyle, 2013). One studying nonverbal communication may have a greater ability to recognize nuances of pupil dilation, pitch of voice, and limb movement; however, the common individual will not necessarily understand or look for these differences.

The construct of "using emotions" focuses on the way individuals recognize their current emotion, along with the strengths and weaknesses associated with said emotion (Salovey & Grewal, 2005). Once recognized, the individual is able to capitalize on the emotion in order to best use the mood to enhance a current task which needs to be completed (Salovey & Grewal, 2005). When a client understands that a particular emotion causes him or her to have distracted thinking, for example, this understanding provides the opportunity to choose to complete or engage in a task which does not require focus. The individual can then save the task which requires concentration for another time when his or her mood has changed.

Understanding emotions involves truly delving into the depth provided by emotions (Salovey & Grewal, 2005). This includes the idea that emotions develop, wax and wane, have "complicated relationships with other emotions" (Salovey & Grewal, 2005, p. 281), and vary from other emotions (Salovey & Grewal, 2005). The ability to learn the complexity of emotions involves a sophisticated understanding of things like the origin of emotions, blending feelings, and how one emotion may naturally transition into another (Brackett, Rivers, & Salovey, 2011).

Finally, managing emotions consists of regulating one's emotions (e.g., controlling emotions) as well as others' emotions (Salovey & Grewal, 2005). One might ask how it is possible to manage another individual's emotions, a question best answered when viewing the concept as using oneself to encourage or elicit a response in another. In essence, one can craft his or her emotions in order to use the emotions to work towards personal goals. This can be done through preventing, enhancing, reducing, or modifying their emotions in a given situation (Brackett, Rivers, & Salovey, 2011). Understanding a client's baseline functioning in each of the four areas may assist counselors in determining focus and appropriate interventions in an aim to increase the emotional intelligence of the client.

Assessment

Measuring each of the emotional intelligence constructs can provide a baseline from which to begin the counseling work. Although there are several performance tests which measure the four components of emotional intelligence, the Diagnostic Analysis of Nonverbal Accuracy Scales 1 & 2 and the Mayer-Salovey-Caruso Emotional Intelligence Test (MSCEIT; Mayer Salovey, & Caruso, 2002) for adults will be described.

Gaining an understanding of the baseline levels of each of the current areas of emotional intelligence functioning is imperative prior to goal-setting. The MSCEIT (2002) though time-intensive, can be performed on a computer in the counselor's office, or on paper. This tool takes approximately 40-45 minutes to complete, and tests an individual's abilities in each of the four areas of emotional intelligence (Brackett et al., 2011; Salovey & Grewal, 2005). This testing involves items which ask an individual to choose which emotion is portrayed in a photograph, to rate adjectives in terms of how alike they are to another emotional adjective, to choose words which depict how emotions blend together, and to determine effective courses of action regarding emotional coping (Brackett et al., 2011).

The resulting scores are compared to, and based on, expert norming (Brackett et al., 2011). Higher scores on the MSCEIT are correlated to measures of psychological well-being (Brackett & Mayer, 2003; Lopes, Salovey, & Straus, 2003), while lower scores have been associated with major depressive disorder, schizophrenia, and substance abuse disorder (Hertel, Schutz, & Lammers, 2009). A counselor can examine the scores in each of the four areas and work with the client collaboratively to construct goals for improving certain areas of emotional intelligence, while assessing for other issues.

Counseling Implications

The purposes of assessing for emotional intelligence include: exploring possible mental disorders or issues of living, determining which areas of emotional intelligence can improve, providing a numerical picture from which to begin the goal-setting process, and helping a client better understand certain life issues by quantifying emotions. This section will briefly describe the importance of each counseling purpose.

For clients with military experience, counselors should consider the issues which may accompany the transition to civilian life when considering treatment planning. The side effects of

avoidant behaviors, chronic stress activation, and from deployment in general can mimic multiple areas of mental health disorders (i.e., depression, anxiety, and inability to sleep). Using the MSCEIT scores to determine whether to further assess for depression, social anxiety disorder, or other emotional disturbances can help provide a more accurate strategy for deciding if treatment for a comorbid disorder is appropriate (Brackett et al., 2011; David, 2005). After assessing, the counselor can then move to examining the levels of emotional intelligence with the client.

The client and counselor can review the scores of the MSCEIT together, with the counselor providing information related to what higher or lower scores may mean in the context of setting counseling goals. Providing the client with descriptions of each of the four areas of emotional intelligence and asking questions to clarify specific areas within each of the domains can help organize counseling goals. The client can rate the subjective importance for each area and goals can be set accordingly. By looking at emotions in terms of a number, it may be easier for the military client to objectively analyze the issues associated with each area.

Quantifying emotions by providing a score in each area may help the military counseling client remove the subjectivity from the goal-setting process. When rating emotional intelligence areas in order of importance, the counselor can provide strategies which are evidence based. Providing evidence to these strategies mirrors strategic analysis within the military environment, with the collaborative team of counselor and client selecting strategies to complete each mission. Areas of concern or potential hazards can be discussed, with plans of action set in place. Mirroring the methods used in the military may provide a level of comfort with the counseling process and be easier to implement in civilian life, though research has not yet been conducted to determine the efficacy of these methods.

Braithwaite (2000) suggested utilizing the concept of distinguishing self and action, demonstrating to clients that bad actions do not define a person as a bad person. Counselors can then help military and Veteran clients work through other areas of remorse, including self-punishment, their personal value, and guilt (Cornish & Wade, 2015; Potter-Efron, 2005; Webb, Colburn, Heisler, Call, & Chickering, 2008). After working through remorse, moving to a discussion of which behaviors will be restorative, and to which values to commit or recommit may help clients make amends with some of the more negative experiences (Cornish & Wade, 2015). Finally, working towards renewal through self-acceptance techniques may help clients move towards self-forgiveness (Cornish & Wade, 2015). Self-acceptance techniques such as rewriting chapters of their experience, using the definitions created through counseling, or writing letters of self-forgiveness may help clients shift along the forgiveness continuum (Cornish & Wade, 2015). With this shift, counselors can then begin to employ emotional recognition interventions. Helping clients recognize more accurately verbal and non-verbal expression of emotion is one aspect for building emotional intelligence (Brackett et al., 2011). Focusing on how the perception of an emotion has changed due to military experience is imperative to changing the client's ability to accurately recognize and interpret emotions. The new stories can then be analyzed and coded to determine themes of growth and change in Veteran self-talk. This improvement in the area of perceiving emotions may be beneficial to some Veteran clients, while others may benefit from working on the consequences associated with chronic stress activation.

Chronic stress activation results in a variety of negative consequences for a Veteran. Asking simple questions regarding the quantity and quality of sleep obtained each night may be a critical component to addressing consequences resulting from exhaustion and fatigue. Assessing clients for depression and anxiety using the Beck Depression and Beck Anxiety Inventories may provide a baseline understanding of whether depressive symptoms are present. Finally, working on symptom management skills resulting from depressive or anxiety symptomology can provide military clients with the necessary tools to combat these issues in the civilian world. Grounding exercises, deep breathing, and recognizing physiological arousal symptoms are important to helping clients understand how various symptoms are experienced with certain emotional experiences (Lorber & Garcia, 2010). Defining emotions and separating guilt and shame from sadness or anxiety may be a part of transitioning from the military environment (Lorber & Garcia, 2010). Helping Veteran clients recognize the impact of hyperarousal symptomology (i.e., anger and irritability) on current relationships is one way to begin to implement the strategies for increasing facets of emotional intelligence. This portion of emotional intelligence involves understanding the complexity of emotions. When clients can identify their emotions more fully, they may be better able to interpret and manage their subsequent thoughts and behaviors (Brackett et al., 2011).

Increasing understanding of the relationship between these emotions and the risk for intimate partner violence, angry outbursts, or workplace struggles may be helpful when setting collaborative goals for counseling (Erbes et al, 2008). Working through issues associated with avoidance and chronic stress activation are a way to integrate the psychoeducational component of emotional intelligence with the struggles faced specifically by transitioning military clients. Emotional intelligence has shown to be negatively associated with maladaptive lifestyle behaviors (Brackett et al., 2011). Recognizing ways in which smoking, alcohol use, or substance use impact healthy functioning and providing methods for replacing theses coping strategies with others is one way to help clients increase their emotional regulation. Comparing problem-solving strategies utilized in the military setting with problem-solving strategies appropriate in both the workplace and home is vital to demonstrating the need to be flexible and reflective when determining the best way to interact when faced with a negative situation. When appropriate, selecting military strategies or specific techniques which apply to effective communication in a civilian setting may also be used in the counseling setting.

Creating an acronym for the Veteran clients to help them remember how to help their emotions function effectively is one way to mirror military techniques in the civilian world. One example may be creating an acronym such as *AITB* (Attend, Interpret, Think, Behave). Providing an acronym is commonplace in the military, and in this instance it creates an opportunity to pause, reflect, and possibly manage their emotion more effectively in the moment. Additionally, encouraging a client to teach this acronym to his or her intimate partner and/or children is a method for inspiring positive communication within the family system.

Implications for Research

After administering the MSCEIT, the following areas may be important to discuss when collaborating on goals for the counseling process, and serve as a baseline for researching the effectiveness of the tool with this population. The MSCEIT can provide a rich resource for

research. Prior to enlisting, individuals may be administered the MSCEIT to provide an initial score, then completing the assessment and comparing the scores when separating from the military. The scores of military and Veteran counseling clients may also be compared with scores from other groups to examine differences and similarities.

Current coping strategies which employ avoidance methods (e.g., distancing and emotional numbing) should not be discouraged; rather, replaced with healthier forms of coping once the client has established an emotionally safe space through counseling. The choice to avoid may be based on a number of experiences, and understanding those experiences is imperative to helping work through difficult emotions and establishing more effective strategies. A counselor may find a discussion on self-forgiveness revealing, as many who were deployed may experience self-critical feelings based on causing significant harm to another person (Cornish & Wade, 2015; Friedman et al., 2007). This area can also serve as fodder for qualitative research.

Coding stories of Veterans to discover themes, particularly those incorporating self-criticism, may provide insight for future work with this population. Working with Veteran clients to examine their stories and define areas associated with self-forgiveness may be beneficial for directing counseling goals towards the four areas of self-forgiveness (as defined by Cornish and Wade; 2015). These areas include: responsibility, remorse, restoration, and renewal (*for a more complete understanding, see Cornish & Wade, 2015).* This research may provide a method for decreasing shame and resentment for the client. A discussion surrounding the responsibilities associated with military service can help Veterans recognize the impact of their service as a responsibility to their country, and redefine some of the activities as a necessary part of providing freedom to the citizens of that country. This new definition may help a client abandon feelings of resentment towards self and their service; however, negative feelings associated with the details of that responsibility may still be present.

Conclusion

The purpose of utilizing emotional intelligence assessment and psychoeducation within the context of a counseling setting with Veteran or military clients is to help clients have a more positive and effective transition to the civilian world. Combining intelligence with emotions and viewing this through the strategy of navigating the civilian environment (Salovey & Grewal, 2005) may be a novel way to approach issues surrounding this population. Associating a number with an emotional area, through the use of an assessment tool, may remove stigma associated with the discussion of feelings in a counseling setting. Discussing the components of emotional intelligence, assessing for areas specific to the Veteran counseling client, and using military language and strategies to increase rapport may positively impact the future of counseling in this area. It is the responsibility of the counseling community to better understand the many unique challenges faced by Veteran clients so they feel comfortable seeking out assistance from a mental health provider, and serve them as they have served our country.

