Kentucky Counseling Association Journal

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Kentucky Counseling Association Journal

PRACTICE, THEORY, & RESEARCH

PROFILES

Mental Health Services for Military Veterans and their Families

Miles Matise

Over 2 million U.S. service members have been deployed to Iraq and Afghanistan since 2001 (U.S. Department of Defense, 2007). Based on data indicating that each U.S. service member has an average of 1.5 dependents the impact of these conflicts is far reaching (Monson & Snyder, 2012). This paper addresses the "changing-face" of modern warfare (e.g., moral injury, asymmetrical warfare). In addition to posttraumatic stress disorder (PTSD), high comorbidity and other behavioral challenges have indicated that mental health practitioners must be equipped to assess and treat these issues to aid service members more effectively.

Keywords: PTSD, moral injury, asymmetrical conflict, suicide, trauma treatment

Since 2001, more than 2 million United States veterans have served in Operation Enduring Freedom (OEF– Afghanistan) and Operation Iraqi Freedom (OIF– Iraq) (Sayer, 2011). According to the Veterans Health Administration (2009), approximately two-fifths of these veterans receive some kind of healthcare and social services through the Department of Veterans Affairs (VA). Of the remaining three-fifths, if they seek treatment, they do so through community resources. "Over one-third of veterans returning from deployment have a mental health diagnosis, and many more struggle with challenges of reintegration to family and civilian life" (Snyder & Monson, 2012, p. 301).

While not all returning veterans from OIF and OEF have a mental health diagnosis, most experience some kind of adjustment issues as they reintegrate into civilian and family life because the thoughts and behaviors needed to survive in war are not necessarily helpful in a civilian life-style. According to the United States Department of Defense Task Force on Mental Health (2007), mental health personnel lack the resources and are unable to meet the demands of service members and their families in a timely manner (as cited in Snyder & Monson, 2012). The purpose of this paper is to address the vulnerability of military veterans to certain psychological disorders from engaging in the wars in Iraq and Afghanistan. It will also summarize several evidenced-based treatments that are proven effective with disorders of this unique population.

The effects of war extend their influence and affect more than the individual combatant, to include family, friends, and even community. While more soldiers are surviving the visible wounds of war, they still may carry the invisible wounds of war, largely existential and psychological. Moreover, the diagnosis of posttraumatic stress disorder (PTSD) alone does not address the ethical dimension of combat trauma adequately, namely that of moral injury (Loeffler, 2013). Studies have shown that between 35–50% of veterans receiving care in the VA healthcare system have a mental disorder diagnosis (Brancu, Straits-Troster, & Kudler, 2011; Cohen et al., 2010) and according to the VA, approximately 27% of veterans from OEF and OIF have been diagnosed with PTSD (Bagalman, 2011). This number is probably underreported due to veterans' reluctance to seek treatment, while other veterans may seek treatment outside of the VA healthcare system or not at all.

What Makes These Wars Different?

According to Monson and Snyder (2012), the wars in Iraq and Afghanistan are different than the Vietnam War in that: (a) an all-volunteer

military is involved in OIF and OEF; (b) there is more reliance on Reserve and National Guard forces; (c) veterans are more likely subject to multiple deployments, rather than a single deployment; (d) there is an increase in physical and mental long-term disabilities (Milliken, Auchterlonie, & Hoge, 2007); (e) on the whole, service members are older; (f) the armies include more women serving; and (g) it is more likely that the current veterans will be married and have children, compared with prior generations of veterans. In 2009, approximately 50% of service members were married with 25% having dependent children. "Alongside traumatic brain injury, we believe that the 'signature wound' of the wars in Iraq and Afghanistan is the combat-related mental and physical health issues that adversely impact couple and family functioning" (Monson & Snyder, 2012, p. 6).

The Moral Crisis of a Just War

It is not new to recognize that combat in war can result in psychological malady. Shay (1995) coined the term "moral injury" to describe how "an essential part of any combat trauma that leads to psychological injury is that the moral dimension of trauma destroys virtue, and undoes good character" (p. 20). Litz et al. (2009) defined moral injury as "perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations" (p. 698). Moral injury requires an act of transgression that contradicts the individual's ethical beliefs and values.

Moral injury differs from PTSD in that PTSD is an extreme reaction to a traumatic event that affects and alters how your brain functions and adapts to the stressful event and its aftermath; manifestations of fear, flashbacks, nightmares, and hyper vigilant behaviors to cope with the recurring triggers then follow. Moral injury deals more with the ethical and existential issues concerning acts, behaviors, or events of a potentially traumatic situation; thoughts about what happened and a feeling of

violation or discord from one's closely held values then follow. This is often referred to as "cognitive dissonance" in which the person comes to a conclusion that they are behaving incongruently with their beliefs. More recently this has been referred to as "soul injury" (Brock & Lettini, 2012). Symptoms can be similar to those of PTSD, such as depression and anxiety and the potential to self-medicate by abusing substances to assuage the guilt and shame of what one has done.

Brock and Lettini (2012) contended that the wars in Iraq and Afghanistan have left soldiers uniquely vulnerable to moral injury. The aftermath of the mental torment of moral injuries may cause haunting or highly aversive states for the victim. The soldier may exhibit emotional responses, including guilt, shame, anger, and anxiety. Additionally, behavioral manifestations resulting from moral injury may include: self-harming, such as suicidal attempts or ideation; self-condemnation and withdrawal; characteristics of self-handicapping, such as drug and alcohol abuse; and a sense of purposelessness, social instability, and alienation (Nash & Litz, 2013). Additionally, the condition of moral injury can result in the emotional numbing, avoidance of symptoms, and re-experiencing of the event, much like symptoms of PTSD (Polusny et al., 2011). More than just suffering, this materialization of moral injury leads to a possible array of negative behaviors. It comes down to a loss of confidence in one's own ability to make a clear moral judgment, rather than a case of "right" or "wrong."

Although war killings can be a precursor to moral injury, it is imperative to recognize that not every war killing results in negative outcomes for veterans. However, certain factors need to be present for the occurrence of moral injury, such as a supposed transgression, which goes against shared or personal moral expectations (Loeffler, 2013). The psychological and emotional effects of combat are often referred to as the "hidden wounds of

war." Whether a person is spiritual, religious, or secular, moral injury can challenge one to question the very assumptions we are taught in the culture we are embedded. Moral injury and other combat-related traumas, such as PTSD are not simply private individual problems cured by medicine and psychotherapy. These are larger social challenges that require engaging family, communities, and society as to the moral questions about decisions to go to war (Brock & Lettini, 2012).

Factors of Asymmetric Warfare

In conventional warfare, a small number of high level commanders make the ethically challenging decisions, but in the case of asymmetrical conflict, the ethically challenging decisions fall on the shoulders of the soldiers on the ground. These high levels of moral challenges for the soldiers mean that they are exposed constantly to actions and choices that challenge their moral codes and mental comfort, leaving them open to developing mental illness as a result of the constant tension between their conscience and the decisions they have to make (Brock & Lettini, 2012). The moral responsibility that comes with participating in asymmetrical combat has served to increase the numbers of veterans who suffer from mental health issues, such as mental illness, depression, and PTSD.

Asymmetrical conflicts shift the way in which forces wage war and requires rethinking what is permissible killing (Gross, 2010). Gross (2010) asserted that efficacy takes a priority over humanitarianism because the necessity is that there is always an exception and thus justification to the killing of those considered "enemy combatants" whether it is a country, a person, a group or otherwise. These new norms and boundaries of war are justified by "national interest" and "emergencies" when they occur.

Since the terrorist attacks on September 11, 2001 a global counter-terrorism style of warfare of the 21st century, called asymmetrical warfare is replacing the just-war tradition (Bell, 2012).

Asymmetric conflict normally involves two forces differing greatly in their resources. One of the forces has greater military capacity compared with the opposing forces. The norms and conventions governing conventional conflict were not designed to deal with asymmetric warfare, which is the face of modern warfare (Bell, 2012). In such instances, the lesser-resourced force cannot afford to take on the more endowed military force in the same way, and they have to adopt novel tactics and innovations in the way they approach their adversary. That makes the war unconventional, creating situations where the enemy combatants are forced to be more aggressive and brutal in their quest for victory. The tactics employed become more gruesome, creating situations of extremism. The experiences witnessed in asymmetric conflict are fertile grounds for traumatic experiences that can result in PTSD and involve many situations that present moral issues for the soldier (Bell, 2012).

With close to 2 million military service members taking part in OIF and OEF, the unique stress of multiple deployments and reintegration back into their communities make for various difficulties (Carrola & Corbin-Burdick, 2015). The type of warfare soldiers are being asked to conduct, make it an ethically complex form of war, as well as the political policies for entering the war, which contribute to the blurring of moral, ethical, and legal guidelines soldiers have to follow (e.g., international laws, treaties, public policy, court rulings) (Moten, 2010). The conflict between a soldier's duties and conscience can lead to situations in which a soldier's moral compass may be challenged and even violated. For instance, in OIF and OEF, the lesser-resourced side can resort to guerilla tactics that inflict personalized attacks whose impact is very devastating to soldiers. The experiences resulting from such unconventional warfare activities can create situations where traumatic experiences are more probable for those involved (Brock & Lettini, 2012). The effects

of asymmetrical warfare are more personalized in nature, thus prompting the events potentially to have a more severe traumatic affect. The personal nature of unconventional warfare makes the events of war potentially more traumatizing than they would be otherwise (Brock & Lettini, 2012).

Posttraumatic Stress Disorder

The Vietnam War inspired more empirical research that heightened public and professional awareness of mental health disorders among soldiers and veterans and was a major reason for the inclusion of PTSD in the third edition of the DSM (American Psychiatric Association, 1980). Traumatic experiences that led to PTSD in veterans returning from OEF and OIF involved exposure to knowing another soldier who was injured or killed in combat, killing an enemy combatant, or being shot at (Hoge et al., 2004).

Symptom related behaviors may be delayed as a result of the relief of returning home and signs of this disorder may be masked until the veteran engages in work and social functioning (Sundin, Fear, Iversen, Rona, & Wessely, 2010). This can leave the veteran with a false sense of whether or not he or she is truly suffering from a mental disorder or PTSD. For veterans, this can have a debilitating effect on their ability to form necessary work-related associations, rendering them unemployable, challenging marriages and families, and generally making their reintegration into civilian life difficult (Litz et al., 2009).

The PTSD Debate

There is an ongoing debate on the renaming of PTSD focused around the word *disorder*, which is thought to be stigmatizing and making many soldiers experiencing symptoms of PTSD and other psychological disorders reluctant to ask for help (Ochberg, 2012). Critics have urged a change to rename PTSD to something perceivably less stigmatizing and more accepting among military culture, with the hopes that more treatment would be sought among those who are suffering.

Since its inclusion in the third edition of the *Diagnostic and Statistical Manual*, PTSD, as a diagnosis, was created as an effort to legitimize the suffering of Vietnam War veterans, as well as to convince insurance companies to pay for treatment. Tedeschi and Calhoun (1995) coined the term *Posttraumatic Growth*, trying to put more of the focus on the sufferer's personal strengths and a more optimistic view of recovering from the trauma. In 2000, the Canadian Military invented the term *Operational Stress Injury* (Veterans Affairs Canada, 2014).

Chairelli (2011) proposed an alternative name – *Posttraumatic Stress* – to drop the word "disorder" from the diagnosis, believing that the word indicated a preexisting condition and was therefore thought of as "weakness" among military personnel. In 2012, trauma psychiatrist, Ochberg led an effort to rename PTSD to *Posttraumatic Stress Injury*; instead, proposing to shift the focus from the person as "disordered" by arguing that the trauma changes the physiology of the brain and is more accurately identified as an injury from an outside force.

The goal of changing the name of the disorder, is to reduce the stigma of suffering from a psychological injury while ultimately encouraging soldiers to seek mental health care in a timely fashion. Trauma researcher, van der Kolk (2012) believed that a name change was a waste of time, stating that the DSM is a product of our cultural mores and beliefs, in which categories, diagnoses, and wording change with each revision of the DSM, and professionals will always have disagreements about diagnoses.

Suicidality in an Overstressed Military

The Army Study to Assess Risk and Resilience in Service Members (Army STARRS) was one of the largest studies of mental health risk and resilience conducted (Kessler et al., 2014).

Findings revealed that suicidality was not only among deployed soldiers but also those who never deployed. Nearly half the population sampled reported suicidal thoughts prior to enlisting in the military. Soldiers reported higher rates of certain disorders, such as attention deficit hyperactivity disorder, intermittent explosive disorder, episodes of extreme anger and violent behaviors, and substance abuse disorders, than the general public. An increased risk of suicide among females who were deployed compared with men, and a correlation between demotion and suicide risk and level of education were noted (Kessler et al., 2014). Soldiers without a high school diploma or its equivalent, as well as white males, were at the highest risk of suicide. These studies provided much needed information to develop strategies and treatment options to combat suicide in the military by advocating and strengthening protective factors of the individual.

A United States military study established that there were as many as 5000 veteran suicides annually (Litz et al., 2009). Studies also reported a prevalence rate of 20% for PTSD and depression amongst all Iraq and Afghanistan veterans. Despite this high prevalence rates, the study's authors also noted that only about 50% of those exhibiting PTSD and depression sought help for these complications.

Suicides in the military during OIF and OEF have increased and in 2012, averaged nearly one a day with totals having exceeded United States combat deaths so far in OEF in Afghanistan (Burns, 2012). In 2012, suicide rates among full-time soldiers increased to 29.7 deaths per 100,000 soldiers, above the 25.1 per 100,000 civilians' rate (Zoroya, 2014). Suicides, particularly in the Army, have increased, and in the Army National Guard, the suicide rate among men was 34.2 per 100,000 soldiers in 2012, which was higher than other branches (Zoroya, 2014). According to the Department of Defense, suicide rates are especially high among veterans age 30 to 64 years of age (Miles,

2010). Male veterans commit suicide at a higher rate than their female counterparts, but female veterans have close to twice the suicide rate compared with females in the general population.

In the general population, suicide completion risk factors include being male, having access to a firearm, and having a co-occurring medical condition and mental health problem (Zoroya, 2014). Other stress factors often are a role in increasing the probability of suicidal behavior among individuals. Individuals who are divorced, widowed, experiencing financial difficulties, living alone, and are unemployed are at a higher risk (Perlis & Stern, 2004). In the military, however, it is noted that primary risk factors for suicide are romantic, occupational, and legal difficulties (Nelson, 2004).

According to Sundararaman, Panangala, and Lister (2008), this profile describing people most at risk for suicide in the general population, also describes OIF and OEF veterans. Other risk factors for veterans include frequent deployments; experiencing traumatic events when deployed; service-related injuries; mental and behavioral health issues; and traumatic brain injury; and all increase the likelihood of suicide behaviors (Brancu, et al., 2011). Jakupcak et al. (2009) found that veterans diagnosed with PTSD were up to four times more likely to have thoughts concerning suicide – often a predictor of carrying through – than those not diagnosed with PTSD.

With more female service members than ever before, it is reported that more female service members are likely to divorce compared with male service members, with female enlistees three times more likely to divorce (Karney & Crown, 2007). Because female service members are more likely to be married than their male counterparts, this can cause increased stress and tension between job-related duties and home responsibilities, especially with a dual-working family, and if children are

involved, placing this population at risk for suicide (Snyder & Monson, 2012). Mansfield et al. (2010) reviewed the medical records of over 250,000 Army wives, accounting for over 6.5 million outpatient visits. It was found that those wives with a deployed husband were more likely to be diagnosed with and receive services for a mental health disorder compared with those who did not have a spouse deployed and that these numbers increased the longer the deployment.

Evidence-based Treatments

Evidence-based practice (EBP) generally refers to the application of research findings to the treatment of clients (Tanenbaum, 2005). More specifically, EBP is the integration of the clinician's expertise, client values, and research evidence in making the best decisions for client care (Sackett, 2002). EBP is not only reliant on outcome research, but also takes into account the client's values and the professional judgment and expertise of the counselor in order to make a collaborative and informed decision for treatment. While there is some debate on how evidence is defined in EBP for the social sciences, it is noted that in medical research- where the term was first coined- it is very different when you are testing medication and its efficaciousness versus mental health issues and all the factors involved that relate to whether or not a treatment is efficacious or not. That being said, Chambless, Baker, et al., (1998) purport a criteria for efficacious psychological treatments. For a psychological treatment to be considered efficacious, the evidence base supporting it must involve at least two experiments showing the treatment is superior (statistically significant) to a control group (Chambless, Baker, et al., 1998). The following list of treatments in this paper have met or exceeded the criteria for efficacious EBP.

In the treatment of trauma, three primary components need to take place (van der Kolk, 1994; van der Kolk, McFarlane, & Weisaeth, 2012): processing and coming to terms with the

horrifying experience; controlling and mastering the physiological and emotional reactions to the stress; reestablishing secure social connections and interpersonal relationships. Trauma specialists contend that trauma needs to be treated differently at different phases of a person's life and thus recommend a "phase oriented treatment" modality (Foa, Hembree, & Rothbaum, 2007; Herman, 1992; van der Kolk, 1994). For example, stress inoculation may be more effective in the initial stages of trauma treatment to prepare the individual to enter a middle-phase of treatment, whereas with prolonged exposure, using flooding techniques may be more effective. At a later phase of treatment, the aim of therapy may be to teach skills to help stabilize and encourage reintegration into one's social milieu.

Cognitive-processing Therapy

The American Psychological Association (2014) has sanctioned several evidence-based treatments for treating combat- related trauma. Cognitive-processing therapy (CPT) is a form of cognitive behavioral therapy (CBT) and focuses on the traumatized person's thought processes to change negative, irrational, and unrealistic messages a person thinks about themselves and their environment. CPT also adds an exposure component to assist with desensitizing the person to triggers for their trauma.

Trauma- Focused Cognitive Behavioral Therapy (TF-CBT) is a model based on the core concepts of CBT and adds a narrative component, in which the person writes about their trauma experience to assist in modifying cognitive distortions (J. Cohen & Mannarino, 2008). TF-CBT is designed to help individuals affected by trauma to such an extent that they fail to function in society (Fontana & Rosenheck, 1999). It is designed to help the affected person take out some of the intensity from the memories of the traumatic event. This helps in eliminating the excessive anxiety and

behavior that makes it hard to live with others and to function effectively in social settings.

Prolonged Exposure Therapy

Prolonged exposure therapy (PET) was developed to assist persons who have experienced trauma by gradually exposing them to remembering the experience (Foa et al., 2007). Through repetition and in a controlled fashion, slowly exposing the person to remembering their experience can help them to gain a sense of mastery over their thoughts toward the experience, as well as their feelings about the trauma. Eventually, the person is not as reactive to triggers, thoughts, and feelings related to their past trauma due to gaining a greater sense of self-mastery.

PET is a process whereby emotional disturbances are absorbed (processed, integrated, and neutralized) to the extent that other, *more healthy* behaviors and experiences can proceed without disruption (Foa & Kozak, 1985; Foa et al., 2007)). Cognitive structures in our memory organize our knowledge (i.e., fear structure), and a fear structure includes information about the feared stimuli (objects, people, situations), including fear responses and meaning of the feared stimuli. Activities that promote emotional processing include repeated exposures, rehearsals, talking, habituation, catharsis, and relaxation (Foa & Kozak, 1985; Foa et al., 2007).

Eye-movement Desensitization and Reprocessing

According to the clinical division of the APA, EMDR, exposure therapy, and stress inoculation therapy were listed as empirically supported for the treatment of PTSD. EMDR is based on the information processing model that posits that traumatic experiences are stored in memory in a state-specific form, including the person's cognitive and affective state of mind at the time of the trauma (Shapiro, 1995).

The working assumption is that the symptoms of PTSD are caused by disturbing memories stored in the nervous system, in the same form in which it was initially experienced, and has been blocked for some reason (Shapiro, 1995 Shapiro & Maxfield, 2002). Due to the imbalance of the information processing system, information is stored at the time of the traumatic event, such as what was seen, felt, smelt, sounds, and other sensations, which are then frozen in that state and not processed properly. Even though the experience may have happened in the past, similar images, smells, and sensations can trigger it, interrupting the functioning of the affected person's life, in the way of dysfunctional behavior, addictions, and cognitive distortions (Shapiro, 1995; Shapiro & Maxfield, 2002). There are eight phases of treatment for best practices, and it is imperative to follow them when applying EMDR with traumatized persons to ensure the best results and recovery.

Group Therapy and Letter Writing

Because of the tendency of an individual to personalize their traumatic life experience, a key component of any treatment for individuals suffering from trauma is to help them integrate the unacceptable and terrifying experience that they now identify with and may be stuck on (van der Kolk, 1994). Group therapy is a therapeutic outlet for the integrating of a person's traumatic experience by talking about within the safety of a therapeutic group, facilitated by a trained mental health professional. Critical elements for treating trauma and moral injuries include the telling of one's story. It is imperative for the soldier to feel safe enough to tell and often retell his or her story and feel heard in validating way (Dewey, 2004). The "communalization of the trauma" and storytelling has significant effects on the restoration of character and personhood for the traumatized soldier (Keenan, Lumley, & Schneider, 2014; Shay, 1995). Keenan et al. (2014) indicated that soldiers suffering from moral injury or trauma are often not given the opportunity of "telling their story" and "being fully heard." A group format gives a soldier the opportunity to share with others who may have

suffered similarly or to listen to how other soldiers tell their story and thus integrate and assimilate the traumatic experiences into conscious awareness.

Group work can be essential in overcoming detachment and reestablishing connection with others who can offer a healing presence to lean on (Keenan et al., 2014). Group work can inspire the grieving process, which is essential in the healing of loss. "Loss" in the life of a veteran can be the loss of a comrade; the loss of innocence; the loss of a moral compass; loss of a way of life due to what they have seen and experienced. Loss can come in various forms; however, the psychological process of dealing with loss is to grieve. The combatant cannot grieve while in battle due to feeling vulnerable and thus unsafe. This state of mind often carries over into civilian life after returning and act to paralyze them psychologically from reintegrating back into a normal way of life (Keenan et al., 2014). Group therapy is essential in helping soldiers regain a sense of safety, and the telling of their stories with other soldiers who have a shared history of trauma is effective in creating community and shared support.

Eventually, the letter writing technique is introduced within the group context as a way of making amends and repairing a relationship with the transgressed. It also leads to reconnecting with the veteran's feelings about the situation and transgression experienced. Often soldiers have repressed these memories in order to survive on the battle field, albeit at great cost to their psychological well-being. A letter is written by each group member concerning his or her grief, shame, guilt and is then read aloud to the rest of the group. The third phase of treatment is "aftercare" and focuses on reconnection of group members in previously avoided activities in the community to bolster connection with others as a supportive resource to maintain the gains of group work. This phase can last up to a year according to Keenan et al. (2014).

Adaptive Disclosure Therapy

According to Gray, Schorr, et al., (2012) Adaptive Disclosure (AD) takes into account the unique aspects of military service in war by addressing difficulties such as moral injury and traumatic loss. The researchers evaluated 44 marines who received AD treatment and found it was well tolerated, brief, and significantly reduced symptoms of PTSD, depression, negative posttraumatic appraisals, and associated with increases in posttraumatic growth (Gray, Schorr, et al., 2012).

Adaptive disclosure therapy is a self-forgiveness intervention. Litz et al. (2009) asserted four foundational assumptions to care for the morally injured soldier. The first assumption is that the morally injured soldier possesses a moral belief that can be injured and thus repaired. The second is that healing includes processing the memory or the injury at an emotional level and to identify and dispute negative self-judgments within the safety of a caring community. The third assumption is that those who are morally injured need a forceful "contradictory experience." The fourth is that there is no short cut to healing. The key is for the soldier to obtain clarity on what happened and to determine what it means to "move forward" in terms of forgiveness and hopefulness (Litz et al., 2009).

Adaptive Disclosure entails an eight-step treatment strategy that considers elements of the military phenomenology so that challenges, such as traumatic loss and moral injury, are addressed (Maguen et al., 2009). The method approaches the situation by selecting whether the war event was fear or life threatening and capitalizes on exposure as a sole approach. When the distress is due to the loss of an ally, patients are encouraged to have an imaginary dialogue with the deceased, and the dialogue is emotionally evocative and in real-time (Bernstein, 2005). Moral injury victims are aided through the dialogue carefully, with a compassionate and forgiving moral authority,

often a counselor, pastor, or other healing presence.

The last of the eight steps in Adaptive Disclosure is geared toward identifying times when the transgression will intrude or reappear in the soldier's life and how will he or she cope with this challenge. It is a future rehearsal of if the past event will arise and demand attention from the person who committed the act. The goal is to foster greater awareness of the individual as to how and when to reach out for professional help (Maguen et al., 2011).

Ecopsychology

Buzzell and Chalquist (2009) described ecopsychology as a term that encompasses various treatment models that focus on the natural environment as a source of healing for individuals. Assumptions underlying ecotherapy include: (a) Modern people living in industrialized nations are more disconnected from the natural world, which is an indicator of psychological maladies, such as anxiety, depression, increased stress, and interpersonal conflict; (b) Reconnection to the natural world, whether plants, animals, gardening, or walks in nature can help reduce symptoms of isolation, loneliness, anxiety, and depression (Chalquist, 2009). This process of reconnection tends to make a person feel more alive in a sensory capacity and a part of a greater whole, more than just with other people, to counter the sense of isolation and inner numbness.

Because such a large part of healing in trauma work is reconnecting the individual with themselves and others, ecopsychology is promising in its evidence as a catalyst for healing (Buzzell & Chalquist, 2009). Soldiers, while in a combat setting, were most likely exposed to a more natural environment with less modern comforts, thus disconnecting them from their experience of self and others, so their return to civilian life could be a shock to their psychobiology. Not only the restoration of psychological well-being but the potential savings in medical costs makes ecopsychology

a viable option in the treatment of combat-related trauma (Buzzell & Chalquist, 2009).

Spirituality as a Resource for Trauma

Walsh (2009) noted that the Vietnamese term for PTSD is "spiritual sadness." She contended that spiritual sadness or distress is an inability to invest life with a sense of meaning. Religious practice and spiritual rituals have long been used as solace in consoling the wounded soul of a person. These practices have helped people create meaning out of suffering, tragedy, and loss in their lives.

Koenig (2013) led a study of a systematic review of every study in the English language in a health science journal that measured religious or spiritual involvement and health outcomes. He found that religious practice of one's beliefs was related consistently to higher levels of emotional health and well-being. In particular, religious practice was associated with lower rates of coronary heart disease; lower blood pressure; better immune and endocrine function; lower rates of cancer; greater longevity; and overall health. Koenig (2013) revealed that individuals who engage in religious practices are less isolated, have more social support, and live healthier lives, perhaps due to religious expectations and accountability. Individuals who engage in religious and spiritual practice tend to have a more positive outlook on life, themselves, and world events, thus also affecting their physical health and mental well-being positively.

The crisis of combat can existentially challenge a soldier's belief system. Spiritual and religious belief systems have the power to shape a person's world view by giving an explanation for history, current experiences, and future outcomes, as well as ultimate meanings about life, purpose, and death (Campbell & Moyers, 1988). While these beliefs and practices can be valuable assets to a soldier's recovery from trauma and restoration to self and others, it is imperative for treatment providers not to impose our personal or cultural template

of spirituality to them. While approximately 86% of Americans believe in God, a higher power, or a universal spirit (Gallup, 2008), a person's conception of God and of how their beliefs guide their ethics varies. In terms of treating trauma, religious and spiritual practices, such as prayer, meditation, and rituals, can be valuable as adjuncts to other treatments and restoring interpersonal relationships with family, friends, and community (Campbell & Moyers, 1988).

Implications for Counselors

The unique stresses of deployment and combat related issues for individuals and families leave their mark in the way of symptoms, disorders, interpersonal struggles, and displacement. These unique stressors can also extend to the treatment providers helping these individuals and their families by way of "vicarious trauma" and compassion fatigue. It is essential for professionals to remain resilient by addressing their own needs in therapy as needed and to maintain their own social networks for support. Recognizing and addressing the signs of burnout, fatigue, irritableness, and ineffectiveness need to give counselors pause for reflection and to take action so that they remain intact as healthy individuals. If counselors are not in a state of health and wellness, then they are less likely to be as effective in helping others achieve stability and mental well-being. Knowing when to seek additional support is essential for counselors who treat victims of trauma. Other factors to consider are the changing definitions and rationales for trauma, especially in the DSM edition 5 (APA, 2013). Because there is much debate on the variable definitions of trauma and diagnostic criteria, this may contribute to uncertainty and thus low counselor self-efficacy in treating survivors of trauma (Jones & Cureton, 2014).

Conclusion

Treatment for veterans of OIF and OEF is largely dependent on the identification of the mental health issues affecting the veteran. Treatments are done by utilizing psychotherapy, medications, group therapy, and other forms of treatment modalities that may serve as adjuncts to healing. A combination of these methods of treatment is also employed in treatment regimens for mental illnesses. Veterans of the United States military obtain medical care from select medical centers that take care of their physical and mental health services (Fontana & Rosenheck, 1999). However, many of these medical centers have long waiting times and inadequate service personnel to deal with the large numbers of veterans that require help. Many veterans, if they seek treatment at all, may do so in community mental health settings or with private practitioners. There is an increased promotion to implement EBP in the field of mental health that requires counselors to utilize skills, such as exploring the diversity of client's values, researching the literature, and applying evidence from the research literature to deliver the most efficacious treatment for clients. The changing-face of modern warfare is complex and will require counselors to be equipped to assess and treat these issues. "While it is known than not all combat wounds are physical, the moral dimension of psychological injury remains unexplored within mainstream mental health" (Loeffler, 2013, p. 3). It is our role as counselors to help alleviate the suffering of those who struggle from these unseen scars.