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Understanding the Emergency Service Culture: A Primer for Counseling Professionals

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Abstract

Emergency service personnel primarily consisting of emergency medical technicians, firefighters, police, public safety, first responders, and emergency dispatch personnel often place themselves in harm's way in order to assist others. These professionals risk health and injury in the performance of duties that may easily lead to debilitating health issues including acute stress, compassion fatigue, PTSD, and vicarious trauma. These stressors are impacted by multiple factors including public perception, media scrutiny, and the resilience, coping, and support structures of the emergency service personnel themselves. To effectively work with these populations, counselors must have a cultural and reflective awareness of the population, its needs and motivations, and an understanding of the potential dangers, both physical and affective, these professionals face.

KEYWORDS: emergency service personnel, first responders, PTSD, vicarious trauma

Understanding the Emergency Service Culture

Realities of the Work

Emergency service (ES) personnel work in a very different world than most "civilians" might readily understand. Their ranks include fire service; police, constables, marshals and sheriff; public safety; ambulance service including emergency medical technicians and paramedics; first responders; and emergency dispatch personnel. They are exposed to events involving human pain and suffering on a daily basis. They go into the burning building when everyone else is trying to get out, they extricate people from mangled vehicles, they provide care for those in need, and attend those who are dying (Regehr, Goldberg, & Hughes, 2002). They

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may be paid professionals or volunteers, may work for government or municipal services, and they may live and work in urban, suburban, or rural areas of the country. They can work long shifts, sometimes up to 24 hours at a stretch. Their work can be unpredictable, highly stressful with a high risk of personal injury, and often places them in dangerous situations. They are regularly faced with tragic situations beyond the scope of everyday experience (Regehr, 2005). They must constantly be on guard against potential injury to their selves and those they are attempting to help, and threats to and from their environment. They must contend with administrations often motivated by politics, a frustratingly increasing scarcity of resources, an always watching public and the ever-present threat of litigation (Mildenhall, 2012; Sterud, Hem, Lau, & Ekeberg, 2011; Vettor & Kosinski, 2000). Surprisingly, though, most counselors are not familiar with ES culture and the stresses that are common to this field of helping professionals, and therefore, may not be fully prepared to work with members of this community. As such, through this article the authors' goal is to identify challenges and potential mental health issues related to the emergency service work environment, explore the opportunity for personal growth encountered by ES personnel, and provide important contextual and cultural insights for counselors who may work with these professionals.

Identity as Emergency Service Personnel

ES personnel often pride themselves as "being able to cope with anything" because "our routine is anyone else's worst nightmare." This emotional toughness may be the result of a historical quasi-military culture and has support from social stereotypes. ES personnel have been characterized by Mitchell and Bray (1990) as inner directed and action-oriented, obsessed with high performance standards, socially conservative and traditional, easily bored, highly dedicated, desiring to be in control of situations and themselves, and needing to be needed.

Informal descriptions of the personality styles of ES personnel have been highly consistent (Mitchell & Bray, 1990), and one common trait is that such people are motivated above all else by a desire to help others, regardless of the circumstances. This behavior is best described as empathetic and pro-social as the emotional concern for the plight of another person leads to efforts to help the individual in distress, perhaps at great personal risk when such activities could be avoided. Anyone might perform in this way on rare occasions, but ES personnel choose to do so routinely (Linton, 1995). As such, engaging in stress-producing work-related activities serves to define these professions and the members of them.

Unfortunately, while ES personnel may be trained on what to expect in the technical performance of their duties, they are seldom prepared for the emotional toll the job can take over time. Continued exposure to traumatic events can change their perception of themselves and the populations they serve and can result in an "us" and "them" mentality and behavior which may include gallows humor, altered language to protect themselves by dehumanizing patients, personal and professional isolation, establishing a community of those with shared experiences and a common self-perception that removes them from the normal population due to their experiences and understanding of the world and its dangers (Arrowood, 2000; Eriksson, Foy, & Larson, 2004; Figley, 1995a; Linton, 1995; Mitchell & Bray, 1990; Pearlman & Saakvitne, 1995; Regehr, 2005; Regehr & Bober, 2005; Regehr, Goldberg, Glancy, & Knott, 2002). This "otherness" is often accepted by the ES personnel as a form of professional identity to the extent

that there is a reluctance to recognize the potential psychological impact of work as a source of distress (Alexander & Klein, 2001; McCammon & Allison, 1995).

Although this aspect of professional identity may serve to bond ES personnel together, it can also cause stress in other support systems both in and outside of the job, particularly when significant others are not in emergency services and, therefore, are not considered a part of the "us." Over time these stresses can cause isolation and distance between the ES personnel and their support networks as well as with their organizational administrators and the general public. Such conditions have been found to cause higher than average rates of substance abuse, divorce, and burnout with loss through attrition (Linton, 1995).

Stressors and Trauma in the Line of Duty

The duties of ES personnel are saturated with stressors that continually impact their performance and perceptions. These stressors can result from interaction with situations that range from the catastrophic to the mundane and it is easy to see that, due to the very nature of their duties, ES personnel are particularly vulnerable to the effects of work-related stress and trauma (Miller, 1995; Mitchell & Everly, 2001; Shakespeare-Finch, Smith, & Obst, 2002). While it is easy to understand that ES personnel could be subjected to stress and trauma from overwhelming and chaotic situations, frequently it is cumulative effects of multiple individual events that trigger the most intense responses. Such events as the quiet passing of an elderly patient or the death of a child can have a resounding effect on the personnel involved (Miller, 1995; Regehr, Goldberg, & Hughes, 2002).

All of these stressors can be significantly magnified when the ES personnel are working in rural areas and in their own communities. These environments put a higher perceived responsibility on the shoulders of ES personnel as they are frequently alone, unsupported, and are the only emergency intervention available to the patient. This can become significantly worse when ES personnel are working in their own communities as their patients and those they are trying to help can easily be their neighbors and families. These situations can create a personal/professional conflict for the ES personnel which can isolate them from their social support networks and put unusual stress on those supportive relationships. As with other professionals that work with traumatized populations in small and rural communities, ES personnel may feel a conflicting sense of duty to their profession, their community and their family (Cates, Gunderson, & Keim, 2012; Eriksson et al., 2004).

For ES personnel, traumatic situations tend to occur as critical incidents, which are defined as events that have the potential to cause an individual or group of individuals to feel overwhelmed by, and unable to cope effectively with, the experience (Mildenhall, 2012; Mitchell & Bray, 1990). These incidents may manifest as a physical threat to the ES personnel themselves, the death of a person in their care, the death of a colleague, or some other event beyond their control. These incidents overwhelm the person's assumption that the world is predictable and controllable and his/her perception that he/she can manage almost anything is damaged, if not crushed. This new awareness is particularly difficult for ES personnel as they value being in control and see themselves as helpers. When they become the ones needing help they are faced with the dilemma that they are no longer one of "us" and due to the stereotypically

expected behaviors of their profession they have no easily accessible support as such feelings are usually not acceptable in their professional environments. This is complicated by the fact that, given enough traumatic exposure, these behaviors become more deeply rooted in the person's behavioral framework and increasingly difficult to change (Linton, 1995; Murphy, Beaton, Cain, & Pike, 1994; Tsai, El-Gabalawy, Sledge, Southwick, & Pietrzak, 2015). As such, these critical incidents have been recognized to potentially result in post-traumatic stress symptoms and depressive symptoms in emergency service workers (Calhoun & Tedeschi, 1998; Regehr, Goldberg, Glancy, et al., 2002; Regehr, Goldberg, & Hughes, 2002). These critical incidents may not only come from the direct experiences of trauma by the ES personnel but also from their interactions with those who are in traumatic situations. The acute stress ES personnel may experience may be due to direct or indirect trauma and each has its distinct concerns.

Due to the nature of this field of work, it is common for ES personnel to experience trauma during their careers and for some trauma can be an everyday occurrence. This does not necessarily mean that the ES personnel themselves are injured or traumatized but that they would likely work with patients who themselves are traumatized by injury or circumstances. "Trauma" comes from the Greek word meaning "injury" and is generally accepted to have occurred when the ego is overwhelmed and the person feels helpless to defend themselves against the situation or circumstance. Because individual reactions to trauma can vary greatly, there is much discussion about what may or may not constitute trauma to the extent that it generally centers in the perception of that person having experienced it (Beaton & Murphy, 1995; Cerney, 1995; Figley, 1995b; Shakespeare-Finch, Smith, Gow, Embelton, & Baird, 2003; Valent, 2002). The event that may precipitate the trauma can vary and so can the situations in which they occur. Some reactions to a traumatic event may lead to lasting impairment and debilitation and may result in anxiety, depression, PTSD, or other psychological issues. For others, the traumatic event may only add to increasing feeling of helplessness in the face of recurring events such as the duties of ES personnel (Shakespeare-Finch et al., 2003). Some studies of ES personnel have indicated that traumatic distress may not be related to certain types of trauma but to the severity of threat of the trauma (Cerney, 1995; Eriksson et al., 2004; Fischer, 1991).

While many ES personnel report that they have been assaulted in the performance of their duties, these events do not generally stay with them. Many stated that they learned through experience to take a more non-reactive approach to dealing with patients, particularly those that are not acting coherently or rationally (Regehr, Goldberg, & Hughes, 2002). Although ES personnel are generally able to deal with the rigors of the job through adaptation and personal perspective, sometimes these events may have a significant, lasting impact on them (Regehr, 2005; Regehr, Goldberg, & Hughes, 2002). Cross-sectional studies have shown that approximately 25% to 33% of paramedics have symptoms consistent with a diagnosis of PTSD (Alexander & Klein, 2001; Regehr, Goldberg, & Hughes, 2002). This traumatization may also be contagious, rippling outward to encompass others such as employers, spouses and children (Regehr, 2005).

Organizational and Professional Stressors

Many of the stressors that contribute to ES personnel burnout are organizationally related and have to do with the more mundane nature of their duties. Increased call volume,

inappropriate calls, traffic while on-duty, changing schedules, changing coworkers and personnel (especially partners), inadequate supplies and equipment, public perception, and continued scrutiny of their performance to ensure quality all contribute to a high stress load (Regehr, 2005) and some research has shown that organizational stressors may cause the greatest degree of distress for ES personnel (Regehr, Hill, Goldberg, & Hughes, 2003).

The organizations that employ ES personnel can be highly influential on the stress, burnout, and career longevity of the ES personnel as they may support job satisfaction or contribute to burnout. Unsupportive organizational administration, lack of operational resources, and difficulties in providing client services can contribute to higher burnout rates, which can result in the loss of experienced staff which then diminishes the quality of client services for that community (Arches, 1991; Bell, Kulkarni, & Dalton, 2003; Marmar et al., 2006; Regehr et al., 2003).

The most commonly cited mundane stressor for the ES personnel and their families is the "shiftwork" - the non-9-to-5 schedules many ES personnel work. For ES personnel and their families this not only involves the assumption of living schedules different from the standard 9 to 5 of other families and friends, but also involves disruption of schedules due to the unpredictability of the work, overtime, and late calls that cause the shift to run past its scheduled ending time (Miller, 1995; Regehr, 2005; Regehr, Goldberg, & Hughes, 2002; Shakespeare-Finch, Gow, & Smith, 2005; Vettor & Kosinski, 2000).