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Multicultural Considerations for Counseling Military Personnel and Veterans with Co-occurring PTSD and SUD

Shedeh Tavakoli, Nicole M. Zook, and Greg S. Hall

The crisis mental health needs of U.S. military veterans have reached a significant magnitude. A "one-size-fits-all" treatment plan to care for veterans with co-occurring Posttraumatic Stress Disorder (PTSD) and Substance Use Disorder (SUD) is currently common practice, despite the diversity in today's armed forces. A review of existing literature revealed a lack of empirical studies examining culturally sensitive interventions for co-occurring PTSD and SUD. Treatment options for counseling veterans with co-occurring PTSD and SUD have been proposed and examined, but none specifically address the needs of ethnic minority veterans. Within the context of empirically supported interventions, we suggest possibilities for infusing cultural considerations throughout the assessment and treatment planning process.

Keywords: veterans, posttraumatic stress, substance use disorder, multicultural, treatment

Current U.S. military personnel and veterans experience a wide range of mental health concerns. According to the U.S. Department of Veterans Affairs, the most widespread diagnoses among veterans are Posttraumatic Stress Disorder (PTSD; 21.8%), depression (17.4%), and – among younger veterans – high rates of co-occurring PTSD and Substance Use Disorder (SUD; Seal et al., 2009). A study of 602 veterans conducted by Forman-Hoffman et al. (2005) revealed that 32% of those surveyed had an existing mental health disorder. Generally, many U.S. veterans from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) returned home from combat with PTSD (Hoge, Auchterlonie, & Milliken, 2006). According to research findings, there is also an increase in cases of SUD among veterans from OIF and OEF (O'Brien, Oster, & Morden, 2013; Wilk et al., 2010).

Hoge et al. (2006) conducted a study of army soldiers and marines deployed to Iraq, Afghanistan, and other locations and found prevalence of mental health related problems as high as 19.1% among OIF veterans, 11.3% among OEF veterans, and 8.5% among veterans who served in other locations.

Starting in 2005 there has been a significant increase in incidence of death by suicide among U.S. veterans. An alarming estimate shows the number of deaths by suicide increased by 22 veterans per day from 2005 to 2010 (Kemp & Bossarte, 2012). Furthermore, research shows alcohol and substance abuse to be highly correlated with suicide risk (LeardMann et al., 2013). The rising trend in suicide rates and an upward spike in diagnosis of PTSD and SUD have led researchers to examine potential risk factors (Ramchand, Acosta, Burns, Jaycox, & Pernin, 2011). Characteristics such as marital status, pay grade, and race/ethnicity have been predictive of mental health-related concerns among veterans (Armed Forces Health Surveillance Center, 2008; Clinton-Sherrod, Barrick, & Gibbs, 2011).

Compared to White American veterans, ethnic minority veterans are more likely to develop PTSD and other mental health related complications (Alegría et al., 2013). There are marked differences in development of PTSD across ethnic minority groups. Roberts, Gilman, Breslau, Breslau, and Koenen (2011) reported that lifetime prevalence of PTSD was highest among

black veterans, intermediate among Hispanics and whites, and lowest among Asians. Additionally, alcohol and substance abuse among ethnic minorities in the U.S. particularly among Latino veterans, is higher than SUD among White Americans (Guerrero, Marsh, Khachikian, Amaro, & Vega, 2013).

The number of ethnic minority veterans in the U.S. military services has steadily increased over the past decade (National Center for Veterans Analysis and Statistics, 2014). With White veterans receiving care at disproportionately high rates, it is up to the mental health community to raise important questions regarding the needs of ethnic minority veterans. We must assess whether ethnically diverse veterans are reaching out for support for their mental health needs, if current interventions may be driving ethnic minority veterans away from care, or if current approaches are not addressing stigma surrounding impaired mental health that can be found in some ethnically diverse communities. The August 2014 enactment of the Veterans' Access, Choice, and Accountability Act requires more hiring of mental health counselors by the VA and more referrals to providers outside the system (2014). Civilian counselors will inevitably be facing veterans with co-occurring PTSD and SUD; and with higher rates among ethnic minority veterans, it is critical that counselors are able to provide culturally appropriate interventions for the nation's veterans. As an attempt to help counselors prepare, we provide a review of literature on co-occurring PTSD and SUD, briefly review interventions that address both conditions concurrently, and offer suggestions for incorporating multicultural considerations into clinical practice with veterans.

Co-occurring PTSD & SUD

A high rate of co-occurring PTSD and SUD has been reported in several epidemiological studies (Creamer, Burgess, & McFarlane, 2001; Kilpatrick et al., 2000; Petrakis, Rosenheck & Desai, 2011).More recently, Gielen, Havermans, Tekelengburg, and Jansen (2012) found a significantly high prevalence rate of co-occurring PTSD and SUD in clinical populations – in fact, they found that rates are much higher than clinicians assume. SUD and PTSD substantially affect the military veteran population, as the prevalence rate for PTSD and SUD among veterans between the ages of 18-53 is 18.2%, about five times the rate for general population (Substance Abuse and Mental Health Services Administration, 2007). The prevalence of PTSD and SUD is three times higher among veterans from OIF compared to OEF veterans, but research has demonstrated a high prevalence of PTSD, depression, and SUD among veterans returning home from both conflicts (Hoge et al., 2004; Hoge et al., 2006; Milliken, Auchterlonie, & Hoge, 2007; Seal et al., 2011).

There is ample evidence of concurrent PTSD and SUDs in today's U.S. veterans (Stecker, Fortney, Owen, McGovern, & Williams, 2010). An astonishing finding showed cannabis use disorder has increased more than 50% in the past seven years among veterans. Additionally, incidence of PTSD and other psychiatric disorders was higher among cannabis users. This cohort of veterans was also less motivated to engage in treatment, particularly among veterans with co-occurring disorders (Bonn-Miller, Harris, & Trafton, 2012). Among OIF/OEF veterans surveyed, 33% had a high rate of "problem drinking," but again, very few utilized mental health or substance abuse services, and an even smaller number actually remained in treatment (Najavits, Norman, Kivlahan, & Kosten, 2010). The specific relationship between PTSD and SUD is unclear and often muddled by other variables; however, studies show alcohol is the most frequently abused

substance among individuals with PTSD (Calhoun, Elter, Jones, Kudler, & Straits-Tröster, 2003). Petrakis and colleagues (2011) found that among veterans with mental illness, the rate of SUD ranged from 21-35%. Further examination of their study revealed that 26% of White, 27% of White Hispanic, 29% of Black Hispanic, 56% of Black, 44% of American Indian, and 16% of Asian veterans with mental illness also had a co-occurring SUD. Notably, Black and American Indian veterans had the highest rate of comorbidity compared to other groups (Petrakis et al., 2011).

McLeod et al. (2001) have proposed several possible hypotheses for the high prevalence of co-occurring SUD and PTSD among veterans. One potential theory is the "shared stressor hypothesis," which states the rate of combat exposure determines PTSD symptoms and SUD. Their second postulation is the "consequence of PTSD hypothesis," which claims that SUD stems from PTSD and is used as a means for self-medicating and avoiding the negative symptoms of PTSD. Their third supposition, "shared vulnerability hypothesis," draws an association between environmental (shared experiences within the family) and genetic factors and comorbidity between PTSD and SUD (McLeod et al., 2001). Although McLeod et al. have some evidence for their three proposed hypotheses, contemporary researchers have suggested that focus on combat exposure has hindered understanding of how other important factors affect mental health outcomes among veterans (James, Van Kampen, Miller, & Engdahl, 2013). Thus, exploration and review of potential risk and protective factors are merited.

Risk Factors

A prior history of stressful life events such as childhood sexual abuse among Vietnam veterans has been shown to have a strong correlation with combat-related PTSD (King,

King, Gudanowski, & Vreven, 1995). A more recent study also found a relationship between reported childhood physical or sexual abuse and PTSD and SUD diagnosis among veterans (Koola et al., 2013). Additionally, comorbidity of mental illness and other factors increases suicide risk among veterans (Brenner, Homaifar, Adler, Wolfman, & Kemp, 2009). For example, OIF/OEF veterans with neuroticism and ideations of perceived threat showed significantly more PTSD and depressive symptoms at 6, 12, and 24 months post-deployment (James et al., 2013); however, these two factors were not associated with alcohol misuse among the study sample. Nunnink, Goldwasser, Afari, Nievergelt, and Baker (2010) found a trend toward increased problematic alcohol consumption among both active duty and reservist female OIF/OEF veterans and a significant relationship between SUD and PTSD. Other findings suggest risk for problematic drinking increases for those in lower pay grades, individuals 25 years of age and younger, and females (Bray & Hourani, 2007; Nunnink et al., 2010). In addition, factors such as marital status, such as being single and never married, (Seal et al., 2011) and being of ethnic minority status (Jacobson et al., 2008) have been linked to co-occurring PTSD and SUD, as well as help-seeking behavior.

Research on ethnicity and its association with mental illness development in veterans is limited and the results have been inconsistent. Many influences contribute to the discrepancy of findings in research studies, including use of unreliable instrumentation and variability among samples and geographic locations (Friedman, Resick, Bryant, & Brewin, 2010). Despite research limitations, there is an irrefutably consistent theme across most studies showing that ethnic minority veterans are at a higher risk for co-occurring PTSD and SUD

(Dohrenwend, Turner, Turse, Lewis-Fernandez, & Yager, 2008; Jacobson et al., 2008). Some authors (e.g., McLeod et al., 2001) related their findings to greater combat exposure. However, other studies of veterans who served in the Persian Gulf War revealed that ethnic minorities were more vulnerable to psychological risk, regardless of war-zone exposure (Sutker, Davis, Uddo, & Ditta, 1995).

Ethnic Minority Status

Studies demonstrate ethnic minority veterans are more likely to develop PTSD and other mental health problems compared to non-Latino White veterans (Stephens et al., 2010). The study by Roberts and colleagues (2011) mentioned above clearly demonstrated patterns of lifetime PTSD varied by ethnicity, with Black veterans having the highest rates. In another study, Vazan, Golub, and Bennet (2013) examined the prevalence of SUD and other mental health disorders among minority veterans who returned to low-income minority New York City neighborhoods between 2009 and 2012. They found overall prevalence of PTSD, traumatic brain injury, and depression was about 20% in their sample. The estimated prevalence rate of alcohol use disorder was 28%, drug use disorder about 18%, and SUD 32%. Furthermore, only 40% of veterans with any diagnosis received some form of treatment. For alcohol use disorder, the estimate of unmet needed treatment was 84% (Vazan et al., 2013). Such high rates of unmet mental health needs are alarming and demand further investigation.

Certain ethnic groups that have historically been oppressed by mainstream society may be more vulnerable to development of PTSD (Brave Heart, 1995, as cited in Diller, 2011). Some experts in the field of substance use and racism consider addiction to be a derivative of discrimination, poverty, and the absence of opportunities

(Reid, 2000). However, it is advised that this association not be interpreted as ethnic stereotyping. It is important to explore how particular ethnic groups view mental illness and substance use.

According to Brown and Landrum-Brown (1995), there are varying worldviews of help-seeking versus "saving-face" behaviors. Many cultures believe asking for help is humiliating and will result in loss of dignity and pride in the community, so its members do not seek mental health services in order to "save face." For example, the Hispanic/Latino culture considers family a priority (*familismo*), and family is the first choice of support (Andrés-Hyman, Ortiz, Añez, Paris, & Davidson, 2006). A similar worldview is found in the African American culture, which relies considerably on the support of extended kinship (Hines & Boyd-Franklin, 2005). Such varying worldviews and cultural factors are present in minority veterans prior to deployment (Lincoln & Sweeten, 2011) and are often reinforced in the military culture (Vogt, 2011). As a result of the culture, minority service members may be highly susceptible to stigmatization (Greene-Shortridge et al., 2007; Wright et al., 2009).

Higher rates of PTSD and more difficulty readjusting to civilian life among Hispanic/Latino veterans have been associated with "traditional ethnic issues" such as *machismo* principles (a sense of having masculine/manly pride) (Sohn & Harada, 2008). Other risk factors include limited economic opportunities and exacerbation of stress caused by experiences of racism before, during, and after discharge from the military (Sohn & Harada, 2008). African American veterans share similar pre-war vulnerability factors such as limited education, low socioeconomic status, limited economic opportunities, and stress related to racism (Sohn & Harada, 2008). Race-related factors have also been identified as a risk

factor for Asian Americans in developing PTSD (Sohn & Harada, 2008). An interesting study of Asian and Pacific Islanders revealed that the prevalence of PTSD among the 44 veterans in the study was 0% in Americans of Japanese ancestry, 13% in Chinese Americans, 29% in Native Hawaiians, and 40% in a mixed group of Korean, Filipino, and Samoan veterans (Matsuoka, Hamada, Kilauano, & Coalson, 1992). The significant within-group differences found in this study support the need for culturally appropriate interventions, which can be modified to meet the unique needs of individual veterans.

Examination of existing literature lends to important inquiries and exploration of the most effective culturally sensitive assessment and treatment options for U.S. veterans. A literature search did not reveal any information regarding evidence-based practices specifically designed for ethnic minority veterans. As a result, we describe current treatment options and offer recommendations for incorporating culturally-sensitive practices into these existing approaches. We then focus on assessment approaches that aid in culturally appropriate conceptualization and treatment planning for ethnic minority veterans with PTSD and SUD.

Treatment Options

Mental health providers working with clients with co-occurring PTSD and SUD often feel challenged by how to best engage and treat this co-occurring condition among veterans (Najavits et al., 2010). In a unique study, 205 Department of Veterans Affairs mental health providers rated co-occurring PTSD and SUD as more difficult to treat than either disorder alone, and reported desiring training in co-occurring disorders significantly more than any other resource (Najavits, Kivlahan, & Kosten, 2011). While a small number of providers reported believing clients needed to be abstinent from substances before beginning PTSD treatment, the most common concern reported was the lack of integrated treatment models within the VA system (Najavits et al., 2010).

To date, the sequential treatment approach has been the primary standard of care for co-occurring PTSD and SUD (Killeen, Back, & Brady, 2011). According to this approach, the clients must first address the SUD alone before targeting PTSD. However, it is very difficult for clients with PTSD and SUD to maintain sobriety for 3 to 6 months when dealing with untreated PTSD symptoms (Tomlinson, Tate, Anderson, McCarthy, & Brown, 2006). Many PTSD symptoms serve as triggers and often lead to relapse. In a recent study of veterans with co-occurring PTSD and SUD, participants completed a questionnaire regarding treatment preferences and participated in interviews. The majority of the participants (94%) reported they perceived a relationship between their PTSD and SUD symptoms, 85% felt their substance use worsened when their PTSD symptoms flared up, and 66% preferred an integrated treatment approach that focused on both simultaneously (Back, Killeen, et al., 2014). Notably, 51% of their participants were African American veterans.