An additional source of ongoing dissatisfaction for ES personnel is the highly varied pay scales across emergency service certification levels (Patterson, Probst, Leith, Corwin, & Powell, 2005). Due to relatively low pay and long periods of off-duty time, many ES personnel are regularly employed at second full-time jobs or other employment efforts. While this may serve to support the family economy it also adds to the stress and carryover effects from other employment. Many of these employment endeavors are related in some form, if not directly, to their primary emergency service careers (Mitchell & Bray, 1990; Murphy et al., 1994). Occupations that have a high demand of job performance elements and are coupled with low control of job characteristics may increase the stress on workers (Murphy et al., 1994). Many studies have suggested that feelings of self-efficacy and the ability to control one's environment are associated with lower levels of trauma in ES personnel (Regehr et al., 2003; Vettor & Kosinski, 2000).

Educational recognition is also a major concern for some ES personnel. The lack of college credit for the time they have dedicated to education and training and the absence of personal recognition through licensure or certification is a source of frustration for many. While current EMS and fire service training has moved towards a higher level of professional training which may include a college degree, many ES personnel still acquire their professional training in smaller technical school educational settings. Many feel they cannot use their professional training to acquire educational credit in order to enter other, perhaps more lucrative, professional fields. Their training and experience as ES personnel does not always translate to other professional fields and may limit ES personnel's professional growth and career opportunities (Patterson et al., 2005).

ES personnel are often faced with life-threatening and uncontrollable situations where quick response and calm action is called for. Failure to act according to professional protocols in these situations may result in professional sanctions, community scrutiny, and the threat of legal action (Regehr et al., 2003). While the initial response to a traumatic incidents or situation may be an outpouring of support both from the community and its leaders, every critical incident may become a point of inquiry in an effort to consider what might have been better managed. Following the occurrence of a significant or catastrophic traumatic event a postmortem inquiry is generally performed at multiple levels of emergency service. These inquiries can take the form of inter-organizational reviews to determine if ES personnel acted properly within established protocols, and/or may take the form of public inquiry into the potential liability of the actions taken. Such inquiry is always highly stressful for ES personnel involved and can result in loss of employment, loss of status, and criminal liability (Regehr et al., 2003). Those involved in these reviews are more likely to take leaves due to stress from work than those were not involved in reviews and internal organizational reviews may cause the highest stress for ES personnel as it may undermine an individual's sense of support from the organization and question their professional capacity and judgment. Many ES personnel have suggested that the review process is more stressful than the critical event itself (Regehr et al., 2003; Vettor & Kosinski, 2000).

Manifestations of Trauma in Emergency Service Personnel

Experiencing trauma through service to patients can result in the traumatization of the ES personnel manifesting as acute stress and PTSD and indirectly as compassion stress, burnout, compassion fatigue, and vicarious traumatization (Figley, 1995b). These forms of trauma can be damaging in multiple ways including disrupting the individual's frame of reference (or identity, world view, and spirituality); impairing the individual's capacity to tolerate emotions; their ability to maintain a stable sense of self and their ability to maintain an inner sense of connection with others; disrupting fundamental needs and beliefs about the self and others, including one's interpersonal relationships; and impairing internal resources (Pearlman & Saakvitne, 1995).

Stress reactions. Acute stress reactions can occur when the individual is flooded with stimuli that cannot be effectively processed (Linton, 1995). This stress is immediate but temporary, lasting only a short time. If the stress is not processed, or builds upon previous unresolved stresses, then the acute stress may develop into a deeper anxiety or stress reaction (Fullerton, Ursano, & Wang, 2004). If the stressor is of sufficient intensity then it may become a traumatic or critical incident. It is important to note that many paramedics do not have acute stress reactions to every potentially stressful incident. This may be due to individual differences such as personality, previous experiences, perceptions of stress, and personal coping strategies (Mildenhall, 2012).

If ES personnel experience a situation that creates an intense sense of helplessness to the extent that they cannot affectively process it, they may begin to experience symptoms of posttraumatic stress disorder (PTSD; Wee & Myers, 2002). The general symptoms of PTSD include (a) recurrent, distressing and intrusive memories or dreams of the traumatic event(s); (b) avoidance of stimuli associated with the event(s); and (c) negative alterations in cognitions and moods associated with the event(s) ((American Psychiatric Association, 2013). When these generalized symptoms are filtered through personal experiences they can easily manifest as

persistent fatigue, cynicism, and diminished job motivation; hair-trigger emotional reactions such as anger, frustration, and irritability; chronic but minor health problems such as headaches or backaches unrelated to injury; sleep irregularities including the inability to feel rested or refreshed; chronic feelings of being overwhelmed or constantly pressured; overindulgence (i.e., food, caffeine, nicotine, drugs, and/or alcohol); feelings of hopelessness or helplessness; and isolation or withdrawal from social networks. More severe symptoms include substance use and abuse; emotional distress elevated to diagnostic and clinical levels; and suicidal thoughts or feelings (Vettor & Kosinski, 2000).

The PTSD that ES personnel experience may be different than that of primary victim PTSD for several reasons. First, ES personnel generally view trauma as a part of their work, something they are expecting to routinely encounter. Their reactions to stressful situations may be less severe as their commitment to saving lives and helping people is a foundational element of their professional identity and may mitigate some stressors and the potential onset of PTSD symptoms (Mitchell & Bray, 1990). In contrast, many PTSD victims experience trauma in unexpected and unplanned circumstances such as assaults, auto accidents, fires, and medical emergencies. The sudden and catastrophic nature of these events can more readily lead to traumatic experiences. Second, the danger of traumatic incidents for ES personnel may not only be in the intense exposure to traumatic and occasionally catastrophic circumstances, but in the repetitive nature of this exposure and in the exposure to the trauma experienced by their patients and those they are committed to helping (Wee & Myers, 2002). The cumulative and long-term processing of traumatic situations and critical incidents may have long-term effects (Beaton, Murphy, Johnson, Pike, & Corneil, 1998).

Compassion fatigue, secondary traumatic stress, and vicarious trauma. A distinction has been made between direct and "indirect" trauma, which is also referred to as compassion fatigue (CF), secondary traumatic stress (STS; Figley, 1995a), and vicarious traumatization (Pearlman & Saakvitne, 1995). This distinction refers to the impact of a traumatic incident on a person other than the person immediately witnessing or bearing the traumatic situation, a role that is typical for ES personnel (Figley, 1995b; Kirby, Shakespeare-Finch, & Palk, 2011; Mitchell & Everly, 2001). Multiple studies have documented that exposure to the injured and dying is highly stressful and has significant negative effects on mental health, and all ES personnel may have repeated exposure to trauma which may be potentially cumulative and threatening to personal safety, health, and their personal survival (Alexander & Klein, 2001; Beaton & Murphy, 1995; De Soir et al., 2012; Dutton & Rubinstein, 1995; Regehr, Goldberg, Glancy, et al., 2002; Regehr et al., 2003).

Secondary traumatic stress reactions and vicarious traumatization can be considered inevitable in the ES population (Figley, 1995b), and may occur regardless of race, gender, age, or level of training (Edelwich & Brodsky, 1980). This process is thought to occur in part as a result of empathic engagement between ES personnel and the client through hearing the emotionally-laden details of other peoples' traumatic experiences. Over time this intense involvement with traumatized populations can result in ES personnel experiencing traumatic stress symptoms that include intrusive imagery, generalized fears, sleep disturbances, nightmares, anxiety, grief, a changed worldview, and affective arousal (Figley, 1995b; Regehr, Goldberg, & Hughes, 2002; Saakvitne & Pearlman, 1996). These stress issues can have a devastating effect on ES personnel

leading to mental health and health concerns, isolation and alienation from family and community (Regehr, 2005), substance use and abuse, and long-term disability (Buchanan, Anderson, Uhlemann, & Horwitz, 2006; Figley, 1995b; Mitchell & Bray, 1990; Regehr, Goldberg, & Hughes, 2002; Saakvitne & Pearlman, 1996).

The costs of compassion fatigue and vicarious traumatization can extend beyond the individual and his/her families to the organizations he/she works for and the communities he/she serves. These costs can easily manifest as higher reported rates of physical illness, greater use of sick time (Austin, Goble, Leier, & Byrne, 2009), and lower morale and productivity (Figley, 1995b; Mitchell & Bray, 1990; Regehr, Goldberg, & Hughes, 2002). All of these are indicators of burnout which can result in higher turnover rates (White, 2006) and lower patient satisfaction with services provided (Austin et al., 2009; Ray, Wong, White, & Heaslip, 2013).

Burnout. Burnout has been described as a process rather than a static condition or state. It generally consists of three elements; the first involves feelings of emotional exhaustion and occurs as a result of excessive psychological and emotional demands being made upon the person. The second element involves the tendency to depersonalize patients and clients. Depersonalization is used to minimize the intense emotional arousal that may occur in crisis situations. The third element of burnout is the tendency for helping professionals to negatively evaluate themselves in the self-perception of their work, which leads to perceptions of reduced personal accomplishment and reduced commitment to their profession (Bell et al., 2003; Maslach, Schaufeli, & Leiter, 2001; Schaufeli, Leiter, & Maslach, 2009). Individuals in the helping professions are susceptible to burnout and emotional exhaustion as they attempt to provide care in traumatic and emotionally stressful situations. As their emotional resources are depleted, they are no longer able to be as supportive as they need to in order to be effective. Paramedics have been reported to have the fastest burnout among health professionals (Grigsby & McKnew, 1988) as the average length of the professional paramedic career has been reported to be less than four years (Beaton et al., 1998; Bell et al., 2003; Vettor & Kosinski, 2000).

Emotional numbing. One of the most common traumatic symptoms reported by ES personnel is that of depersonalization in the face of a critical incident or catastrophe. This depersonalization creates a feeling of unreality and distance between ES personnel and the potentially overwhelming emotional weight of the circumstances they are involved in. The person avoids experiencing the emotional impact of the event by consciously minimizing emotions and focusing on the technical aspects of the job (Regehr et al., 2003). ES personnel continue to function in spite of their distanced feelings and many feel that personal stress reactions would interfere with their ability to act effectively during critical situations. For this reason, overwhelming emotions are usually suppressed during the incident so that efficient and proper care can be rendered (Beaton & Murphy, 1995). These strategies do not necessarily represent an absence of empathy for the patients or their family but allows ES personnel to maintain a separation between themselves and those they help ((Regehr, Goldberg, & Hughes, 2002). This emotional distance allows ES personnel to do the work that must be done to aid those that require it without becoming emotionally compromised in the administration of highly corporally intrusive medical procedures, restraint of patients, and attempts to render aid in emergency and rescue situations.

Unfortunately, the skills learned in the performance of their high-stress professions do not always transition well to the family life of the off-duty ES professional. Research has indicated that the emotional numbing that may serve the ES professional so well in critical incident situations is significantly associated with negative feelings of family members toward the relationship (Regehr, 2005; Regehr, Goldberg, & Hughes, 2002).

Family impact and impairment. The emotional distancing many ES personnel experience and employ in the performance of their jobs can frequently carry over to their interactions with their families. Although this may be a coping mechanism to protect themselves from the high stress and emotional strains of their work, it may not always be easy for ES personnel to turn it off and resume "normal" emotional interactions with their families and other significant relationships (Regehr, 2005; Regehr, Goldberg, & Hughes, 2002). This can result in emotional distancing and isolation from family members as the ES personnel attempts to come to terms with their own experiences and not burden their family and friends. But the experiences of the work can intrude into family life in other ways, such as parenting. Frequently, ES personnel may become highly concerned and overprotective about the safety of their families and particularly of their children (Regehr, 2005). This can result in the ES professional making demands of his/her family's behavior and awareness which the family may be reluctant to adopt as they do not have a shared experience and understanding of the potential dangers they may encounter (Paton, 2006; Regehr, 2005; Regehr, Goldberg, & Hughes, 2002).