There are several trauma-focused, integrated treatment options with promising outcomes. Prolonged Exposure (PE) therapy, an evidence-based treatment for PTSD that involves two major components: (a) in-vivo exposure in which clients approach safe – but anxiety provoking – situations in real life, and (b) imaginal exposure in which clients recall the traumatic memory repeatedly in session (Foa, Rothbaum, Riggs, & Murdock, 1991). Data gathered from studies that employed PE among people with SUD has demonstrated a significant decrease in both PTSD and SUD severity (Back, Foa, et al., 2014; Najavits, Schmitz, Gotthardt, & Weiss, 2005). These studies support McLeod and colleagues' (2001) "consequence of PTSD"

hypothesis, where reduction in PTSD symptoms leads to reduction in SUD-related behavior. A recent empirical study that utilized a randomized controlled trial of 103 participants (Mills et al., 2012) compared an exposure-based integrated SUD/PTSD treatment called "COPE" (Back, Foa, et al., 2014) with a treatment as usual (TAU) group, which was mainly substance abuse treatment. The findings indicated that there was significant reduction in PTSD symptoms in the integrated therapy group compared to the TAU group, but the TAU group only showed changes in SUD symptoms. According to Najavits (2013), past-focused PTSD treatment approaches such as exposure therapy (e.g., Foa & Rothbaum, 1998), eye movement desensitization, and reprocessing (Shapiro, 1996), and mourning (Herman, 1997) can trigger re-experiencing of the trauma and may increase the likelihood of worsening SUD, hence present-focused interventions maybe implemented prior to past-focused interventions.

Our search revealed that Seeking Safety is the most extensively studied integrated treatment. Seeking Safety, a present-focused treatment developed specifically for individuals with co-occurring PTSD and SUD, has proved to be one of the most effective approaches for addressing co-occurring disorders simultaneously (Najavits & Hien, 2013). The intervention, which evolved from the past-focused treatments commonly used in the 1990s, was first reviewed by Najavits, Weiss, Shaw, and Muenz in 1998 and has advanced significantly since that time. Based on research findings, it is recommended that counselors complete a comprehensive evaluation and examine whether clients with SUD are in need of a period of stable abstinence and functionality prior to working on PTSD treatment. Most importantly, the client's coping skills should be assessed to see if they possess impulse control. Clients

may use substances to cope with the emotions triggered by treatment of PTSD. The major goal of this approach is "an empathic approach that names the trauma experience, validates its connection to substance use, provides psychoeducation, and offers specific safe coping skills to manage the often overwhelming emotions of this dual diagnosis" (Najavits, 2007, p. 147). An objective of this approach is to help clients understand the connection between PTSD and SUD and how one can trigger the other. The counselor's role is critical, and counselors are encouraged to pay attention to the paradox of countertransference in the co-occurring disorders (Najavits, 2007). The effectiveness of this approach has been supported in work with women in prison (Zlotnick, Najavits, Rohsenow, & Johnson, 2003), low-income urban women (Hien, Cohen, Miele, Litt, & Capstick, 2004), and both male and female veterans (Cook et al., 2013), but to date there are no studies that examine the efficacy of this approach for ethnic minority veterans. Najavits and colleagues' (2011) study indicated that Seeking Safety was the model rated most helpful for co-occurring PTSD and SUD by providers, but it was not the most implemented approach and ranked first among models in which the providers felt they would like more training. Counselors working with minority veterans with co-occurring PTSD and SUD may want to consider utilizing the main concepts of Seeking Safety as it encompasses psychoeducation, cognitive restructuring, and development of interpersonal skills and intrapersonal awareness.

Multicultural Counseling Considerations

While the providers in Najavits et al.'s (2011) study described a need for integrated PTSD/SUD treatment and ways the existing options could be adapted for use with veterans, cultural considerations were not taken into account. Cohort and generational

differences were mentioned, but culture was not prominent enough in responses to be mentioned in either article on the study or in the appendix (Najavits et al., 2010; Najavits et al., 2011). We believe multicultural considerations must be taken into account to provide appropriate care for ethnic minority veterans. Important multicultural treatment considerations include: (a) understanding of pretraumatic, peritraumatic, and posttraumatic factors that impacts the client; (b) acknowledging that while there are cultural similarities, there are also many within-culture differences; (c) examining the client's subjective views on the relationship between PTSD and SUD; (d) deciding on a treatment protocol that addresses PTSD and SUD either sequentially or simultaneously, depending on the client's stated needs; and (e) modifying the approach so it addresses the unique needs of the individual client.

The DSM 5 highly recommends the use of the "Cultural Formulation Interview" (CFI) to obtain a more comprehensive understanding of the client's subjective experiences (APA, 2013). Using the CFI, counselors facilitate the therapy process by inquiring about the idiosyncratic cultural influences that impact the overall functioning of the client. This style of assessment focuses on an individual's values, ordinations, and assumptions derived from the client's association with a diverse social group. A major strength of the CFI is its person-centered approach to obtaining relevant information. Counselors aim to form a therapeutic working alliance with the client, showing genuine care and curiosity, while exploring four domains of the client's interpretations: (a) cultural definitions of a problem; (b) cultural perceptions of cause, context, and support; (c) cultural factors affecting self-coping and past help-seeking; and (d) cultural factors affecting current help-seeking behavior. In assessing the subjective cultural definition of the problem, the

clinician can ask the question "what troubles you most about your problem?" Additional questions to examine cultural perceptions regarding the cause of the presenting issues are "why do you think this is happening to you? What do you think are the causes of your problem?" In addition to the CFI's specific questions, the assessment process involves in-depth understanding and exploration of the client's environment and how the client's system may exacerbate or reduce symptoms.

Incorporating CFI questions within the context of the Seeking Safety model is an important multicultural consideration. For example, it is beneficial to examine the client's subjective understanding and belief regarding the relationship between PTSD and SUD and how this may differ from the commonly held beliefs of the client's culture or family. The CFI may also facilitate in-depth exploration of the client's systemic influences, which is critical when working with ethnic minority clients and the very diverse worldviews they bring into the session. Counselors are encouraged to gain insight regarding the client's views on help-seeking behavior and how that may or may not parallel the views of the client's unique culture.

A holistic concept calls for integration of a developmental-ecological evaluation (Collins & Collins, 2005) to enhance the CFI. Based on Bronfenbrenner's ecological model of human development (1977), Collins and Collins' (2005) approach emphasizes comprehensive analysis and assessment of the client's various systems (microsystem, exosystem, and macrosystem) and how the client influences and is influenced by each level. Weiss et al. (2012) have recommended taking an ecological approach and assessing multiple systems and worldviews – the veteran's culture, ethnicity, family, and military culture – that are in continuous interplay with the individual. Through

analysis and examination of the relationship between each system, a client becomes more aware of his or her subjective interpretation of PTSD and SUD, how his or her family and community defines and views PTSD and SUD, and how these factors impact the manifestation of symptoms. In a collaborative exploration of the interplay of each ecological system, the client can identify barriers and supportive factors that support symptom reduction and overall treatment process. Within the context of progression of the assessment process, the client narrates subjective experiences and stories. As counselors gain more insight about the client, they become better equipped to identify treatment options that meet a client's specific needs. Effective counseling interventions will then utilize and incorporate the findings of the assessment.

Conclusion

Manifestation of symptoms and the risk of co-occurring PTSD and SUD may differ across ethnically diverse groups. Factors to consider include the "the type of traumatic exposure, the impact on disorder, severity of the meaning attributed to the traumatic event, the ongoing sociocultural context, and other cultural factors" (APA, 2013, p. 287). Culture-specific idioms and the meaning given to an event influence the clinical expression of symptoms and the potential co-occurring disorders. Feldner, Monson, and Friedman (2007) proposed that increased vulnerability is dependent on cognitive, behavioral, and interpersonal factors. Hence, taking a holistic approach that includes systemic assessment and integration of the CFI is a critical multicultural consideration. Research has also identified variables that buffer the impact of PTSD and social functioning among veterans, including quality of romantic relationships, social support, and coping styles (Tsai, Harpaz-Rotem, Pietrzak, & Southwick, 2012). Assessment and case conceptualization from

a systemic lens assists with identification and discussion of protective factors already in place for the client. Utilization of the CFI and integration of the developmental-ecological evaluation allows in-depth exploration of such social functioning. Inquiry and assessment of such factors throughout the counseling process sets the stage for a culturally appropriate treatment modality tailored to the unique needs of the individual client.

Effective clinical practice requires counselors to be mindful of possible vulnerabilities, risks, and protective factors that impact the treatment process and to be conscious of individual differences that exist within homogenous groups. It is also important to acknowledge and be aware of individual differences and other potential barriers that may impact the counseling process. Ethnic minority veterans may experience barriers including a fear of reduction in supplemental payment (Gary, 2005), low motivation (Najavits et al., 2010), and decreased social status and stigmatization within the military culture (Exum, Coll, & Weiss, 2011). Hence, therapeutic goals may include helping clients gain awareness, understanding, and insight regarding these factors. The study conducted with army soldiers and marines who completed combat deployments to Iraq and Afghanistan, found that fear of stigmatization was the primary reason the majority of respondents did not seek mental health treatment (Hoge et al., 2004). Overcoming potential obstacles such as shame, especially for veterans with co-occurring PTSD and SUD, is a significant obstacle to overcome when counseling the veteran population. It is key to view each veteran as an individual who brings unique concerns and issues to the counseling process. Allowing each veteran to relate and define his or her own story is crucial to the therapeutic relationship and overall therapy outcome.

Understanding multicultural issues and taking ethnic minority status into consideration plays a large part in the culturally-appropriate assessment and treatment planning for each individual veteran. Our review of the literature revealed a lack of empirical research examining the applicability and effectiveness of proposed interventions for co-occurring PTSD and SUD for ethnic minority veterans. We believe the dearth of evidence-based practices warrants more rigorous investigation and research to identify culturally appropriate interventions specific for ethnic minority veterans.

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Veterans: Contemporary Issues in Counseling and Counselor Education

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A growing number of United States veterans from the wars in Iraq and Afghanistan create an increased need for information about veteran-related counseling concerns. This article offers an overview of contemporary issues related to counseling veterans including factors that may increase or decrease the risk for posttraumatic stress disorder (PTSD), how those close to veterans such as family members and others are affected, current best practices in treatment issues, and the impact on counselors in working with veterans. Suggestions for future research are included.

Keywords: counseling veterans, posttraumatic stress disorder, vicarious traumatization

For more than a decade the United States has seen increased numbers of veterans who need mental health services and military families who have experienced the loss of a loved one. Although the value of and meaning of life cannot be reduced to numbers, it may be helpful to consider some statistics related to these military actions. In the Global War on Terror including Operation Iraqi Freedom, Operation Enduring Freedom, and Operation New Dawn, the Department for Veterans Affairs (2012a) reported that from October 7, 2001 through May 29, 2012, a total of 5,078 soldiers died from hostile actions. An additional 1,378 died from non-hostile reasons and a total of 48,374 were wounded in action. According to the Veterans Administration (2012b), that agency provided specialty mental health services to 1.3 million Veterans in 2011. Since 2009, the VA has increased the mental health care budget by 39% and since 2007 the VA has seen a 35% increase in the number of Veterans receiving mental health services, as well as a 41% increase in mental health staff. Although veterans make up approximately 7% of the general population, they comprise nearly 13% of all homeless adults in the United States. According to the U.S. Department of Housing and Urban Development, this means an estimated 62,619 veterans are homeless on any given night (U.S. Department of Housing and Urban Development, 2011).

Recently, the Veterans Administration approved the inclusion of licensed professional counselors as service providers. Consequently, more positions for counselors will become available in the future. It is important for counselors and counselor educators to consider current issues relevant to veterans. The following sections address posttraumatic stress disorder (PTSD) in veterans and related risk factors. Information relevant to other individuals connected to veterans such as families and friends, best practices in the treatment of veterans, and risks to counselors in working with veterans is also included.

Posttraumatic Stress Disorder: Factors that Affect Risk

All veterans are exposed to traumatic experiences and yet not everyone involved in military service will develop posttraumatic stress disorder (PTSD). Sommer (2008) reviewed the criteria for PTSD provided by the *The Diagnostic and Statistical Manual of Mental Disorders*. Those exposed to (or those

who witness or hear about) a traumatic event may develop PTSD. Three classic symptoms include a persistent re-experiencing of the event via flashbacks or nightmares, an elevated startle response, and the avoidance of events or settings that trigger memories of the traumatic experience (Sommer, 2008, p. 62). Dass-Brailsford (2007) compared PTSD and Acute Stress Disorder (ASD) and noted that although both share primary diagnostic criteria noted above, those who experience PTSD have symptoms that continue for more than one month and result in impairment in social and/or occupational areas of life (pp. 35-36).

Investigation into how many veterans experience PTSD is a longstanding research topic. The 1988 National Vietnam Veterans Readjustment Study (NVVRS), when originally studied by Kulka et al. (1990), revealed that 30.9% of veterans developed PTSD during their lifetimes. This was a shockingly high number and the original study received criticism since only about half that number had actually been in combat. Dohrenwend et al. (2006) critically analyzed the same data with new study protocols to include a new variable identified as "record-based military historical measure of probable severity of war-zone stressors" (p. 980). Dohrenwend et al. (2006) found an adjusted rate of veterans developing PTSD during their lifetime of 18.7% and 9.1% for those veterans suffering from PTSD 11 to 12 years after the war. Although these rates were less than in the original study, the findings continued to show that a significant number of veterans struggle with PTSD symptoms and impairment after combat or trauma exposure. Given that relatively large numbers of veterans will experience PTSD, it is helpful to consider whether or not certain factors may increase or decrease a veteran's propensity to PTSD.

Increased risk factor: Diversity related issues

Schnurr, Lunney, and Sengupta (2004) compared factors related to both the development of and maintenance of PTSD in a quantitative study utilizing pre-trauma and post-trauma variables as well as pre-military, military, and post-military experiences. The participants included 414 men and 68 women of varying ethnicity (White, African-American, Hispanic, Native Hawaiian, and Japanese-American) who had been in the Vietnam conflict. Pre-military variables included cognitive functioning and environmental variables such as education, socioeconomic status, and family stability. Any history of childhood antisocial behavior and exposure to pre-military assault, serious accidents or significant tragedy were also included. Military variables included injury, perception of danger, exposure to atrocities, and malevolent environmental factors such as having been taken hostage or exposed to extreme weather conditions. Post-military variables included aspects of social support as well as any exposure to trauma similar to the pre-military factors. Schnurr et al.'s (2004) results indicated that all identified variables with the exception of "pre-Vietnam trauma" were related to the development of PTSD. In terms of ethnicity, Hispanics tended to show a higher risk of developing PTSD. Herrera, Owens, and Mallinckrodt (2013) also noted Hispanic heritage as a correlate for development of PTSD and they pointed to the traditional machismo associated with Hispanics as one possible reason.