The day-to-day normality of family life can be significantly impacted by the work schedules of ES personnel by long shifts that can range from 8 to 24 hours at a time and cyclical schedules that place them on-shift several times a week. These long shifts can be non-stop and dangerous, but can also take on the element of a secondary life where normal living must continue amidst the requirements of the work. In any event, the extended shifts and hours affect job performance, normal sleep patterns, and social and family life when the ES personnel returns to their "normal" lives (Monk et al., 2013; Murphy et al., 1994). While extended shifts and compressed working weeks may free up blocks of time to allow the ES personnel more time for leisure and family activities they may also cause significant disruption by the desynchronization of the work shift to the normal rhythms of the family and social environment. These disruptions can produce a sense of social and familial alienation and are considered a significant stressor of those in emergency service professions. Several studies have shown the link between stress of shift-workers and the conflict of shiftwork on highly valued non-work activities (Pisarski, Bohle, & Callan, 2002; Regehr, 2005). The stress ES personnel manage is not limited to the traumatic and critical incidents but includes the regular day to day monotonous routine of paperwork, lack of administrative support, long hours and shiftwork, low wages, and the ever present threat of litigation in the performance of their duties (Grigsby & McKnew, 1988; Vettor & Kosinski, 2000).

Resilience, Satisfaction and Growth

Emergency service is an emotional paradox with its tedium offset by its moments of situational chaos, and all of it underscored by the regular grind of work duties (Patterson et al., 2005). It is equal parts job-related stress and satisfaction. The work-related issues previously discussed create high levels of stress in the work environment and can serve to isolate ES

personnel from their families, communities and colleagues. Within all of this, however, are elements that ES personnel can use to protect themselves and support their own emotional resiliency and give themselves a repertoire of coping methods that can be used flexibly and selectively (Alexander & Klein, 2001).

It is generally accepted in emergency services that personnel develop, over time and with experience, the ability to more effectively cope with highly stressful situations. Trauma is said to occur when the coping strategies employed by an individual are overwhelmed and they are unable to emotionally process the events they have witnessed or participated in. But as coping is a process in which the individuals manage the demands placed upon them and the emotions generated by a stressful situation (Shakespeare-Finch et al., 2002), it is possible that previous experience has taught ES personnel to cope more effectively with future critical incidents (Shakespeare-Finch et al., 2002). In an effort to protect themselves, ES personnel may develop numerous coping skills to assist them in dealing with the more grueling aspects of their jobs and establishing personal control of their environment (Iwasaki, Mannell, Smale, & Butcher, 2005; Mitchell & Bray, 1990; Palmer, 1983; Pisarski et al., 2002; Regehr & Bober, 2005; Regehr, Goldberg, Glancy, et al., 2002; Vettor & Kosinski, 2000). These coping strategies may be adaptive or maladaptive and may shift depending on the context of the situation and critical incident ES personnel are dealing with (Kirby et al., 2011; Zuckerman, Knee, Kieffer, & Gagne, 2004). However, counselors have to be careful when labeling any coping strategy as maladaptive as it may be a learned and successful approach to a previous experience, such as the professional and emotional detachment used by many ES personnel during critical incidents (Figley, 1995b; Kirby et al., 2011).

Just as ES personnel work with and around traumatic situations, so too the organizations that employ those personnel have to work with the stressors of the profession and inevitably encounter secondary traumatic stress in their workforce. All institutions that work with traumatized populations will have personnel that are exposed to secondary traumatic stress and will find that stress can exact a high price on the efficient functioning of the organization unless deliberate steps are taken to address it (Catherall, 1995). Organizations that have placed preventive mechanisms and education into their procedures and policies may find that they are far better prepared to address the traumatic situations and critical incidents that inevitably occur in emergency service. These organization-level preventative approaches, such as psychoeducation, preparedness training, debriefing, disaster relief planning, Critical Incident Stress Debriefing (CISD) and Critical Incident Stress Management (CISM) can help ensure that the concerns have been anticipated, are recognized for what they are and that all involved have the opportunity to process the situations in a supportive and helpful environment (Catherall, 1995; Marmar et al., 2006; Mitchell & Everly, 2001; Pisarski et al., 2002; Regehr et al., 2003).

Support in the performance of their duties can be a significant element in the continued health and capacity of ES personnel and can be the difference between a long career built on the satisfaction of service or a short career ended in burnout. The support network of ES personnel is paramount in reducing the impact of a highly stressful profession. This is seen most specifically in the support of family, spouse, and friends as their support has been significantly negatively correlated with scores on trauma symptom scales, depression scales, and their ability to cope with stress (Catherall, 1995; Mildenhall, 2012; Paton, 2005; Regehr, 2005). A supportive family

environment can reduce the stress of extended shift-work (Pisarski et al., 2002) and enhance emotional resilience (Shakespeare-Finch et al., 2002).

Beyond the family, ES personnel can find significant support from their professional colleagues. Professional peers have been viewed by many ES personnel as highly supportive and helpful as they understand the work and have shared experiences (Pisarski et al., 2002; Regehr, Goldberg, & Hughes, 2002). However, not all collegial support is considered beneficial as concerns about the stigma of weakness may prompt many ES personnel to mask their anxieties and concerns through the perceived threat to their careers and non-support of their colleagues (Alexander & Klein, 2001).

Humor. Humor is often regarded as one of the highest forms of coping with life stress (Moran, 2002). In the context of working with traumatized population and managing one's own potential secondary stress reactions, cognitive reframing is an effective approach to the treatment of emotional and stress-related disorders. Through humor ES personnel can reduce the tension of a situation and promote a reinterpretation of stressful circumstances. Creating an emotional distance, humor helps the ES professional focus on the task at hand rather than on her or his own emotional reactions (Moran, 2002). This dark humor and view of the world helps ES personnel to continue to function in situations that could conceivably overwhelm their ability to emotionally cope if the situation were taken too seriously (Lefcourt et al., 1995; Moran, 2002).

Compassion satisfaction. While it may seem inevitable that ES professionals will eventually display symptoms of secondary traumatic stress and vicarious traumatization (Figley, 1995b), it is also possible that they will develop a resistance to the effects of traumatic stress. A significant identity element of ES personnel is a desire to help others; many find a professional and personal satisfaction through the performance of their duties and their contentious efforts on the part of those in need (Ray et al., 2013). This satisfaction may create a protective framework against the stresses of the work and may provide an emotional and cognitive structure in which to better understand and place traumatic experience (Alexander & Klein, 2001; Mitchell & Bray, 1990).

Post-traumatic growth. There is a connection between the work of ES personnel and post-traumatic pathology (Buchanan et al., 2006; Figley, 1995b; Mitchell & Bray, 1990; Regehr, 2005; Regehr, Goldberg, & Hughes, 2002; Saakvitne & Pearlman, 1996). Critical incidents can create psychological imbalance which compromises an individual's capacity to organize his or her experiences into meaningful contexts. This imbalance can lead to an inability to process the cognitive and emotional information and ultimately lead to disruptive thoughts and behaviors as the individual attempts to integrate her or his newfound awareness.

The imbalance can also lead to a potential for post-traumatic growth, which is seen as significantly positive and beneficial changes in cognitive and emotional functioning, or life awareness that follows psychological trauma (North et al., 2002; Paton, 2005; Paton & Violanti, 1996; Tedeschi, 1995; Triplett, Tedeschi, Cann, Calhoun, & Reeve, 2012; Yalom, 1980). The need to address the challenge to one's cognitive and emotional understanding provides a context for positive change to occur in the face of potentially overwhelming stress. This does not mean that negative outcomes cannot also occur, but that a balance of both positive and negative

outcomes may exist concurrently (Cann, Calhoun, Tedeschi, & Solomon, 2010; Paton, 2005; Paton & Violanti, 1996; Shakespeare-Finch et al., 2003; Tsai et al., 2015; Violanti, Paton, & Dunning, 2000). For some, the experience of trauma can act as a catalyst for change and lead to changes in priorities, philosophy of life, improved relationships, or in perceptions of personal strengths (Shakespeare-Finch et al., 2003). The coexistence of these interwoven outcomes is a fundamental aspect of traumatic experiences in civilian and military populations and the potential for positive growth in the wake of high-stress activities can create both positive and negative results from the same potentially traumatic stressors (Paton, 2005; Paton & Violanti, 1996; Shakespeare-Finch et al., 2003; Violanti et al., 2000).

Implications for Counseling Professionals

ES personnel are a resilient group of professionals that are driven to serve, and in that service may place themselves in situations that may lead to personal injury or death. Their empathy for others is a motivating force in their desire to help and that empathy can shield them from many of the traumatic circumstances they encounter, but that empathy can also make them more susceptible to debilitating stress, burnout, compassion fatigue and vicarious trauma as they assist patients and survivors of traumatic and catastrophic situations. As ES personnel come to the aid of trauma victims, they may be traumatized by the perils of the work and by bearing witness to traumatic events and human suffering.

For counseling professionals that seek to work with ES personnel and organizations it is imperative that they understand the nature of emergency service work and the demands it places on the ES personnel and their families. Counselors who work with these populations must have a thorough understanding of the culture and prevalent stressors if they wish to effectively address the stress and fatigue that is considered inevitable for this professional population. To impact these issues counselors must be aware of the intersection of an identity, both professional and self, with an occupation rife with the hazards of self-sacrifice readily accepted by ES personnel. They need to understand the common manifestations of stress and impairment, as well as the potential interventions that the ES personnel may have already undergone such as individual counseling, Critical Incident Stress Debriefing (CISD), or Critical Incident Stress Management (CISM).

Counseling professionals must also be aware of the potential dangers that they themselves may face when working with trauma, whether directly with traumatized clients or indirectly through the client's experiences. Secondary traumatic stress, compassion fatigue, vicarious trauma, acute stress and PTSD are very real concerns that the counseling professional may need to address for themselves in their work with ES personnel and may stem from the same empathic response that leads to compassion fatigue and vicarious traumatization in ES personnel. An understanding of the nature of trauma through training and continuing education coupled with clinical supervision that is knowledgeable of the mechanisms of traumatization, not only at the level of the client, but also the potential impact on the clinical counselor will help to mitigate the negative effects of working with traumatized populations and ES personnel who are regularly exposed to traumatic events.

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A Brief Workplace Substance Abuse Prevention Training for US Army Reservists: A Pilot Study

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Abstract

A brief, classroom-style workplace substance abuse prevention training was provided to one group of US Army reservists during their drill weekend by members of a community-based substance abuse prevention coalition. After pre- and post-testing, a significant ($p<.05$) positive effect of the training on participants' prevention knowledge was found but mixed support for the effect on

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behavioral intentions at the civilian workplace was noted. The Army recommends community collaboration for prevention efforts; therefore, Army counselors working with reservists should attempt to collaborate with employer and community providers to address substance abuse prevention and treatment.

Keywords: Soldiers, substance abuse, prevention training

Drug and alcohol abuse is a recurrent issue in today's society. When drugs and alcohol are abused, there are often negative repercussions seen not only on the individual level, but also within the work and home environments. Drug abuse is defined as the repeated use of illegal drugs or the misuse of legal substances (University of Maryland Medical Center, 2013). Approximately 60% of full-time employees have substance abuse problems which can lead to increased absenteeism, decreased productivity, and higher health care costs for employers. Specifically, employees who use illicit drugs are 2.5 times more likely to have a long leave of absence, are almost four times more likely to be injured at work, and are three times more likely to arrive late to work than employees who do not use substances (United States Department of Labor, n.d.).