Increased risk factor: Co-morbidity

Co-morbidity can predispose veterans to develop PTSD when exposed to traumatizing experiences. Koenen et al. (2005) postulated that conduct disorder potentially increases the risk of PTSD through direct and indirect mechanisms. The subjects of the study were drawn from the Vietnam Era Twin (VET) Registry (all males with military experience). Several methodological limitations to the

study were noted and the authors warned against generalizations. In any case, there are strong indicators of a relationship between childhood conduct disorder and both later exposure to trauma and development of PTSD. Noting the strength of the relationship and potential impact on interventions, Koenen et al. (2005) concluded that "data suggests that male military personnel who have a history of conduct disorder are a high-risk group who may benefit from targeted interventions aimed at preventing the development of PTSD" (p. 30).

Decreased risk factor: Spirituality and religion

Chen and Koenig (2006) reviewed several related studies to examine the relationship between combat stress and religiosity. Eleven specific studies were cited and Chen and Koenig noted that each of the constructs examined were slightly different. Of these studies, three had resulted in an inverse association (a higher score on one correlated with a lower score on the other). For these three studies Chen and Koenig (2006) concluded that "controlling for social support, subjective health status, and gender, higher scores on religious beliefs were found to predict lower scores on PTSD symptoms" (p. 375).

Four of the eleven studies showed a positive association (a higher score on one correlated with a higher score on the other). Three of the studies revealed a "mixed association" with elements of both inverse and positive associations and only one study revealed no association. Overall, these are very mixed findings. The authors noted that at least some association was determined on all but one of the reviewed studies. The inconclusive nature of this review leaves room for further study related to the relationship between religion and the development of PTSD. The fundamental variances between types of and strength of participant religious

association may play critical roles in the constructs of these studies.

Decreased risk factor: Unit cohesion

Armistead-Jehle, Johnston, Wade and Ecklund (2011) studied the relationship of military unit cohesion and subsequent development of PTSD and other mental health issues. Hypothesizing that stronger unit cohesion had the effect of limiting the impact of the trauma on resulting development of PTSD symptoms, the authors conducted a cross sectional study on service members returning from deployment in 2007. The resulting analysis of data revealed that "for those reporting high unit cohesion, greater combat exposure was related to less post traumatic symptoms (PTS) [suggesting] that unit cohesion acts as a buffer between combat exposure and PTS" (p. 85). Armistead-Jehle et al. (2011) concluded that military leadership could use the data and work to strengthen unit cohesion to "protect against the later development of mental health issues in their units" (p. 86).

It appears that a variety of factors affect a veteran's risk of developing PTSD. The roles played by ethnicity, and other diversity related factors, and the development of unit cohesion clearly merit ongoing investigation. However, veterans are not the only ones affected when PTSD emerges. The impact on family and loved ones can be significant.

Veterans and their Families and Loved Ones: How Others are Affected

Harrington-LaMorie and McDevitt-Murphy (2011) addressed the huge number of losses faced by military families in the past decade in light of the wars in Iraq and Afghanistan. They noted that "[F]or every military casualty, the loss ripples through multiple social networks, including comrades-in-arms, military leadership and personnel, surviving immediate and extended family members, friends "back home," as well as American society more broadly" (p. 262).

They pointed out that the fellow service personnel and primary and secondary next of kin are those the military acknowledges in terms of traumatic death in the military. Yet, many others not formally recognized may also be affected by such loss (i.e., ex-spouses, same sex partners, significant others). Harrington-LaMorie and McDevitt-McMurphy (2011) further noted that "[t]he grief and pain of these survivors are often unrecognized, hidden, stigmatized, or not acknowledged by society, which can lend itself to a more complicated and disenfranchised grief process" (p. 263). Although there is little research on these disenfranchised others, studies have addressed the effects on spouses and children of veterans.

Romantic partners and spouses

Recently, investigators have begun to look at the relationships of veterans diagnosed with PTSD and their families and loved ones. Tsai, Harpaz-Rotem, Pietrzak, and Southwick (2012) conducted a cross-sectional study of 164 veterans applying for care via the Veterans Administration within one year of active duty in Iraq and/or Afghanistan. According to these authors, 52% of veterans "who screened positive for PTSD reported greater difficulties in their relationships with romantic partner, less cohesion in their families, less social support, poorer social functioning, and lower life satisfaction compared to other treatment-seeking veterans" (p. 135). Ahmadi, Azampoor-Afshar, Karami, and Mokhtari (2011) conducted a study related to secondary trauma stress (STS) with the spouses of a veteran who had been diagnosed with PTSD. Questionnaires were filled out separately by the veterans and spouses about their life and the veteran was given an additional test to measure the severity of their PTSD. Ahmadi et al. (2011) noted that although previous studies had suggested that 30-39% of partners of veterans

with PTSD experienced related trauma "[i]n this study, all of the partners of known PTSD veterans reported moderate to severe degrees of STS" (p. 641). Ahmadi et al. (2011) referred to this new finding as "remarkably different" from previous studies (p. 641). In a similar vein, Monson, Taft, and Fredman (2009) reviewed and summarized findings related to avoidance and diminished self-disclosure and noted that "veterans' inability to experience and express emotions and to engage with others takes its toll on all family relationships…" (p. 709). Monson et al. (2009) emphasized that veterans diagnosed with chronic PTSD and their romantic partners report a higher number and greater severity of relationship problems than veterans not diagnosed with the disorder.

Children of veterans

The effect on children of a parent who is veteran can be devastating as well. Davidson and Millor (2001) studied "50 children (aged 16–30) of 50 male Vietnam veterans, subgrouped according to their fathers' PTSD status … [who] completed questionnaires with measures of self-esteem, PTSD symptomatology and family functioning" (p. 345). All questionnaires had demographic questions, family functioning scales, self-esteem, and PTSD symptomatology. The veterans/fathers completed information related to combat and service history. Davidson and Millor (2001) concluded that "[u]nhealthy family functioning is the area in which the effect of the veteran's PTSD appears to manifest itself, particularly the inability of the family both to experience appropriate emotional responses and to solve problems effectively within and outside the family unit" (p. 345). Similarly, Dinshtein, Dekel, and Polliack (2011) studied 46 adult participants with fathers who had been diagnosed with chronic PTSD after fighting in a war and compared them to 46 others with fathers who were also active in a war but was not

diagnosed with PTSD. Both groups were of the same age, gender, educational, and marital status. Dinshtein et al. (2011) noted "the adult children of PTSD veterans themselves experience higher levels of distress than did members of the control group … [and] adult children of PTSD veterans showed higher levels of stress in the face of repeated terrorist attacks than members of the control group …" p. 118).

Based on the studies discussed above, it is evident that close family ties to a veteran with PTSD can lead to related effects on spouses and children. Given the prevalence of PTSD among veterans and the multiple levels of impact related to it, treatment options merit discussion.

Treatment Issues related to Veterans: Current Best Practices

There are a variety of treatment options for veterans who suffer from PTSD. These include cognitive processing therapy, prolonged exposure, group therapy, eye movement desensitization and reprocessing, virtual reality therapy, art therapy, and pharmacological treatment options among others. Assistance for unemployed veterans and suicide prevention techniques are also relevant treatment issues impacting veterans with PTSD and their families.

Veteran Administration recommended practices

Best practices in the treatment of veterans have become increasingly important as this population has grown significantly in recent years. The U.S. Department of Veterans Affairs (VA) officially has "established a national initiative to implement cognitive processing therapy (CPT) and prolonged exposure (PE) for the treatment of posttraumatic stress disorder (PTSD), an effort that has involved training over 2,700 clinicians to deliver these interventions" (Laska, Smith, Wislocki, Minami, &

Wampold, 2013, p. 31). According to Laska et al. (2013), CPT consists of pyschoeducation, modifying cognition as well as emotion, exposure, and assignments for practice between sessions. CPT is typically 12 sessions and is often implemented in an individual format. "Prolonged exposure (PE) is an effective first-line treatment for posttraumatic stress disorder, regardless of the type of trauma, for Veterans and military personnel" (Rauch, Eftekhari, & Ruzek, 2012, p. 679). PE is also an effective treatment for clients with single or multiple traumas because it creates habitual emotional responses to repeated and prolonged trauma stimuli, which in return leads to a reduction in trauma related avoidance (Rauch et al., 2012).

Treatment is important for veterans with PTSD because not only does it affect the veteran mentally and emotionally, it affects all aspects of their lives, including employment. Savoca and Rosenheck (2000) found that veterans with PTSD are less likely to be employed and if the veterans do find employment they typically make less money than those without PTSD. A growing number of veterans are homeless due to their lack of employability. PTSD was also found to be associated with a lower hourly wage of those Veterans that were employed. PTSD is an obstacle to employment so the Veterans Health Association (VHA) is "currently renewing its commitment to evidence-based mental health treatment" with the goal of fostering "their return to mainstream community employment" (Resnick & Rosenheck, 2008, p. 434). The renewals include increasing the amount and type of services for Veterans who are suffering from PTSD.

Additional strength-based and creative approaches to treatment

Some treatment modalities not specified by the VA also show promise. Castillo, Baca, Clifford, and Bornovalova (2012) studied

cognitive processing therapy with a focus on group participation instead of the individual format. According to Castillo et al. (2012), "Establishing group delivery of exposure therapy will expand options, increase efficiency, and introduce group curative factors" (p. 1486). The original research was conducted on female veterans and PTSD symptoms were evaluated on a common symptom checklist called the PCL. When researchers compared the pre and post tests after treatment, at least 40% of participants showed a significant improvement in symptoms (Castillo et al., 2012).

Eye movement desensitization and reprocessing (EMDR) has received a lot of attention. Clients are asked to imagine the event that was traumatic and the emotions that were attached to that event and the client is instructed to focus on the rapid eye movement while looking at the therapist's finger. EMDR is a type of imaginal exposure that includes respondent and operant conditioning along with emotional interference with learning but differs in the "elicitation of rapid, saccadic eye movements during the imaginal exposure session" (Garske, 2011, p. 34). EMDR remains a controversial therapy due to a lack of research; however, it continues to merit attention in the treatment of veterans.

Due to the impracticality of being able to provide veterans with in vivo combat experiences, virtual reality exposure (VRE) allows veterans to use technology to view a virtual world that would allow them to experience the traumatic stimuli. The technology involved in this type of situation includes body tracking and sensory input devices, head mounted displays, stereoscopic views that change with natural body movements, screens that encompass the entire viewing field, and audio effects that dominate hearing ability. Ready, Pollack, Rothbaum, and Alarcon (2006) noted that VRE has advantages over more traditional treatments

with veterans and they offered compelling reasons for its use including: "(a) increased convenience for both the therapist and patient; (b) increased control over the exposure experience; and (c) a more engaging environment than that which can be obtained with imaginal exposures alone" (p. 202).

Art therapy and other creative, expressive therapies can be helpful. Thompson (2012) noted that "[r]itualized ceremonies for dedications of commemorative flags can be used as a way to promote community awareness of war-related grief and loss as well as the contributions of people in military service across time" and the authors went on to add that "providing a sacred container supportive of the mourning and meaning-making process for survivors" can be instrumental in the healing process (p. 234). The value of such an activity is that it allows for the valuation and maintenance of memories and offers an opportunity for survivors to share stories of their lost loved ones as well as their own stories of grief and recovery.

Taft, Creech, and Kachadourian (2012) found that anger can significantly "interfere with PTSD treatment, and that anger and aggression are linked to PTSD and PTSD severity" (p. 784). Techniques can be shared with veterans to help facilitate the development of relaxation skills, effective communication skills, and constructive coping strategies; however, these techniques are often not enough. Jeffreys, Capehart, and Friedman (2012) pointed to the importance of pharmacological interventions for PTSD which, according to the authors, "can improve the engagement of patients in their treatment" (p. 710). Due to the fact that many veterans experiencing PTSD symptoms will be seen initially by medical professionals in either primary care or general mental health settings, it is imperative that physicians in all specialties become familiar with the initial

management steps, assessment, and diagnosis of PTSD. Lack of training and/or awareness regarding PTSD treatment on the part of physicians has led to an overuse or misuse of some drugs. For instance, "[a]typical antipsychotics … are believed to be overprescribed for PTSD, causing both excessive medication costs and a risk of harmful side effects, including obesity and metabolic syndrome" (Jeffreys et al., 2012, pg. 704).

Suicide specific risks and interventions

Hudenko and Crenshaw (2011) reported that the suicide rate in 2005 among male veterans was 37.19 per 100,000. For females the rate was much lower at 13.59 per 100,000. The researchers noted that there is strong evidence that veterans who experience combat trauma are at the highest suicide risk if they experienced multiple wounds or were hospitalized due to wounds. Exposure to suicide, including witnessing the suicide and being connected to the person who dies, or history of another psychiatric illness can increase risk of suicide in veterans (Hudenko & Crenshaw, 2011). Jakupcak et al. (2010) noted that married veterans and veterans who have supportive social networks have a lower risk of suicide over unmarried veterans or veterans with social networks that are less satisfying. Marriage is thought to be a buffer to suicide due to the increased responsibility of others the veteran with PTSD may have. "Veterans with PTSD are also less likely to use active problem solving and may instead rely on maladaptive coping strategies, such as emotional avoidance or self-blame that can decrease the benefit of close relationships" (Jakupcak et al., 2010, p. 1002).

Despite some of the factors that may diminish the risk of suicide, veterans with PTSD and suicide continue to be an important issue. During a recent interview on National Public Radio, Lawrence (2012) stated that "[for] the first time in a decade of war, more active duty troops died by suicide than fighting in Afghanistan." Lawrence added that 321 troops killed themselves while only 309 troops died in combat and that suicide rates started climbing in 2004. President Obama ordered measures that include doubling the staff at the Veterans Crisis Line to better help the services provided to Veterans to try to help prevent suicide.

Impact on Counselors of Working with Veterans

Trippany, White Kress, and Wilcoxon (2004) mentioned that "in virtually all settings" counselors will experience clients with trauma (p. 31). Working with traumatized clients can be rewarding, but it is important to keep in mind that PTSD affects not only the survivor, but also those who have learned about the event (American Psychiatric Association, 2000). Counselors must be aware of this and acquire the skills to overcome the possible dangers that stem from frequent exposure of traumatized clients. Counselors are not immune to what they hear in a session. Chronic exposure to traumatic stories from clients can not only affect their therapeutic efficacy but also cause problems in their personal lives.

Vicarious traumatization

Exposure to traumatic stories can have a negative impact on counselors. Specifically, counselors typically begin to experience changes in their cognitive schemas regarding trust, safety, power, independence, esteem, and intimacy (Chouliara, Hutchison, & Karatzias, 2009, p. 47). Overall, counselors may begin to withdraw from their loved ones and find themselves sad and unmotivated. The term "vicarious traumatization" (VT) was first used by McCann and Pearlman (1990) to describe these negative effects. Counselors who develop VT may have anxiety, intrusive thoughts and feelings, suspiciousness, depression, somatic symptoms, avoidance,

emotional numbing and flooding, and increased feelings of personal vulnerability (Adams & Riggs, 2008). Any counselor can be at risk for VT. Researchers have attempted to predict why and how some therapists succumb to VT. McCann and Pearlman (1990) proposed that over time, the client's memories can become "incorporated into the memory system of the therapist" causing flashbacks and false memories within the therapist (p. 143). Pearlman and Saakvitne (1995) suggested that some therapists are overexposed to traumatic stories and begin to associate and define their life and past in ways "that parallel the experience of the trauma survivor" (p. 150). It seems as though the therapist's empathy and commitment to help clients could also contribute to their susceptibility related to the development of secondary post traumatic stress symptoms.

Other factors that contribute to the development of VT revolve around the counselor's work load and survivor experience. Harrison and Westwood (2009) stressed the importance of balance in regards to the types of clients counselors see on a regular basis. They suggested a counselor should have a caseload with both trauma and non-trauma related work to avoid overloading the mind with traumatic and negative stimuli. Harrison and Westwood also proposed that if the therapist has a history of personal trauma, personal counseling should be undertaken before working with clients with similar backgrounds. Additionally, Adam and Riggs (2008) stated that the amount of experience a counselor has with counseling survivors of trauma can be used to predict if a therapist will develop VT suggesting that experience may diminish risk.

Research has found no concrete way of knowing just how prevalent vicarious trauma is and therefore it is hard to assess risk. In a qualitative study by Hunter (2012), 7 out of 8 counselors interviewed "believed that they were, in some way, affected by the traumatic stories that they had heard in therapy" (p. 185). Consequently, it is imperative for all therapists to practice self-care and seek help when they feel overwhelmed or challenged.

Burnout

Providing therapeutic care for others can be overwhelming. If one is not aware of stress reactions and does seek help, burnout can occur. McCann and Pearlman (1990) referred to burnout as "the psychological strain of working with very severe psychiatric or social problems" (p. 133). Symptoms of burnout include exhaustion, depression, trouble in concentrating, neglecting responsibilities, new or worsening health problems, irritability, and a feeling of decrease in accomplishment. Burnout is not specific to mental health professionals; however, due to the frequency of difficult and complex cases it is not uncommon for counselors to experience this type of stress and exhaustion. Because burnout has become such a common crisis, the United States government has identified it as a key factor driving the "major problem" of retaining competent staff in "treatment organizations and state behavioral health systems" (Hoge et al., 2007, p. 16).

Counselors working with clients with PTSD could potentially experience burnout at greater frequencies. McCann and Pearlman (1990) specifically discussed how working with trauma victims can increase symptoms stating that "helpers who understand victimization as a reflection of social and political problems may feel hopeless about the potential impact of individual psychotherapy upon the root causes of crime and violence" (p. 134). Although counselors are educated and experienced in listening to other people's crisis stories, they "are not immune to the painful images, thoughts, and feelings associated with exposure to their clients' traumatic memories" (McCann & Pearlman, 1990, p. 132). Frequent exposure to these

difficult cases can evoke stress and ultimately lead to burnout.

Self-Care

Sommer (2008) noted "the likelihood that most counselors will encounter clients who are traumatized" and stressed the importance of education and preparation for students who want to become counselors (p. 62). She stated that "requiring counselor educators to prepare counselors to deal with the effects of vicarious exposure to trauma seems to be a logical and ethical beginning to ensure that counseling professionals have adequate preparation in this area" (p. 66). Counselor educators should instruct students about the personal risks that could occur within the mental health profession, as well as teach them potential coping skills to utilize when they find themselves feeling overwhelmed. In a similar vein, Ben-Porat and Itzhaky (2009) suggested that therapists have workshops and set aside study days to help process and rejuvenate their spirits. Although their research was specific to family violence trauma, their advice for self-care is valuable for all counselors. They emphasized the need to legitimize and develop appropriate frameworks for counselors to process their difficulties and feelings, as well as the need for professionals to recognize the counselors' need to care for themselves and their personal lives, as this could contribute significantly to helping them cope with the distress that they encounter in their jobs (Ben-Porat & Itzhaky, 2009).

Lastly, Hunter (2012) emphasized the importance of good supervision. She explained that it is important "for agencies to offer their staff both formal supervision and informal debriefing with a trusted colleague, as this can be invaluable" (p. 189). In addition, Hunter noted that "if a therapist works in private practice, it is equally important for them to seek out both good supervision and debriefing opportunities" (p. 189). Counseling is not a solitary endeavor and supervision is not solely for licensing or training requirements; supervision should occur throughout the entire career of a therapist. McCann and Pearlman (1990) also discussed the importance of tapping into the potential sources of support in one's professional network stating, "the helper should first avoid professional isolation by having contact with other professionals" (p. 145). They also suggested creating support groups among peers so therapists have a safe environment to share their feelings and reactions to difficult cases.

Self-care is important for clients and counselors. However, when one is overwhelmed with a large caseload or with emotionally demanding clients, the importance of self-care is often overlooked. In order to remain therapeutically effective with clients, counselors must take time out to make sure they are mentally and emotionally capable of helping others.

Implications for Practice and Suggestions for Future Research

There are many issues facing today's veterans, their families and loved ones, and the counselors who provide services for them. The discussion of PTSD and related risk factors merits ongoing investigation. Schnurr et al. (2004) found that various ethnic backgrounds had different influences on veterans' development of PTSD. Additionally, Schnurr et al. (2004) recommended further study on gender related variables. Monson et al. (2009) echoed the need for research related PTSD and gender minority, as well as sexual minority, veterans. They especially noted the absence of empirical research related to same sex couples (p. 713). If there are indeed factors that appear to minimize the risks (Chen & Koenig, 2006; Armistead-Jehle et al., 2011), it is both imperative and ethical for counselors to advocate for measures that would help military institutions to address these factors. The importance of unit cohesion

(Armistead-Jehle et al., 2011) is one particularly meaningful risk factor that merits scrutiny. Other topics will require future investigation. For instance, an attempt to clarify the integral dynamics of the faith and religious affiliation constructs and their relationship to PTSD in veterans is needed.

The necessity to prepare counselors to respond to the needs of veterans now and in the coming decades is evident. Counselor educators must make concerted efforts to include information about working with veterans in core curricula as well as special courses that can provide counselors with in-depth insight into working with this population. Closely related to this need is the grave importance of educating future counselors about vicarious traumatization, burnout, and the need for meaningful self-care practices. The treatment of veterans is currently, and will continue to be, an area of importance in the field of counseling. It is imperative that 21st century counselors are prepared to meet this need.

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An Interview with Dr. Bill Braden former Executive Director, Kentucky Counseling Association; Recipient of the American Counseling Association President's Award; United States Military Veteran.

A Veteran's Journey to Leadership in the Counseling Profession

Daniel Williamson, Jennifer N. Williamson, and Lauren Peyton

J. Williamson: Dr. Braden, thank you very much for coming today. We appreciate your time. You have been a strong force in counseling in Kentucky, and we are happy that you are willing to share your story. Daniel, you have the first question.

D. Williamson: What led to your decision to become a counselor?

Braden: Dan, I've pondered that, and I think it was, sequential. As a kid, I describe my journey as being a refugee. I had a great, pretty traditional upbringing for first five years then we experienced illness and economics. It was the Depression Era, and we were forced to move, and it was quite a different setting with quite a different status. We had to move in with my aunt and uncle. I started getting sick, and I sequentially had pneumonia, and that was tough because it was the thirties, and not many drugs and not much sophistication in treatment. I missed so much of the second part of the first grade that my first grade teacher did the right thing and flunked me. She said "You know you just haven't been able to be here to read!" She was exactly right, but that offended my mother. It was a serious concern that her genius was flunking the first grade; and she marched on the school board, which was chaired by her father in-law, in a really small town, so I think we pioneered "social

promotion."

For the doctoral program I had to take a speed reading course and, and still had problems because that lady was right.

You know, my mother saved that report card from when I flunked the first grade. When I got my doctorate she sent it to me. She said "I remember you when..."

D. Williamson: Wow!

Braden: That was a shift where I saw that families need help. Then, my mother remarried my stepfather, a super guy, but he struggled with small business success. He wasn't tough enough to collect bills and things like that. My mother rescued him quite frequently.

I didn't like poverty either, you lose so many choices, and I finally caught on. You just really lose so many choices, and I thought "people need help with things like this" and then two brothers arrived, two half-brothers [siblings].

In my first teaching job, I taught math and physics, and I had a dynamite principal; he was just a power house. He went to an evening class at IU South East Jeffersonville, in counseling. He came back

and said, "Bill you ought to become a counselor." I wasn't sure what to think. I thought "Is he tired of me as a teacher?" No, I didn't really think that because math and physics teachers were hard to find, and I was department chair. I was thinking that there should be some help here.

It is hard for people when the struggles of life are compounded with ignorance. They can be hard on each other, and it makes their path more difficult. The air force enabled me to go back to graduate school full time, so I took a counseling course. I think it really worked for me because I naturally was solution focused. I finished in 1959, about the same time the National Defense Education Act (NDEA) was launched. NDEA was a major piece that helped me on the other side. Western hired me to run the activities for a national science foundation grant for accelerated high school students. It was a unique opportunity to utilize my counseling and academic skills to help to help people on multiple levels.

J. Williamson: And so was Sputnik about this time when all this was happening?

Braden: Yes, yes. In fact that's what inspired NDEA, it was catching up. They even funded for counselors offices, and had a lot of titles. In fact, I got a loan on another title to get my doctorate. But you are exactly right, sputnik inspired it, and I was in the Air Force and we were chasing sputnik, trying to read the data with radar.

D. Williamson: Isn't it amazing how a ball of metal about the size of a basketball inspired so much change?

Braden: Yeah it did! I mean, we were hunkered down. Dan, it was just a great time. I was an operations officer. I was telling colonels what to do because they

were scared, and I loved it.

J. Williamson: You have recently received two of the professions highest awards, The American Counseling Associations President's Award, and a Lifetime Achievement Award from the Kentucky Counseling Association. What are your proudest accomplishments during your career?

Braden: If it relates to ACA, I have always been impressed with advocacy, and in a democratic country there is a need to do things that way.

This is very much my mother's influence.

I just want to try to help and do what is supposed to be done, and so I have. I've been in advocacy over fifty years and she was my role model. The only time that wasn't funny was when I thought she was going to become PTA president for life. She picked up all kinds of dirt on me being around school all the time. <laugh> Seriously, during my career, I have been able to see licensure from Virginia to California.

I got involved as soon as I finished my doctorate in the seventies. I served on committees, and I've been chair for two consecutive terms. I never thought it could happen. But I enjoyed it.

J. Williamson: Tell us more about your experience with ACA.

Braden: In ACA, counselors are so skilled in connecting with people and advocating…if you just get them mobilized, and ACA is really beginning to thrive in this area. You can do so much, and of course we are going to be tested because you know funds are competitive everywhere.

J. Williamson: What was the secret of your success in the state of Kentucky? KCA has received some very prestigious awards.

Braden: I learned that leadership was so key. You must have the right people to make things happen. I have shamelessly recruited. Karen Cook, the current Executive Director, is a good example. We have so much talent in Kentucky. We have harsh realities of being a small state and being very limited in resources, but you get the right people motivated, and it is amazing what they are able to accomplish. We've won so many state branch awards that they've changed the system.

J. Williamson: Bill, that is very impressive.

Braden: We have been very proud of the success that the state organization has achieved. We have dominated in some areas.

J. Williamson: Wow!

Braden: Over the years, I think that has been my largest contribution is recruiting great people. A couple of people who stand out are Francis and Dillard Prater who were so essential to the development of the organization. I think that's maybe my only talent…being a talent scout.

J. Williamson: Bill, you have been very active in both ACA and KCA. If you were going to identify your strengths in both organizations, how would you describe your role with both?

Braden: I guess if I were going to sum it up: ACA is advocacy, and I think KCA is Leadership.

D. Williamson: You are the person we

think of when we think of those two concepts as well.

J. Williamson: It's true.

Braden: Oh thank you, thank you much!

D. Williamson: Absolutely! In terms of Kentucky, how have you see the face of counseling change just within the state during your career?

Braden: Dan, it used to be that the origins were mostly in the schools, and the money has helped that kind of growth, but it is transitioning. The growth of school counseling has somewhat plateaued. I think that mental health counseling is in a process of ascending, and I think it is great because as I have told my story, you realize that there are so many areas that mental health counselors can help individuals and families work through.

J. Williamson: How do you think it has changed in the nation? Do you think it is similar or do you think the nation has made changes?

Braden: I think it is similar to some degree. KCA provides a 1-800 help line. Karen Cook, the current Executive Director oversees this service. In recent years, many calls are related to licensure issues. The help line receives inquiries about their status, ethics questions, and legal questions.

D. Williamson: How would you envision the development of professional counseling in Kentucky over the next twenty years?

Braden: Dan, there are a couple of things that really make me optimistic, of course that is not my nature, but one is…you know we were just talking about the tragedy in Arizona with some rock climbers? Already.

all kinds of people are volunteering to help. I really think that there's an era now of helping. KCA is currently trying to assist with similar efforts through the Red Cross Disaster Mental Health.

J. Williamson: So do you think it's the same for the nation or do you think there are problems that are facing the nation that are different from those in Kentucky?

Braden: Well, I talked to Brad about that.

D. Williamson: Brad Erford [Current ACA President]?

Braden: Yes.

D. Williamson: Okay.

Braden: He saw a need for [licensure] portability. We have real problems. We probably have fifty separate licensures. Brad [Erford] said that in some places, small countries do it nationally. And it would be wonderful if we could get anything done like that. That's the state differentials. So I think he is right. I think we really have to get that resolved!

D. Williamson: I was talking with someone recently about Tennessee trying to appeal to surrounding states, in terms of portability and having a reciprocity program. So we can see what happens with that.

Braden: Yes.

D. Williamson: Very interesting.

Braden: Yes, this must be a wonderful thing because you know we've had a long run now. We're going to need this kind of systemic change.

J. Williamson: This is true.

D. Williamson: I agree. What advice would you have for young people or new emerging professionals? What would you want to pass on and share with them?

Braden: Dan, I just had someone come to me the other day about this. One of my student leaders is going into the doctoral program at New Orleans, and I was telling him about what I think helped me. I believe you develop a survival system, and you have past, present, and future-oriented members. The past would be a trusted friend who may not even be in the profession, but someone you know and can trust their opinion. The second is a peer who is successful or more experienced. The third is a connection to a scholar. This is somebody you can depend on for advice about pondering the future. To be successful you need to examine the past, the present, and the future.

D. Williamson: That is good advice!

Williamsons: Thank you Dr. Braden for sharing your story. We appreciate the trail that you have cleared for the present and future counselors in Kentucky and the Nation.

Interview with Dakota Meyer, former United States Marine and Recipient of the Congressional Medal of Honor.

A Veteran's Perspective Regarding Mental Health and Advocacy

Daniel Williamson, Jennifer Williamson, and Natalie Vickous

Williamson: Let me start…the first and most important thing, when we talked to you eighteen months ago, you indicated that you were very interested in the mental health aspect of veteran affairs.

Meyer: Yeah, yeah.

Williamson: What you said to me was, "You might not want to hear what I have to say about mental health."

Meyer: That's true, that's true.

Williamson: We do want to hear.

Meyer: Got it.

Williamson: I'm very sensitive to the fact that you have two things – one is the truth, and the second is Dakota Meyer Inc.