Drug and alcohol abuse can lead to a variety of potential negative health effects and dangerous behavior in the workplace. For example, alcohol is involved in nearly half of all serious workplace accidents. Almost two percent of employees go to their workplace while under the influence, seven percent use alcohol at some point during the course of their workday, and nine percent go to work while experiencing the aftereffects of intoxication (Frone, 2006). Heavy alcohol use is found to be highest among blue collar workers including construction workers/laborers, machine operators, and employees in the transportation and food service sectors. It is estimated that 500 million work days are lost each year due to alcohol abuse (United States Department of Labor, n.d.). In addition, marijuana impairs short-term memory and slows reaction time on the job. In recent years, there has also been an increase in the abuse of prescription and over-the-counter medications on the job as well as drugs taken outside of work that also affect job performance (Marcom Group, 2007).

Drug-Free Workplace Programs (DFWP) are mandated by federal law to be available to federal employees, but program resources and development tools are also available to privately-owned companies. A DFWP has five components: a written substance abuse policy, supervisor training, employee education and training, an employee assistance program, and drug testing (Substance Abuse and Mental Health Administration, 2014). The establishment or maintenance of an employee assistance program (EAP) is another effective way for an employer to address alcohol and drug abuse, mental and emotional health issues, financial problems, and marital and family problems that can negatively affect productivity and morale of employees (National Business Group on Health, 2009). All in all, the employer is in an optimal position to intervene and encourage the employee with a substance abuse problem to seek professional counseling. By supporting employee prevention and treatment, employers can reduce the negative impact of substance abuse on productivity and reduce overall costs (National Council on Alcoholism and Drug Dependence, n.d.).

One group of employees who are at high risk for substance abuse that may affect their civilian workplace function is armed forces reservists. Army reservists, citizen Soldiers with skills from the civilian sector, work in direct strategic and operational support roles for the US Army. They keep current in their reserve field through their jobs in the private sector (US Army, n.d.). Because of stress and traumatic events associated with military service, service members and Veterans are at high risk for substance abuse. Service members generally have substance use rates higher than the civilian population as deployment is associated with smoking, drinking, and prescription drug abuse (Committee on Prevention, Diagnosis, Treatment, and Management of Substance Use Disorders in the U.S. Armed Forces [CPDTM], 2013). For these employees, alcohol abuse appears to be higher than in other civilians (Prescott et al., 2014) or in active active-duty service members (Cohen, Fink, Sampson, & Galea, 2015). In addition, when screened post-deployment, about 40% of reservists screened positive for possible alcohol problems (Eisen et al., 2012). Male service members report more substance abuse than female service members (Eisen et al., 2012; Hoggatt et al., 2015). However, for female reservists, it seems deployment and lower rank was associated with increased risk for alcohol abuse, specifically binge drinking (Cuccaire et al., 2015).

Returning from deployment and substance abuse problems negatively affect the civilian occupation functioning of reservists (Erbes, Kaler, Schult, Polusny, & Arbisi, 2011). Regardless of deployment status, though, civilian issues like family and jobs were associated with alcohol abuse (Cerda et al., 2014). Those reservists with substance abuse problems may need assistance programs or other work support in order to successfully function in their work role (Erbes et al., 2011).

Prevention education and training for readiness is provided by the military through the Army Training System and includes information on effects and consequences of substance abuse as well as policy and supportive services available. Collaboration with the local community for prevention efforts is also emphasized (Department of the Army, 2012). Prevention programs that include standardized training in an appropriate setting, relevant information about high-risk situations, social support and assistance information, and non-use norm and impulse control emphasis are recommended for this population (CPDTM, 2013). Therefore, the researchers sought to answer the question: what effect would a brief workplace substance abuse prevention training, provided by community prevention coalition members and supplementing any mandated training, have on US Army reservists' prevention knowledge and behavioral intentions at the civilian workplace?

Methods

Participants

After Institutional Review Board approval, a brief health education training and evaluation was conducted as part of a regularly-scheduled Northeast Missouri US Army Reserve weekend training during February, 2016. The local community-based substance abuse prevention coalition chairperson contacted the Staff Sergeant in charge of education and training at the US Army Reserve Center during the fall to determine the health education training topic and schedule the health education training session. All 22 Reservists attending the weekend training

were asked to participate in the study. All (100%) agreed to participate and completed the consent form. The sample consisted of primarily White/Caucasian (72.7%), male (68.2%), enlisted (90.9%) Soldiers (Table 1). Half of the participants had been on at least one deployment (50.0%).

Table 1. *Demographics of the Participants*

Gender	**n(%)**	**Race**	**n(%)**
Male	15(68.2)	White/Caucasian	16(72.7)
Female	7(31.8)	Black/African American	3(13.6)
Rank		Asian/Pacific Islander	1(4.5)
Enlisted	20(90.9)	Hispanic/Latina/Latino	2(9.1)
Officer	2(9.1)		

Instruments

As seen in Appendix A, the *Dealing with Drug and Alcohol Abuse… For Employees Quiz* (Marcom Group, 2007) assessed participants' change in knowledge of substance abuse at the workplace from pre- to post-training. The seven question quiz that accompanied the curriculum was based directly on the content presented in the curriculum. The quiz included five true-false style questions about substance abuse effects at the workplace, two multiple-response style questions about specific consequences of abuse at the workplace, and three demographic questions: gender, rank (officer/enlisted), and number of career deployments. The number of correct answers out of the seven quiz questions (scores could range from 0 to all 7 correct) determined participant score with higher scores indicating more knowledge of prevention training content.

Behavioral intentions for substance use at the workplace were measured using a six-item *Intention Scale* designed specifically for this study by the researchers (Appendix B). Participants were asked to respond to each item on a scale of zero (Not Very Likely) to five (Very Likely) about their intent to use substances (alcohol, tobacco, other drugs) at the workplace or affecting the workplace in the next six months. A Cronbach's alpha was conducted to assess internal consistency reliability, the consistency of results across test items, on the pre-test ($\alpha = 0.536$) as well as the post-test ($\alpha = 0.572$).

Procedure

After Institutional Review Board approval, training officer approval, and participant consent, a brief (one-hour long) workplace substance abuse prevention training (covering common substances abused in the workplace, how abuse affects the work situation, and how to keep their workplace drug-free) was presented to participants during their reserve training weekend in February, 2016. The training was a standardized, turn-key workplace safety curriculum from a leading publisher of safety training courses for corporations and government agencies. Participants completed both pre-tests (using mother's birthdate as their ID code to match pre- and post-tests), placed them in a sealed envelope, and returned them to the researchers. In a classroom setting, six members of a community-based substance abuse prevention coalition, trained in the curriculum, presented the workshop using lecture, small

group discussion [break-out groups], role-play, and question-answer format. Topics for discussion included categories of abused substances and their affects, dangers of using drugs at the workplace, drug dependence and recognition of signs, workplace policies, and employee assistance; and then back to the large group lecture format for presentation summary. Following the training, participants completed both post-tests, placed them in a sealed envelope, and returned them to the researchers. The pre-post design allowed the researchers to assess baseline data in order to assess statistical change. While a control group design would have been ideal, a lack of funding and difficulty in finding an adequate and equitable control group in the rural region where the study was conducted hindered the ability to implement such a design.

Analysis

Change in participants' knowledge pertaining to substance abuse in the workplace scores from pre- to post-training was evaluated using paired samples *t*-tests. Descriptive statistics (frequencies and percentages) were used to evaluate any change in participants' substance abuse behavioral intention from pre- to post-training.

Results

Knowledge of Substance Abuse at the Workplace

One participant opted not to complete the post-test, yielding a sample size of n=21 for comparison between the pre- and post-test. The results of a paired-samples *t*-test examining the difference in mean knowledge of substance abuse in the workplace scores between the pre-test (M=4.90, SD=0.70) and the post-test (M=5.95, SD=0.92) revealed a statistically significant change ($t[20]=-5.55$, $p<.05$; Table 2). The negative *t*-score denotes an increase in scores between the pre- and post-tests. The items most commonly marked incorrect on the post-test were the items assessing whether or not the participant knew if a known cure exists for alcohol and drug addiction (33.3% incorrect) and the percentage of serious workplace accidents are caused by people drinking on the job (57.1% incorrect; Table 3 on p. 204).

Table 2. *Descriptive Summary of Knowledge Assessments*

Assessment	M	SD	Range	Minimum Score	Maximum Score
Pre-test	4.90	0.70	2.00	4.00	6.00
Post-test	5.95	0.92	4.00	3.00	7.00

Behavioral Intentions for Substance Abuse at the Workplace

Participants reported their likelihood of using substances at the workplace or affecting the workplace in the next six months (Table 4 on p. 205). All participants, both pre- and post-test, reported that they were Not Very Likely/Not Likely to use alcohol or illicit drugs. On the other hand, some both pre- and post-test, reported that they were at least Somewhat Likely to use tobacco.

Table 3. *Item Responses for Knowledge Assessment*

Item		Correct n(%)	Incorrect n(%)	Item		Correct n(%)	Incorrect n(%)
Depressants such as alcohol and marijuana speed up brain activity.	Pre-test (n=22)	18(81.8)	4(18.2)	There are no known cures for alcohol and drug addiction.	Pre-test (n=22)	4(18.2)	18(81.8)
	Post-test (n=21)	20(95.2)	1(4.8)		Post-test (n=21)	14(66.7)	7(33.3)
The residual effect of a substance can cause a person to have an accident days after they have last used the substance?	Pre-test (n=22)	21(95.5)	1(4.5)	What is the most commonly used illegal drug?	Pre-test (n=22)	19(86.4)	3(13.6)
	Post-test (n=21)	20(95.2)	1(4.8)		Post-test (n=21)	21(100.0)	0(0.0)
As people build up a tolerance to a substance they generally become less dependent on it.	Pre-test (n=22)	22(100.0)	0(0.0)	What percentage of serious workplace accidents are caused by people drinking on the job?	Pre-test (n=22)	2(9.1)	20(90.9)
	Post-test (n=21)	20(95.2)	1(4.8)		Post-test (n=21)	9(42.9)	12(57.1)
Addiction to drugs and alcohol is a disease.	Pre-test (n=22)	22(100.0)	0(0.0)				
	Post-test (n=21)	21(100.0)	0(0.0)				

Discussion

US Army reservists are at high risk for substance abuse that may affect their civilian workplace function (CPDTM, 2013). A brief, classroom-style workplace substance abuse prevention training was provided to one group of reservists during their drill weekend by members of a community-based substance abuse prevention coalition. After completion of the intervention, a significant positive improvement of the training on participants' prevention-related knowledge was found. However, mixed support for the effect on behavioral intentions at the civilian workplace was noted. All participants reported that they were not likely to use alcohol or illicit drugs at the workplace or that they would not use in a manner that would affect the workplace in the next six months. For tobacco intention, however, some reported that they were somewhat likely to use tobacco at the workplace or affecting the workplace in the next six months.

Prevention Knowledge

Reservists are an important group for Army educators or counselors to target for a substance abuse prevention educational intervention (CPDTM, 2013). In this study, after participation in an educational training, reservist participants significantly improved their

prevention knowledge, albeit a small amount. Employee education and training at the worksite seems to be an effective way to address knowledge about substance abuse prevention (Substance Abuse and Mental Health Administration, 2014). With foundational knowledge, participants and their civilian and military employers may decrease possible future problems associated with substance abuse like absenteeism, higher health care costs, and work-related injuries (United States Department of Labor, n.d.).

Table 4. *Item Responses for Behavioral Intentions*

Item		Not Very Likely n(%)	Not Likely n(%)	Somewhat Unlikely n(%)	Somewhat Likely n(%)	Likely n(%)	Very Likely n(%)
How likely do you think that you will use alcohol at the workplace in the next six months?	**Pre-test (n=22)**	21(95.5)	1(4.5)	0(0.0)	0(0.0)	0(0.0)	0(0.0)
	Post-test (n=21)	20(95.2)	1(4.8)	0(0.0)	0(0.0)	0(0.0)	0(0.0)
How likely do you think that you will use alcohol affecting the workplace in the next six months?	**Pre-test (n=22)**	19(86.4)	3(13.6)	0(0.0)	0(0.0)	0(0.0)	0(0.0)
	Post-test (n=21)	19(90.5)	2(9.5)	0(0.0)	0(0.0)	0(0.0)	0(0.0)
How likely do you think that you will use tobacco at the workplace in the next six months?	**Pre-test (n=22)**	15(68.2)	0(0.0)	1(4.5)	1(4.5)	2(9.1)	3(13.6)
	Post-test (n=21)	15(71.4)	0(0.0)	0(0.0)	1(4.8)	2(9.5)	3(14.3)
How likely do you think that you will use tobacco affecting the workplace in the next six months?	**Pre-test (n=22)**	18(81.8)	1(4.5)	0(0.0)	0(0.0)	1(4.5)	1(4.5)
	Post-test (n=21)	16(76.2)	1(4.8)	1(4.8)	0(0.0)	2(9.5)	1(4.8)
How likely do you think that you will use illicit drugs at the workplace in the next six months?	**Pre-test (n=22)**	21(95.5)	1(4.5)	0(0.0)	0(0.0)	0(0.0)	0(0.0)
	Post-test (n=21)	21(100.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)
How likely do you think that you will use illicit drugs affecting the workplace in the next six months?	**Pre-test (n=22)**	22(100.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)
	Post-test (n=21)	21(100.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)

Participants' knowledge scores may have improved because the training curriculum followed best practices. The curriculum was a standardized program taught in the relevant setting of weekend drill, covered risky situations, and emphasized non-use as recommended (CPDTM, 2013). In addition, the training was conducted in collaboration with a community-based

substance abuse prevention coalition which is also recommended as best practice (Department of the Army, 2012). It is recommended that any future substance abuse prevention educational training cover in more detail the content related to the two most commonly missed answers to the knowledge quiz related to cures for addiction and accidents caused by drinking on the job.

Prevention Intentions

All participants, both pre- and post-test, reported that in the next six months they were not likely to use alcohol or illicit drugs at the workplace or that affect the workplace. These are positive intentions as alcohol abuse and use of illicit drugs may lead to negative health effects and risky health behaviors at home and work (University of Maryland Medical Center, 2013). On the other hand, some participants reported that they were somewhat likely to use tobacco at the workplace or affecting the workplace in the next six months. As the large teaching group broke into several smaller discussion groups, participants opened up more to the instructors about how the stresses of military service effected their civilian employment and life in general. Possibly, these discussions as well as instruction in the topic of recognition of drug dependence signs contributed to more participant awareness of situations leading to increased tobacco use.

Talking about the stress and traumatic events associated with military service (CPDTM, 2013) coupled with civilian issues like family and jobs (Cerda et al., 2014) may have influenced future tobacco use intention. Deployment has also been associated with tobacco use (CPDTM, 2013). Half of the participants had been deployed at one time, and some participants may have returned or were in the process of being deployed. This may have led to a change in intention to use. For those reservists in this unit, tobacco cessation programs may assist tobacco users with quitting to improve their health and functioning in the military and in civilian employment. Use of cessation resources and intervention programs offered by the military (Department of the Army, 2012) should be encouraged. For those not wishing to use military services, they should be encouraged to use cessation programs found at the civilian worksite and in the community.

Implications for Future Research

Although the results of this pilot study are promising in regards to the ability of the intervention to improve health-related knowledge among Army reservists, several limitations were noted and should be addressed in future studies. The participants in this study were from a single Army Reserve unit in Missouri. It is recommended that a broader sample of Soldiers from around the United States be included in future studies in order to establish generalizability of the data. In addition, the sample size was small and although parametric analyses can be used with small sample sizes (De Winter, 2013), a larger number of participants would have been desirable and is recommended in the future. Due to extremely positive (healthy) behavioral intention scores in the pre-test, it was logical that no vast improvements in post-test scores were achieved. While it is certainly encouraging that the behavioral intention scores were healthy, this unfortunately, did not allow the researchers to truly assess the impact of this intervention on behavioral intentions. The ceiling effect noted in the behavioral intentions assessment did not allow for detection of change between the pre- and post-tests. This fact combined with inadequate Cronbach's alpha scores of α=0.536 (pre-test) and α = 0.572 (post-test) means that future researchers should replicate the study using alternative methods of behavior intention

assessment. Further, although a statistically significant change in knowledge scores was noted, the extent of change was marginal, thus bringing in to question the practical significance of the change in scores. Additional studies should be conducted to confirm the ability of the intervention to critically improve knowledge regarding alcohol, tobacco, and other drugs (ATOD). Moreover, the knowledge assessment provided by The Marcom Group, Ltd. (2007) is only made up of seven items. Future researchers should investigate the use of more inclusive scales designed to capture a broader aspect of ATOD-related knowledge.

Conclusion

Although substance abuse prevention education, training, and supportive services are provided by the Army (Department of the Army, 2012), the civilian employer may sometimes be in the best position to support treatment through employee assistance programs or referral to community-based services (National Council on Alcoholism and Drug Dependence, n.d.). Army counselors or educators working with these reservists should attempt to collaborate with employer and community providers to address substance abuse issues as well as any underlying mental health concerns. Community-based prevention and treatment providers may also possess data and information on current substance abuse trends in the reservists' home region that can be shared with Army counselors for increased awareness. For example, there has been an increase in prescription drug abuse in many areas of the country (The Marcom Group, Ltd, 2007) that may affect civilian and Army job performance of users. Both Army and community-based prevention efforts would then need to address any emerging trends.

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Appendix A. *Dealing with Drug and Alcohol Abuse… For Employees Quiz*

Gender_____ Rank (Enlisted____ Officer___) # Deployments _____

QUIZ

"DEALING WITH DRUG AND ALCOHOL ABUSE... FOR EMPLOYEES"

Name:_____ ***Date:***_____

1. True or False... Depressants such as alcohol and marijuana speed up brain activity?
   _____ True
   _____ False

2. True or False... The residual effect of a substance can cause a person to have an accident days after they have last used the substance?
   _____ True
   _____ False

3. What is the most commonly used illegal drug?
   _____ OxyContin.
   _____ Marijuana.
   _____ Cocaine.

4. What percentage of serious workplace accidents are caused by people drinking on the job?
   _____ 10%
   _____ 15%
   _____ 25%
   _____ 50%

5. True or False... As people build up a tolerance to a substance they generally become less dependant on it?
   _____ True
   _____ False

6. True or False... Addiction to drugs and alcohol is a disease?
   _____ True
   _____ False

7. True or False... There are no known cures for alcoholism and drug addiction?
   _____ True
   _____ False

Note: The MARCOM Group, Ltd. granted permission for this quiz to be used for the purpose of inclusion in the article for publication in the *Journal of Military and Government Counseling*.

Appendix B. *Intention Scale*

Directions: Circle the number that most describes your intention to use that substance at the workplace or affecting the workplace in the next six months.

1. How likely do you think that you will use alcohol at the workplace in the next six months?
   0 = Not very likely
   1= Not likely
   2= Somewhat unlikely
   3= Somewhat likely
   4= Likely
   5= Very likely

2. How likely do you think that you will use alcohol affecting the workplace in the next six months?
   0 = Not very likely
   1= Not likely
   2= Somewhat unlikely
   3= Somewhat likely
   4= Likely
   5= Very likely

3. How likely do you think that you will use tobacco at the workplace in the next six months?
   0 = Not very likely
   1= Not likely
   2= Somewhat unlikely
   3= Somewhat likely
   4= Likely
   5= Very likely

4. How likely do you think that you will use tobacco affecting the workplace in the next six months?
   0 = Not very likely
   1= Not likely
   2= Somewhat unlikely
   3= Somewhat likely
   4= Likely
   5= Very likely

5. How likely do you think that you will use illicit drugs at the workplace in the next six months?
   0 = Not very likely
   1= Not likely
   2= Somewhat unlikely
   3= Somewhat likely
   4= Likely
   5= Very likely

6. How likely do you think that you will use illicit drugs affecting the workplace in the next six months?
   0 = Not very likely
   1= Not likely
   2= Somewhat unlikely
   3= Somewhat likely
   4= Likely
   5= Very likely

Applying the Military Success Model to School Age Children

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Abstract

Given the enormity of stress and the impact of multiple deployments, the Military Success Model (MSM) was designed as a way of conceptualizing working with service members and their families. This article discusses the impact of deployment on children of military servicemembers. Further the impact of school counseling germane to working with students from military families is noted. A direct application of the MSM is discussed while working through the different phases illustrated through a case study. Lastly, implications for future use are discussed.

KEYWORDS: military success model, military servicemembers, military family

The Department of Defense (DoD) recognizes that it is not only the military servicemembers themselves that must adjust in times of deployment, but their families as well. According to the United States Department of Defense 2013 Demographics Report (Department of Defence [DoD], 2014), the United States Armed Forces has 3,616,568 service men and women comprised of 358,156 female members and 1,846,680 male members, 51.7 percent were married at the time of the report. Of those military members 2,204,839 are parents, 50,505 are dual military parents, 744,373 military members married to civilians, and 146,048 are single parents (DoD, 2014). In 2013, there were 1,888,486 military children, 37.4% are 0 to 5 years of age, 30.8% are 6 to 11 years of age, and 24.7% are 12 to 18 years of age (DoD, 2014). Of the 3,616,568 servicemembers, 1,613,480 were on active duty in 2013 including 243,151 females and

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1,366,012 males, 923,331 were married in 2013 and 42.8% having children (DoD, 2013). Of active duty members, 2.8% of them are dual military parents, 35.1% are married to civilians, and 5% are single parents (DoD, 2013). The breakdown of active duty children by age group reflects that of all service members: 42% are 0 to 5 years of age, 31.3% are 6 to 11 years of age, and 22.3% are 12 to 18 years of age (DoD, 2013).

With the overwhelming number of individuals affected by service in the military, there is an increased need for healthcare across the board. Most previous research on long term effects of military service is with those suffering from posttraumatic stress disorder (PTSD) or traumatic brain injury (TBI) who have seen combat. Little research has studied the effects of military service on those who have not seen combat (Whyman, Lemmon & Teachman, 2010). Following the Gulf War, research was begun that examined military members who began reporting physical symptoms and illnesses they attributed to environmental exposures they experienced during deployment. However, the research on these symptoms was hampered by the unavailability of objective measurements to evaluate these symptoms. Subsequently a longitudinal cohort study was established to follow potential health issues of the group of cohorts that came to be known as The Millennium Cohort Study (Smith et al., 2011).

This study found that potential causes of illnesses were due to anthrax and smallpox vaccinations. It served to raise concern about potential illnesses among combat Veterans of Iraq and Afghanistan resulting from unknown environmental exposures during deployment (Smith et al., 2011). Other research has shown that compared to non-veterans, individuals who served in the military are more likely to have chronic conditions, experience work issues, and suffer from serious psychological distress (Collier, 2012).