Meyer: Yeah.

Williamson: The first venue that we want to talk about is the Kentucky Counseling Association Journal, and really wanted to interview you for the special edition addressing veteran affairs.

Meyer: Yeah.

Williamson: Now, feel free to be as blunt as you want to be.

Meyer: Oh, I will.

Williamson: Okay, good!

Meyer: I hear you.

Meyer: Well I've been more open about it, speaking, because I've been getting a lot of questions at the end of my speech.

Williamson: Yes

Meyer: …like what about this PTSD aspect…

Williamson: Right.

Meyer: I've been getting a lot of it, and I probably, about six or eight months ago I finally just came out and said it, how it was…

Williamson: Good.

Meyer: …and told them, you kind of get this, like, everybody in the crowd "whoas" at first, like you can see the eyes get big, and then, you know, after you start explaining it, then they all usually come back around and start clapping. But I can tell you right now, you see the "oh I can't believe he just said that." [Regarding his opinions about mental health services for military personnel]

Williamson: Right.

Meyer: You know what I mean?

Williamson: Hearing that, we might ask you, very gently, tell us, what brings you to that thought?

Meyer: Yeah, and I would explain it, because I don't want people to get the wrong perception.

Williamson: Dakota Meyer Inc. has really given you a format for being able to do something much bigger than yourself.

Meyer: Yeah.

Williamson: We would love to ask questions…

Meyer: Of course.

Williamson: We're going to open it up, and you can tell your story, if you're comfortable with that. Tell us, from your experiences…

Meyer: Yeah.

Williamson: Tell us…what was it like coming out of that experience [heavy combat] and being a part of the system, and…

Meyer: …Yeah, I came back. I was initially coming back…I came home on December 5th of 2009, and I was home for maybe five or six days and was immediately put into a rehab center that was using cognitive therapy. So that was my initial start in it, and I don't really know how much it helped me, but I think it educated me on why I feel the way I feel.

I think a lot of the pains, and you know, what I've seen a lot in the health system is you have people trying to tell you how you're supposed to feel, and not understanding what you're…you know…what's going on. It's more of them trying to take this approach of, "Well, I know you feel this way." They're not problem-solvers. You know, I don't know if it's how they're taught, if it's an education problem on their teaching, or whatever it is, but I can't tell you how many times I've been told, "You're wrong for feeling that way." You know, "You shouldn't feel that way." Well, okay, I got that, maybe I know, but you know, one of the biggest things that I've had to struggle with is the guilt…just the guilt of how did I survive.

How, why didn't I get my guys out alive. I dealt with that initially coming back, but it was magnified even more when I was receiving the medal and was put in the public's eye, because, you know, the way I see the medal is that this is the way to magnify your failure in front of the whole nation.

Williamson: Wow.

Meyer: And so, it's never been a situation where I wanted to ever hurt anybody else. It's been a constant struggle for myself. So that's kind of, I guess, my system, my backup.

Williamson: Okay. If you could go back and have a different experience with the therapist, what would you have wanted them to do?

Meyer: Well, I think first, I think you've got to start with the education side of it.

Williamson: Okay.

Meyer: I think with, so, we're talking, let's talk about PTSD, for example. I think that what we have to do is, we have to go in and really figure out what PTSD is and clarify it, and not only educate people on it, who have it, but educate outside people and make sure that the media doesn't portray PTSD as something that it's not. Because, I would say, there's a difference. Why are we taking depression, and all these factors, and throwing them into PTSD? You know, if it's literally PTSD, post-traumatic stress that needs to be separate. If you have depression, you have depression. If you have bipolar or whatever else, that's all separate stuff. Don't clump that into a label of PTSD, because then you just took the PTSD label through the floor.

Williamson: What I'm hearing you say is, don't give people more problems than they already have.

Meyer: Exactly. Exactly. And also, just as much as that's important, also make sure that you separate their problems. Because you can't take a veteran who gets out, for example, they have bipolar, they're depressed. Well, depression after they get out is not PTSD. Because, depression after they get out could be that they just had a life change, a huge life change, they're transitioning back into the community, they're away from their friends…I mean, that's stuff that anybody who changes jobs or changes communities, kids who leave school, they all deal with this. So don't, label that as PTSD. Is it really post-traumatic stress from a war zone?

Williamson: Or is it an adjustment disorder?

Meyer: Or is it an adjustment disorder…[agreed]

Williamson: It's interesting you mention that too, because it sounds like that's part of what they're telling you. You're supposed to be feeling…

Meyer: Yeah, it is.

Williamson: Sounds like maybe it's a broad-spectrum type problem is what you're trying to tell other people.

Meyer: It is. it's a broad problem, and the issue is, when they tell you how you're supposed to feel with PTSD and what's normal, well, maybe it's normal if you've seen combat or whatever traumatic event that happened, but you getting out of the military and being depressed, you shouldn't feel the same way that you do if you watch your buddies get killed.

Williamson: Okay

Meyer: And that's where we're having a big issue, of all this being wrapped up under one thing, you know. And so, I think the education part would be good. For example, like, Fort Hood shooter, they always say "Well, he's a veteran, he has PTSD." Okay, and then that turns so many people off from it.

Williamson: Go on…

Meyer: If the person who shot up Fort Hood has PTSD and that's why he did it, well then I don't have that.

Williamson: Right.

Meyer: You need to go find me a different label, because I don't feel that way, you know what I mean? So that, I think would be, once you've got the education, the stigmatism fixed, and you start putting people in their right labels, then I think you start getting more people who accept it and start going to ask for help.

Williamson: Gotcha…

Meyer: And I think it also helps the medical professionals, when you do make them label that out differently, instead of saying, okay, you've got this test and you take it…I had to fill out a test when I went in too. I had to do a few of these tests, to see if you have PTSD or not. Every one of them came out, no, I didn't have it. You know why? Because I can "game the game."

Williamson: Ah.

Meyer: I can game it. And all of us don't want that label so bad that we will game the game.

Williamson: Let me ask a follow-up question here. First of all, without giving any revealing information, the rehab center that you came back to when you first came back, in December, was that in Kentucky?

Meyer: Mm-hmm. [affirmation]

Williamson: Let me ask you this: you talk about this labeling system being used, the PTSD, the depression, the bipolar. How does that affect the military person in the views of the military?

Meyer: You know, I think if PTSD was its own label, depression, and everything else, I don't think it changes anything. You know, what happens is, the reason it changes the view inside the military is because you have a Fort Hood shooting and somebody shoots it up, and that guy's really psychotic, and maybe has other issues that are probably causing this. Well, what they do is they claim it as PTSD. So anybody gets PTSD, well, we should take guns from them. That's not the case.

Williamson: What I'm hearing you say is that clinicians need to be more accurate in diagnosing?

Meyer: Yes.

Williamson: Clinicians don't need to see a veteran and say, PTSD.

Meyer: Exactly. And you know, and another thing is a lot of these veterans…hold on, let me rephrase this…I think part of the problem is the honesty of the veterans sometimes. Did they really see combat? I have heard of people getting PTSD disability and didn't even graduate boot camp.

Williamson: Okay.

Meyer: You know, there has to be some level of accountability in the system, and that's another big problem. Okay, so you take me for instance, I used to come home every day and I would drink a bottle of Crown like it was nothing, you know. So, maybe I did have PTSD, but that still doesn't excuse it. "I drink because I have PTSD." Okay, well that's not an excuse.

Williamson: Right.

Meyer: I know for a fact that if somebody knows that they have PTSD and they get drunk and they have guns all around them, that nothing good is going to happen….Well then don't do it!

Williamson: Okay.

Meyer: You know, somebody needs to hold them accountable.

Williamson: What I'm hearing you say is that veterans themselves have a lot of power to change their fate.

Meyer: Exactly.

Williamson: Okay.

Meyer: They still, no matter what, no matter how severe the situation is, you still have, you still have a, the control to change the fate.

Williamson: You have a choice.

Meyer: You have a choice. And you still consciously make that choice, so, after they drink, they consciously made the choice that made them not consciously make the other choices. You know, and that's why we've got to bring that level of accountability back to the table. We've got to call them out.

Williamson: All right…tell me about the stigma. I'm really interested in the stigma that the military holds for people who have diagnosable conditions.

Meyer: You know, I think it's more accepted in the military than you would think. But now, who commands acceptance? I think the commands that don't really accept it are the ones who are not a combative command. Maybe in a different military occupation specialty…I mean, in commands that I was in, if they're a gunny or above, they've been to combat five or six times.

They've all been there and done that. They understand, they deal with it. So they understand what that means. I think the ones that don't know are the ones that haven't been there. And I think that's where you get the problems. The stigmatism, look, we all joke about it, you know, I think the ones you've got to worry about are the ones who don't have it.

Williamson: Okay.

Meyer: I think it's, what we have to get across is it's a normal reaction. You stick your hand in a fire, what happens? You get burned. You're going to have blisters. You're going to lose feeling. It's going to hurt, right? You go to war and you watch people die, you're going to have nightmares. You're going to, this stuff is normal. It's not different.

Williamson: Right.

Meyer: And I think once we classify it as normal, you're going to start solving a lot more problems.

Williamson: When you experience trauma you're going to have a reaction.

Meyer: Exactly. Exactly. You stick your hand in a light socket; you're going to get shocked.

Williamson: Yes

Meyer: You walk out in front of moving traffic; you're going to get run over. I think that's the classification we need to look at. Hey, this is what it is. It's a normal reaction to an abnormal situation.

Williamson: Gotcha. Okay.

Meyer: I think that would make a huge difference. But the approach we're taking right now is we're coddling. You know, we don't want to touch it. We don't want to hold them accountable. We're scared to say it. We don't want to make anybody mad. And a lot of that is, is because of the number of population, since 9/11…less than one percent of veterans have carried the war. So less than one percent of the nation's population has carried the burden of the longest war in our history. All volunteers. It's actually .45 percent.

Williamson: Wow.

Meyer: So part of the issue is a lack of people knowing and understanding what it is, and being able to be educated on this. I think that has a lot to do with it.

Williamson: You really feel like educating the public would be one thing we could use, as a profession and…

Meyer: …Yeah, and you start with the media. Once you start educating, fixing, and changing it, then they don't start classifying it as every time there's a shooting that's a veteran, "Well he had PTSD." Because they always go to the medical records. So once we fix that, you start changing the whole ball game.

Williamson: We are really interested in training therapists and when you think back to your experiences, with different therapists throughout your time, coming back, what would you have liked for them to have said? What do you think would have been more effective?

Meyer: You know, I think one thing that could make therapists effective, is having someone…let's say if they do groups or something like that, bringing someone in who is a realist. Bringing someone in who has the credibility, inside this community, okay? I think that would help them. I think this approach of, I've got a ton of education or I'm a doctor or whatever else, you're not going to get in to them.

You need someone who can speak to them. I think that if you could ever build a system to where you have peers, using more peers, using these people to talk to each other. If you take someone in my situation and I'm looking at them, and they're telling me this, I'm going to tell them that, you shouldn't feel that way. Yeah, I might feel that way, but you shouldn't, because of this, this, and this. And when they start binding with each other, they start seeing this, you know, but here's why it's hard.

It's hard because you have this inner-branch rivalry, so you know, if it's not a Marine, it's Army, you got this. You've got some people that take it to the extreme, and part of the issue is how the military set it up. The military almost sets you up for failure sometimes, with this mindset of, "Well, civilians don't get it. I don't want to be a nasty civilian." I talk to these people and there is the perception that "civilians don't

care." And you know what? A lot of times, I feel like they don't.

I mean, that's probably the biggest frustration I deal with at home, is just seeing people that don't care. But you really have to put it in perspective for these veterans to be able to open up and start with an open mind of, "so I don't like civilians, I don't want to be a civilian, but the day that I don't re-enlist in the military, I come out, and I'm a civilian." And the other thing I find so unique is, I was sitting with a bunch of guys who were talking about this, and I said, you know, "Why did we go fight?" Because it's an all-volunteer force. (So we all raised our right hands) so we could all go and protect and make sure that people, we don't even know, would never have to see war on our soil.

That's the reason we went. Well, you come back, and they don't understand it, and they don't get it, because they weren't there, and you're mad at them because you did your job good. So exactly what you just went and fought for, and was willing to give your life for, you hate it.

Williamson: That's a powerful realization.

Meyer: And it's the truth.

Williamson: What led you to join? What led you to raise your right hand and make that decision?

Meyer: You know, I never forgot 9/11. I mean, that image of those towers falling, of people jumping out the windows, and seeing what it did to our nation. And you know, I'll never forget it, I was sitting in my eighth grade classroom, in art class and I remember they pulled out the television on one of those stands that rolled through. I can remember it, I can see it plain as day right now, and I could never forget, because he pulled it in there after the first tower had been hit, and we watched the second plane fly into it. I mean, that image is burned into my mind, and you know that every person that I fought next to was the same way.

Williamson: The towers…

Meyer: … it's that. It's seeing it happen, and you know, I didn't really care about going to Iraq.

Williamson: Yes

Meyer: But I wanted to go to Afghanistan because I wanted to make them pay for what they had done to our country.

Williamson: Interesting. That's a powerful image. Let's shift gears here for a second. I'm interested in knowing, what was it like for you after you came back, your encounter with the education system, colleges?

Meyer: It was horrible. I won't say any names, but I came here to this college, and everyone supported me to the utmost. You know, at the higher level. But I can tell you that I would never set foot in a classroom again and I lost all interest. I wanted to be everything I could be and do great at education and go pursue it, and when professors are speaking the ignorance that they're speaking, it ain't happening. The level of ignorance…and I guess if it was kids talking about it, I would be fine with it. But when you have someone

who has an impact to make a difference, and they're speaking on things that they have no idea about, it's no different than the Taliban going and using their power to educate people the wrong way.

Williamson: What kind of issues?

Meyer: The first class that I ever went to, I went in and the professor walked in, we're all sitting there, and it was on the day that Iraq war ended. And he came in, and he's walking up front, back and forth, and he said, "You all know what today is?" I wasn't going to raise my hand, I was sitting in the back. I wasn't going to be that person to know it all, you know, and he goes, "Yep, today, I didn't figure anybody did, today's the day that Iraq war ended." I was like, okay, maybe it's going to be good, maybe people are going to learn, and he starts talking about how we fought for nothing. And this and that, and went into it, and Iraq and Afghanistan. I sat there for a minute, and I told myself, if he says it one more time, I'm going to say something. And he did, and you know, the kids started chiming in. He said it again, and I stood up and said, well, "How did we start talking about how we lost?" I said, "How did we lose? What stats are you looking at?" I said, "Are you looking at? How many people we killed? Because we killed more of them than they did of us." I said, "Are you looking at how many battles we won?" I said, "Because we won more battles than them." I said, "Nobody gives a first place trophy in war."

Williamson: Right.