Navy Admiral (retired) Mike Mullen, former Chairman of the Joint Chiefs of Staff, has stated the belief that the military needs to be more encouraging of those in need of mental health care ("DoD focuses," 2009). He sees the primary issue as helping military members to seek mental health care when they need it rather than being concerned about their reputations and about how their military careers will be affected ("DoD focuses," 2009). The wars in Iraq and Afghanistan have resulted in over two million military combat veterans and of those; over one million have been diagnosed with one or more psychological disorders (Russell et al., 2015).

Children and adolescents are at risk for increased stress, for disruptions across the developmental spectrum, and for poor skills in coping with deployment during pivotal developmental phases of emotional and social development. Many children of military personnel are resilient but others may struggle with this, especially those who struggle with mental health or behavioral disorders prior to the deployment of a parent or those who develop the mental health or behavioral disorders during the deployment (Lincoln & Sweeten, 2011). Of those children or adolescents who struggle during a parental deployment, 2.8% of them are displaced due to dual military parents (DoD, 2013). In the early phases of development, trust and caregiving relationships are crucial to children's development. In regards to behavioral or mental health, lack of these elements is evidenced by disrupted attachments leading to separation anxiety, disruption of cognitive development, emotional disruption, anxiety, depression, acting

out aggressively, and defiance. Children of returning soldiers also struggle with reunification and coping with the after effects of the services members' mental health including PTSD, depression, and combat fatigue. Children and adolescents at increased risk for mental health issues include those in low income families, those in protective services and juvenile justice services and those in military families (Stagman & Cooper, 2010).

Effects of Deployment on Children

Children and youth in military families tend to have higher rates of mental health problems and those mental health issues are especially pronounced when a parent or parents are deployed. Twenty-two percent of children in military families scored *high risk* for psychosocial morbidity—two and a half times that of the national average. Emotional and behavioral difficulties between ages 11 and 17 years old are seen more frequently among military youth than among the general population and children between 3 and 5 years old who have a deployed parent exhibit more behavioral symptoms than do children without a deployed parent. Additionally, child maltreatment in military families is 42% higher during deployment than during non-deployment (Stagman & Cooper, 2010).

A link has been established between combat-related service members with PTSD and psychological distress in spouses (Renshaw et al., 2011). There are several reasons for this including because the spouses are mediating and translating on behalf of service members and the rest of the world to help reduce stress and lower outbursts for services members with PTSD (Fredman, Monson, & Adair, 2011) and because of marital problems due to lower levels of self-disclosure and intimacy from combat Veterans (Solomon, Dekel, & Zerach, 2008). Renshaw et al., (2011) suggested that lack of spousal understanding of service members' symptoms may play a role in their distress. Other factors may be excess burden, extra household responsibilities, seeing their partners suffer, and helping to manage their partners' psychological difficulties (Beckham, Lytle, & Feldman, 1996; Calhoun, Beckham, & Bosworth, 2002; Caska & Renshaw, 2011; Dekel, Solomon, & Bleich, 2005; Manguno-Mire et al., 2007). It is highly recommended that families participate in therapy during all stages of the deployment cycle to cope with the changes that occur.

In one particular study of 940 military spouses (Eaton et al., 2008) it was found that 17% reported experiencing moderate to severe emotional, alcohol, or family problems. Nineteen percent reported an interest in receiving help for those problems. Twenty percent met the DSM-IV criteria for major depressive disorder or generalized anxiety disorder.

Robust evidence shows that a significant number of military spouses experience increased levels of depression, anxiety, stress, and adjustment difficulties in all three stages of deployment—before, during and after (Kees & Rosenblum, 2015). Twenty-one percent of these spouses report symptoms associated with major depressive episodes, 13% with posttraumatic stress, and 11% with hazardous alcohol use. This indicates that military spouses are at psychological and emotional risk at nearly the same level as service members (Kees & Rosenblum, 2015). In fact, studies have shown that stress on non-deployed parents is so increased during deployment that the risk of child maltreatment is as much as three times as high as it is during non-deployment (Gibbs, Martin, & Johnson, 2007).

School Counseling

The art of managing an effective, data-driven, comprehensive school counseling program is a skill that school counselors learn, execute, refine, and reflect upon (American School Counselor Association, 2012). A professional school counselor's ability to create and implement such a program is a combined result of education, training, consultation and collaboration amongst school personnel, shared experiences among school counseling colleagues, and intention of the American School Counseling Association (ASCA) National Model. Pivotal to the integral aspect of successful school counselor leadership is the innate ability to ascertain what decisions are needed to achieve results that will align with the vision of their school counseling program (Dollarhide & Saginak, 2012).

Following the ASCA National Model, school counselors are responsible for supporting the needs of all students, including military students, in their schools within the three domain areas of academic, personal-social, and career. A growing culture, more than 60,000 students in one California county alone (Adams, 2016) within school communities is students of military personnel. While there is a growing literature and research base relating to the military, very few school counselors have been exposed to or required to demonstrate proficiency working with this cultural group within their education and training. Professional school counselors are in a unique position to assist children of military parents overcome challenges they may face before, during, and after deployment. For example, it was school staff that identified that deployment negatively affected a significant amount of social and emotional functioning of children and youth (Chandra, Martin, Hawkins, & Richardson, 2010). As it relates to students who are identified as children of military personnel, the military success model (MSM) seems to provide a framework for working with such populations.

The military success model is a strength-based (Duchac, Stower, & Lunday 2013) and brief framework making it a suitable fit for professional school counselors who are implementing a comprehensive school counseling program, and it addresses the ASCA's National Standards for Students (ASCA, 2004; 2012a). The MSM consists of three phases in which the first phase is relationship building with the counselor and the client. The second phase is identification and definition of the problem as well as admitting it is one in need of assistance. The third phase is one where resolution is reached in both the individual (student) and the family (and/or school/class). One goal of many school programs is a way to incorporate the education with family life and the MSM allows for the two to be integrated (Duchac et al., 2013). As most children spend a majority of their day in school, the support from the school counselor for students of military personnel is vital. An effective conceptual counseling framework such as the MSM provides professional school counselors with a practical way to focus on student's emotional and psychosocial responses ranging from acting out behaviors, underachievement, separation anxiety, and social isolation.

Case Study

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J.J is a 12-year-old male who has been having increased behavioral problems both at the youth center on base and at his school, which is also located on base. Currently, he is in the sixth grade for a second time. At the end of his first attempt he was expelled for bringing a knife to

school. During this year, he has had numerous anger outbursts and has been picking on other kids within his classes. The youth center that he attends has met with his mother and asked that she either get him some help or withdraw him from the program. In addition, the school has indicated that he needs to get some help or that he will likely soon be suspended. The mother, who serves in the Army, approaches the school counselor seeking assistance. She has been gone for two out of the past five years on deployments and even when she is home reports that she is pre-occupied and often too tired to spend the time with her son that he needs. She is a single parent and when she is deployed J.J. resides with her parents.

In looking at this case study there are several areas that one could pursue. For many there might be an initial focus on J.J's behavior and working with him and asking him to change or examine his thought process. Instead of one of these approaches this section will be written utilizing the phases of the MSM. The first phase, as suggested by Duchac et al. (2013) is to examine the elements of his mother's deployments and see how these may have impacted his symptoms both good and bad. As an example, during his mother's deployments does he seem to take more initiative or respond differently to others? Does he communicate in a manner that is not always consistent with anger? Does he relate to other children differently? This phase will focus on establishing the relationship and acknowledging that a problem or area of concern exists. Through these three to five sessions a great deal of time will be spent on (S) the sense of duty that exists, (U) the uniqueness of the experience, and (N) noteworthy achievements.

From J.J.'s perspective, it is important to note the pride that exists for this client as he speaks about his mother and the role that she serves in the Army. Knowing that she is helping others and has such an impact on others does make a difference in terms of how J.J. thinks. Secondly, J.J.'s experiences, though similar to others his age that have a parent deployed, are unique to him. During the past five years he has been uprooted for about two and half years away from his home. During this time he has resided with his grandparents, but has still experienced the changes that occur with brief moves. In addition, in speaking with J.J., he has been constantly worried about his mother during each deployment and while she is away for training. Taking these feelings into consideration will prove beneficial to helping him. From a noteworthy achievement perspective, it is interesting to see that when his mother is deployed that J.J. seems to have improved grades and that he changes in terms of how he seeks to gain the approval from others, particularly his mother. Since their communication is infrequent during a deployment, there tends to be a focus on the more positive attributes. In discussing these characteristics with J.J., he was able to see how his behavior was different while his mother was gone versus when she was at home and had more participation in his life.

Phase II consists of taking the area of concern and attempting to provide some resolution with the overall goal being that of awareness. Specific elements of the model that are addressed in this phase include: (D) determination, (A) an apprehension to engage, and (E) empowerment. Identifying strengths for this student and taking those strengths and using them in a way of lessening apprehension and fostering empowerment are essential. Through this self-discovery, rapport and trust on behalf of the student will be increased and progress will be made on an incremental process, building upon future successes.

Phase III, consists of working with the student to develop his capabilities while stressing his courage in engaging and trusting you as the therapist. Additionally, the utilization and understanding of available resources will prove vital in this phase of the therapeutic process. Lastly, stressing the poise that is being displayed by this student will allow for the student to replicate future positive behavior, which will aid in the overall coping of J.J. Overall, this approach will allow the school counselor to work with J.J and help him to transition from the behavioral struggles that he is facing into more positive experiences that he can begin to process through in a self-efficacious manner.

Implications

Considering the enormity of the impact children experience when they have a parent or parents that are deployed, a method recognizing their emotions as roots of negative behavior would seem helpful, both to the child and the school counselor. The MSM is such a method that provides the skills for such recognition in an expeditious manner by incorporating the child, the school, as well as the family unit. By doing so it also provides the child with skills to form a support system in whatever environment he or she finds him/herself. Employing such a method would seem important. The concept of "no man is an island" is not new. In fact, it is the one that the military itself operates from.

What is needed is to apply this concept to children from military families. This sense of mutual dependency is inherent to military families from the early days of military life. It is communicated to children either implicitly or perhaps more explicitly. Either way the child adapts to this expectation. Usually, no questions are asked. By using a model such as the MSM, one helps the children to focus on their strengths, thus placing focus on them rather than exclusively on the negative attitudes or behaviors. Even though the school environment may, of necessity, be focusing on the negative, disruptive behaviors, this approach is likely to yield the same or better results than other strengths based treatment. Significant advantages to using the MSM in a school setting include the expeditious results it tends to produce and the fact that it specifically allows for the consideration of life with the military (Duchac et al., 2013).

With use of this model, not only are the negative behaviors reframed with the focus on positive attitudes and behaviors, but the disruptions are limited fairly quickly. With the MSM, where the three phase approach being utilized, the Phase I being primarily establishing and building the therapeutic relationship, Phase II being the recognition of the problem and the fact that it is in need of professional help, and the Phase III being actual working on the issue with individual and the family working toward problem resolution, there is swift resolution of the issue with working as a team (Duchac et al., 2013). Perhaps the most important result of the MSM is the fact that it develops skills in the child that he/she will be able to use for a lifetime. One of the benefits of this model is that it is teachable. He/she learns how to step back from a situation, look at the bigger picture and reframe the negative perspective. This is a critical skill that is beneficial to the child as well as his/her family and, ultimately, the military.

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The Need for Culturally Relevant Psychotherapies for Veteran Men with PTSD

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Abstract

Despite advances in counselling and psychotherapy, current evidence-based treatments do not sufficiently address the needs of military men with PTSD. The military constitutes its own culture with a unique set of values, beliefs, and traditions that strongly endorse traditional male ideology. As such, military culture influences the meaning ascribed to self, others, and the world in the aftermath of traumatic events. Consequently, military men experience a unique symptomatology in response to trauma, both due to the nature of the trauma and the influence of military culture. However, current evidence-based treatment models for PTSD were developed and validated in the context of civilian trauma. Further, these models target the core symptoms of PTSD but overlook the unique experiences of military men.

KEYWORDS: military Veterans, trauma, military culture, psychotherapy, counselling

Although many innovative psychotherapies have been designed to treat posttraumatic stress disorder (PTSD), three evidence-based interventions have been considered the most effective: prolonged exposure therapy (PET), cognitive-processing therapy (CPT), and eye-movement desensitization and reprocessing (EMDR) therapy (Albright & Thyer, 2009; Steenkamp & Litz, 2012). These same three interventions are highly endorsed for the treatment of combat-related PTSD among military populations (Creamer & Forbes, 2004; Karlin & Cross, 2014). These evidence-based interventions may be effective in treating the three core symptoms (i.e., re-experiencing, hyperarousal, and avoidance) common among individuals with PTSD but do not adequately address the intersection of military culture and combat exposure that give way to the peripheral symptomatology (i.e., shame, guilt, and moral injury) of combat-related PTSD in Veteran men (Monson et al., 2006; Nash et al., 2013).

This paper takes the position that current evidence-based psychotherapies for PTSD necessitate further cultural development to meet the needs of Veteran men who have been traumatized. To this end, it is first necessary to discuss the cultural context in which combat-

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related PTSD emerges and how these elements present challenges for evidence-based psychotherapies. Second, some of the limitations of the current research on evidence-based psychotherapies as applied to Veteran men with PTSD are identified. Finally, the relative absence of culturally relevant adaptations to evidence-based psychotherapies are noted and future opportunities for collaboration among practitioners and researchers are highlighted.

Military Culture and Combat Exposure

An analysis of military culture and its interaction with combat exposure gives way to a unique symptom presentation among Veteran men with PTSD (Fox & Pease, 2012; Hoge, 2011; Lorber & Garcia, 2010; Monson, Price, Rodriguez, Ripley, & Warner, 2004). Traditional male gender norms such as fearlessness, invulnerability, and emotional toughness are heavily endorsed in the military (Lorber & Garcia, 2010) and this exerts a powerful influence on the experience and presentation of PTSD in Veteran men. Specifically, research has found that service members have reduced ability to identify, express, and regulate emotion (Monson et al., 2004). These factors increase Veteran men's difficulty in coping with the emotional impact of combat exposure in that military training has taught Veteran men to rely on norms of invulnerability and fearlessness (Lorber & Garcia, 2010). As such, trained behaviours that once served to protect Veterans in combat become unhelpful and destructive following deployment (Hoge, 2011). Indeed, the mechanism of hyperarousal is important for the soldier as it supports his functioning with inadequate rest; emotional suppression may help the soldier to cope with the stresses of war (Hoge, 2011). Likewise, avoidance of potentially life-threatening circumstances may be critical to soldiers' survival (Hoge, 2011). As such, the explicit focus on reducing the core symptoms of PTSD during the exposure components of PET, CPT, and EMDR may deter Veteran men from continuing therapy because it conflicts with the behaviours endorsed during military training and deployment (Jakupcak, Osborne, Michael, Cook, & McFall, 2006). Furthermore, emphasis on emotional processing may conflict with Veteran men's cultural norms of emotional suppression (Monson et al., 2004) and may serve as a barrier to developing rapport between client and therapist.

Fox and Pease (2012) emphasize that Veteran men experience shame in response to the occupational and social dysfunction traumatization brings. The experience of shame often stems from Veteran men's perception of failing to meet standards of masculinity (Good, Thomson, & Brathwaite, 2005) and the salient loss of his occupational identity as a soldier (Fox & Pease, 2012). Veterans may perceive the strong emotional states associated with PTSD as weakness or as a breach of traditional masculine norms (Jakupcak et al., 2006). As a result, a therapeutic problem arises from the fact that CPT, PET, and EMDR emphasize the mitigation of fear and anxiety but place little emphasis on the severe guilt and shame experienced by Veteran men (Fox & Pease, 2012).

Despite the tragedies experienced among military personnel with exposure to combat, many Veteran men do not perceive themselves as victims (Hoge, 2011). Rather, many Veteran men develop the core symptoms of PTSD in response to their experience as a perpetrator (Nash et al., 2013). The term *moral injury* represents alternative forms of combat stressors, such as killing another either directly or indirectly and committing atrocities towards civilians (Nash et al., 2013). However, historical conceptualizations of trauma are framed as a phenomenon

exclusive to victims (Fox & Pease, 2012). Likewise, PET, CPT, and EMDR are highly structured interventions underpinned by victim-based models of trauma (Foa, 2011; Foa & Kozak, 1986; Resick & Schnicke, 1992). Therefore, the generalization of these approaches to Veteran men highlights the areas of congruence and conflict between the worldview of Veteran men and the assumptions of trauma-focused therapies. Consequently, the underlying goals of these approaches may conflict with Veterans who adhere strongly to traditional masculine norms and those who do not identify as victims.

Social considerations also have implications for Veteran men with PTSD and the therapeutic environment (Laffaye, Cavella, Drescher, & Rosen, 2008). The fear of breaching traditional male norms may prevent Veterans from reaching out for the social support they need following deployment (Lorber & Garcia, 2010; Jakupcak et al., 2006) and, therefore, further alienates the Veteran men. Because evidence-based trauma therapies focus on the core symptoms of PTSD, little opportunity exists for exploring social factors, relational influences, and gender prescriptions within military culture that serve to maintain symptoms of PTSD (Fox & Pease, 2012).

As previously stated, the interaction between combat exposure and military cultural norms gives way to a unique symptom presentation among Veteran men with PTSD (Fox & Pease, 2012; Hoge, 2011). From a multicultural perspective, cultural values and beliefs play an important role in shaping individual responses to traumatic events (Tummala-Narra, 2007). Veteran and military populations constitute a culturally diverse clientele and traumatic experiences, such as combat exposure, occur within a unique cultural context influenced by military values, beliefs, behaviours, and traditions (Butler, Linn, Meeker, McClain-Meeder, & Nochajski, 2015; Tummala-Narra, 2007). As such, practitioner mastery in military values and behaviour remains a critical component to working effectively with military and Veteran populations (Butler et al., 2015; Smith, 2014). Furthermore, it is necessary that practitioners possess an understanding and willingness to explore elements of military culture (i.e., social factors, relational influences, and gender prescriptions) and their implications for exposure to traumatic events during military service (Bray, 2014; Butler et al., 2015; Smith, 2014). In doing so, practitioners hold the expertise and knowledge needed to balance an understanding of the broader influence of military culture (i.e., social factors, relational influences, and gender prescriptions) with the recognition that Veteran men, while influenced by cultural norms, are also individuals who have each experienced unique traumatic events that have influenced their life experiences in distinct ways.

Critical Appraisal of Research

Within the last 10 years, a growing body of research has investigated therapeutic approaches to treating Veterans with PTSD (Albright & Thyer, 2009; Bradley, Greene, Russ, Dutra, & Westen, 2005). However, these studies have focused almost exclusively on measuring changes in the three core symptoms of PTSD (Hoge, 2011). This oversight downplays the manner in which etiology, clinical presentation, and circumstance vary as a function of gender and subculture. Furthermore, the majority of the empirical research has overlooked factors that may inform gender-based modifications to treating PTSD in Veteran men, such as guilt and moral injury.

Few outcome studies have focused on the clinical features and characteristics unique to Veteran men (Hoge, 2011). Indeed, even if empirical studies in this area were able to investigate gender differences by recruiting more female participants, it is unlikely that any true differences between genders would be detected because of the tendency of investigators to focus exclusively on common factors of PTSD (Hoge, 2011). This is problematic because clinical experiences consistently find unique features of PTSD in Veteran men that extend beyond narrowly defined core symptoms (Hoge, 2011; Good et al., 2005). Therefore, the limited scope of measurement tools used in this body of research is further contributing to the absence of culturally relevant treatments for combat PTSD in Veteran men.

A great deal of literature discusses the role of guilt in maintaining PTSD symptoms (Gonzalez-Prendes & Resko, 2011). However, the nature and etiology of guilt among Veteran men has received less attention (Nash et al., 2013). Monson et al. (2006) studied the effectiveness of CPT in treating military Veterans with PTSD. In addition to the three core symptoms of PTSD, Monson and colleagues measured the construct of trauma-related guilt and its three subscales: global guilt, global distress, and guilt-related cognitions. Significant differences emerged between treatment and controls in measures of global distress but not in guilt-related cognitions or global guilt scores (Monson et al., 2006). The investigators concluded that the expression of guilt may have changed through CPT but the guilt itself had not been alleviated (Monson et al., 2006). These results suggest that exposure therapies do not sufficiently address guilt associated with combat-PTSD and support the notion that guilt may have a unique etiology in Veteran men (Nash et al., 2013).

The methods employed in empirical studies in this area have also contributed to a narrow definition of combat-related PTSD. The tendency to measure only the changes expected to occur (e.g., three core symptoms of PTSD) increases the likelihood of favourable results and gives the illusion that PET, CPT, and EMDR involve both necessary and sufficient components for treating the impact of combat exposure on Veteran men. Yet, evidence to support that these interventions capture the full scope of symptoms and suffering experienced by Veteran men is lacking. This is perhaps best illustrated by the clinical experiences of Monson, Price, and Ranslow (2005) and research conducted by Beidel, Frueh, Uhde, Wong, and Mentrikoski (2011). Monson et al. (2005) fostered emotional engagement in Veteran men with PTSD by incorporating therapeutic elements that addressed traditional male gender roles and observed enhanced effects of CPT in treating PTSD. Similarly, Beidel et al. (2011) compared two forms of therapy: exposure therapy combined with social-emotional rehabilitation and exposure therapy alone. Veteran men improved on all core symptoms of PTSD in both treatment conditions, but only those in the social-emotional rehabilitation condition experienced significant improvements in social and interpersonal functioning (Beidel et al., 2011). These results provide further evidence that exposure therapies are necessary, but not sufficient in treating Veteran men with PTSD and that reductions in core symptoms of PTSD do not translate to improvements in overall functioning.

Conclusion and Recommendations

Overall, the majority of research on Veteran men with PTSD targets only the core symptoms of PTSD. This presents challenges for counselling practice as preliminary research

demonstrates that exposure components of front-line interventions are necessary in reducing the core symptoms of PTSD, but they are not sufficient in improving the more chronic, unique clinical features of Veteran men. Evidence-based psychotherapies require adaptations informed by Veteran experiences, military cultural norms, combat exposure, and the practitioners who work with military men. To enhance the cultural responsiveness and relevance of psychotherapies for Veteran men with PTSD, it is crucial that practitioners recognize and address the ways in which social factors, relational influences, and gender prescriptions may influence individual Veteran men's responses to traumatic events. In moving forward, a concerted effort among researchers and culturally responsive practitioners is warranted. Future research should measure changes in the peripheral and chronic features of PTSD among Veteran men, and evaluate effectiveness and outcomes of cultural adaptations of trauma-focused, evidence-based psychotherapies for Veteran men.

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