Meyer: …And it made him mad, and he turned around, and he looked at everyone, and he goes, "Let me tell you

all something right now. I'm a veteran myself, and until any of you in those seats have been there or done that, I don't care what you say." And I was still standing up, and he looked at me, you know, the whole class turns, and I go, "Well let me tell you, I've been to Iraq and Afghanistan, and I lost my whole team, and I'm going to tell you right now that I'm not going to let someone like you sit here and tell me that my guys died for nothing." And I got up and walked out. I went straight up to the Dean's office and told him that level of ignorance is insane. And then come to find out, all the man did was play baseball in Vietnam.

Williamson: What I'm hearing you say is that educators really need to be mindful of the information being given.

Meyer: Exactly. You [educators] have such an influence. People look at you to gain knowledge. If you don't know what you're talking about, don't talk about it. And I don't think people should be called educators, I don't think they should be called professors; I think they should be called facilitators. I think you take that title away, and it's like taking a CEO to an executive, you know, you take that title away, you understand, I think it puts you in your mindset, I'm a facilitator. I'm a facilitator in order to get whatever the curriculum is, to get them the most knowledge that I can provide them, and if not, provide them where they can locate that. And I think once you do that, it humbles them, and that's the thing.

People think, well I'm a professor, I'm a doctor. Well, you know, doctors are practicing. They get in their little

slump and they know everything, and I know how teachers do it; I do it in my office sometimes. I only ask questions I know answers to. I can walk, I can guarantee I can walk in any of these classrooms right now and hear any subject, and I can stump them on a question. They don't know everything. But they have to know that. Who reminds them of that?

Williamson: Educators need to be very aware of their limitations.

Meyer: Yeah, because it snowballs, because once you start feeling like, "I know everything, I'm a professor." Well, then you [educators] have a thought that comes into your mind that you haven't verified, and you throw it out there like you know it, and nobody's going to question you. And really, you're so far off, you have no idea. You get caught up in your own self. So I think that's what we've got to do in this education system. The education system is a whole other situation, and every problem that I go back to, it's education.

Williamson: Okay.

Meyer: Every issue, whether it's in the medical field…everything I go back to, whether it's all the way back to the war that I fought, it's because of a lack of education.

Williamson: You really feel like that knowledge and education have a transformative capability, have a potential…

Meyer: A big potential…

Williamson: Yes.

Meyer: Knowledge…there is nothing more truer than the words, "knowledge is power." There is nothing truer than that. And continuing the knowledge, I mean, always continuing the knowledge, because you can never learn everything. But first understanding that you don't know everything, and then, trying to know, trying to learn as much as you can…and being open to ideas. I call it the small town complex. Get out of the small town complex and understand things do change. Opinions change. It's a moving target.

Williamson: We all have to be lifelong learners.

Meyer: Lifelong learners. Continuing your education and never knowing everything. I mean, that goes to everything in life, whether it's a parent, whether it's a husband or wife, whether it's a doctor or professor or whatever it is – it's everything, you know, it's everything.

Williamson: That's a powerful concept. Let me ask you this: how were you treated as a vet coming into a higher education system of colleges and universities, trying to get…[crosstalk]

Meyer: …It depends. I've seen some universities who were really good at it. But it's taken care of by veterans. Look, higher education is normally, not really the conservative side. I mean, I would say that most of the time, in the veteran community, we don't ever talk politics in the veteran community, but I would say you have a more conservative approach, I guess. If nothing else, it's more of an independent approach, I would give it.

Higher education is more of a democratic, liberal side of thought pattern. They don't match up. But that's where the college has to be smart and say, "Look, we don't know anything about this, let's find somebody to do it, instead of ignoring the problem." A lot of colleges ignore the problem. I don't really know what it would have been like for me to come here if I didn't know the Dean. I don't know, but I could probably guess that there really isn't a lot going on here [in higher education], as far as helping. There are no communities, there are no events. What do you know about veterans here? Some schools, some colleges, they give grants for purple hearts, they understand combat experts. They know the veterans and they give benefits to them for what they've done.

Williamson: When working with people at Fort Knox, we asked them to help us understand what we need to be training counselors to do? Because I think that the thing we're very aware of is exactly what you're talking about: a moving target. The fact that this is going to be a population that has unique needs. It's not the eighteen-year-old. It's a group that functions in a different way. [Combat veterans]

Meyer: Yes.

Williamson: We want to make sure we understand that, so I completely see what you're talking about. There is a new initiative called Opportunity Knox and they've hired a liaison to function with veterans and colleges to make sure that it's the college that's best matched for them, it's not the college going in and recruiting them, but them helping to connect in the ways they need.

Meyer: Yeah.

Williamson: It's going to be the same between Kentucky and Indiana, they're trying to make this area a more attractive place for vets coming out of the military. For them and their families.

Meyer: Yeah.

Williamson: What they're trying to do is match industry with skill. We met with several heads of industry, people who build bridges, the person who supplies the steel to the man who builds the bridges, and he's saying, "When vets come out, they're disciplined, trained…they're trainable;" he said, "I will send them to welding school if they'll come work for me, I'll pay for them to get that training, and then they can come back and make fifty, sixty bucks an hour being a welder…If I can just find the right guys who are interested in doing that."

Meyer: Yeah, so I worked big on that initiative, as far as Hiring Heroes with the U.S. Chamber of Commerce, so I helped lead that initiative, I help on the initiative. I'll tell you where you know you've really got a problem, is when you find a veteran dead in his vehicle on campus, there's a problem. You know what I mean? There's two problems. Obviously, none of the professors, nobody who knew him, had seen that problem and said anything about it. That's one. And I really find it hard to believe that someone couldn't see an early warning signal on this. It doesn't just happen. The second thing is, is that there wasn't a support system. I don't know what you could do…a club, organization inside the community for

veterans, you know. There wasn't enough of a support system to connect veterans inside of it, to where someone knew where he was at.

Williamson: What would you change? What would you identify as…

Meyer: Well, veterans are different. They're like you said, they're not an eighteen-year-old kid coming from high school.

Williamson: Right.

Meyer: So treat them differently. Treat them in a more mature way. Have a separate link for veterans on your website. Have an easy access page, frequently asked questions with how to enroll, who to get in contact with, for veterans. I'm not saying bend over backwards, but you do it for the football players. You do it for the basketball players. Why don't you do it for the veterans? That's one thing. The second thing is, is who's your liaison? What about an organization for veterans here? The last thing a veteran wants to do is come back and be bored. They don't want to do it. They want to have a purpose. They want to be involved, they want to do something. So come up with an organization that helps the community. Come up with something they can lead. They're leaders. You know, help them mentor kids. Give them options.

Williamson: Okay. You brought up something that I think is really powerful. You identified that veterans who are leaving the military and going into higher education or going other places need a purpose. Tell us about that.

Meyer: Yeah, so I think that's what got me back on track. It's not necessarily that anything's going to change. The nightmares aren't going to go away. You're kidding yourself, I mean, everybody says time heals everything. The answer's not drugs, the answer's not pills that the doctor wants to give me, it's not sleeping pills. You're not going to find a magical answer that makes it go away. It's still going to be there five years later; it's still going to be there every day. So the difference is, you have to change your purpose. What's your new purpose? It's going to change; it's like a new chapter.

So you always have to understand what your purpose is, and always refer back to that purpose whenever it gets hard and you're going through the grind. Everybody has to have a purpose, whether it's your kids or whatever it is, whatever your purpose is, you've got to find it. And that's what you have to do: you have to help these veterans find their new purpose. What's their new reason for being great?

Williamson: Do you think that's a moving target for some folks?

Meyer: Yeah, I mean, yeah, it changes constantly. I think that it changes as your life changes. I think that every time you move up a step it changes. At one point, what was important to me was getting a great job and starting a business. It was, you know, perfecting my speech, making a difference. I think once you get your core of where you stand, I call it your brand. When people say your name, what do you want them to remember? So label it in words. What is that? Is it honor, integrity; is it selflessness. So

what do you want your brand to be first? Identify that, what your brand is, and after you know what your brand is, then what's your purpose? What's your start?

What's your thirty thousand foot view that, no matter what, you know you might have to shift every now and then, but you always go back to…you always revert back to that center point. So that becomes your view to stay focused on, and that's what keeps you going and doesn't let you fall off the wagon. You know that's what's going to hold you self-accountable.

Williamson: If you were going to give a recently discharged vet advice, what would be the steps that you would recommend him/her to develop that brand?

Meyer: Well, you listen first. You listen. "Hey, so what's going on?" Get to know them. Don't start off with, "So we're here today and we've got a thirty-minute session." Don't put a time frame on it. "We've got thirty minutes, so today we're going to cover this…fill these worksheets out and let me see where you're at." That is like the most bogus way ever. All you've got to do is talk to someone. You can go get any veteran out here who's dealt with somebody.

At my office just now, I was playing counselor with one of my employees. I do it all the time. And so, what you do is, you suck all the information out of them. What is going on? What's the biggest concern in your life right now? What is affecting you? If you can't get it, you talk about something else to get their mind off of it, build that trust, and

you come back in and hit it again with a different way.

Try to relate to them. Try to get on their level and relate to them. And once you do that part of it, you start getting this information, and you listen, you take notes, you don't make them feel uncomfortable about it. And then you come back and go through that, those lists of issues that they see is really bugging them, and you try to ask them what's going on. Put accountability on them. "Is it you causing it or is it someone else?" If it's self-inflicted, you can fix it. If it is, you've got to understand that, you can't control what your family's doing, but you can control how you let it control you. Once you identify those, then you come back and you build a plan, an action plan. "What are we going to do to fix this?" "We both know this isn't right…" you relate to them. You empower them to be able to execute that plan. You have to empower them. When they leave, you have to find a way to relate and connect to that person, to empower them to think that they can do it. No matter what the struggle is.

Williamson: That's a powerful piece of self-actualization. How did you come to this?

Meyer: I'll tell you, just dealing with it daily. I guess the way I came up with it is dealing with employees and trying to find a way to make them better for themselves, as well as you, and how do you do that. I knew how I would get myself to do it, so I had to figure out how I was going to do it to use on someone else. It's forming a team. No one can do anything by themselves. You exist by yourself, and you can do it for a

while, but you'll get in a dark place. You will go into what I call "the vortex." You will go in this vortex that is so hard to get out of…if you don't stay around people. You know…that's what humans are for.

Williamson: You're saying staying connected is important?

Meyer: Connection; you have to find that core. I'm saying two or three people that have got you no matter what. Don't, just don't burn a bunch of bridges where you don't have to. No one's perfect. What you're going to start doing is you're going to start slicing them away, and the wood's going to eventually break. You're going to have nothing. I've got people in my life who are great employees, but I would never, ever see them on the street or want to, because there's no telling what they're into, but I know they're great employees so I keep them. Instead of trying to fix everyone, just understand who they are. Understand where your bandwidth is and focus on what you can control.

Williamson: Would you agree that sometimes when we have friends, and you talk about your issues with your friends, that they can help you find reality? Your friends can help reel you in.

Meyer: Yeah, I think that they can. I think that you've got those people that can. I think you've got to have that person who will tell you, "Look, you're being a dumbass."

Williamson: Okay.

Meyer: I think you've got to have that person who will ask, "You really

think that?" "Man, you know, it's just not worth it."

Williamson: What I'm hearing you say is you need people in your life who are going to call you out on your "personal junk."

Meyer: Yeah, who's going to call you out on the personal junk…the feeling sorry for yourself. I deal with this in the company. A family member dies, and this is what I tell them…maybe it's harsh, maybe it's not. But I tell them it's okay to be sad about it. It's okay to feel upset about it. But do you think that person wants you to feel upset? No. Okay, so here's what I want you to do. Tell me how long you need to leave. Because you're not going to get anything done for me here. You tell me how long you're going to need to leave. But what I want you to do is, mark a time when you're going to stop feeling sorry for yourself, and when you're going to come back and go on with your life like they would want you to do. So once you do that, let me know, and you can come back to the office.

I send every one of them home that way. There's got to be the pulse factor, there's got to be the realization. It's not okay to feel sorry for yourself over someone who died a year ago. I mean, it's okay to remember them. You'll always remember them. Laugh, and feel great, and be sad on the day, but it's not okay to be miserable the rest of your life over it. And that's when we've got to have that tough love. You know, it's got to be the tough love.

Williamson: You mentioned something a moment ago. You said that you feel that when people are coming

back, [military discharge] they need to have a brand, they need to have a purpose. And that purpose is going to carry them through. What is Dakota Meyer's brand, and what is his purpose now?

Meyer: The Dakota Meyer brand is honor, integrity; it's selflessness, it's veterans. It's not Medal of Honor. It's loyalty; and the "whatever it takes" attitude. The "standing up for things." The "not going with necessarily the grain, but being the voice of reason."

What's my purpose? My purpose is to make a difference, to change the world. You know, I don't have to, as crazy as that sounds, but it's to change the world and to empower individuals, and to educate and empower individuals to accept nothing less than being great. However I have to do that, whether it's talking to a kid on the side of the street when he needs help, whether it's pulling over and help putting a bus out, that's on fire, whether it's talking to an employee and being there for them, that's what I want to do. I mean, the only reason I create companies is because I want to create an environment that people look forward to coming to. It's opportunity and accountability.

I don't have a company that I've ever taken a dollar from. I do it because I love being able to provide an environment that employees can come to and that they know is stable, they know that someone, their boss, has their back and cares about them, and that they look forward to coming to work. That's what I want to do.

Williamson: That's a great transition, because that gets back to what we

wanted to ask you about your current campaign. What kind of current campaigns or initiatives do you have going right now?

Meyer: I'm talking about writing another book. It's basically going to be "fight adversity," talking about that. It's what I'm trying to do. I still raise money for different organizations. Trying to help, trying to fix this gap with veterans transitioning out of the military. Trying to find the solution, which is a tough one. That's the big initiative.

Running a construction company…we're nation-wide, so I do that. Running and growing a business and trying to set the example, stay on that road. That's kind of what my campaigns are.

Williamson: You said you like to start companies. How many have you started?

Meyer: I've got Dakota Meyer Enterprises; I just actually started a new nonprofit called the Dakota Meyer Leadership Institute. I'm hoping to get it up and rolling. I have a company called "For Those Who Gave All" which is an apparel brand trying to raise awareness. I've got a company called DM Tax Point which is a consulting company for military. I have a company called Dakota Meyer Opportunities, which is another consulting company to the integrative technology side. I've got a company that's called Accountable Performance, that is with a company called Patriot One, and we go out and we put on concerts on military bases.

Williamson: Okay. You've got a lot of irons in the fire. That's a big purpose, as well.

Meyer: Yeah! It's trying to grab everything you can, just make a difference. My big initiative right now is to get this book written, and I don't want this to sound the wrong way, but usually whenever I'm talking to someone with a problem, I think that they usually leave in a better place than where they started. I feel like I could write about how I dealt with adversity and stayed focused on my goals, not just getting the medal…after getting the medal, with all of the lawsuits. How do you keep fighting and weather the storm? I think that you can relate to people that are dealing with the paycheck to paycheck bills and other struggles in America. I hope that they can read it and it empowers them to turn around and do something for themselves.

Williamson: Of all of your initiatives and campaigns and things that you're working on right now, if there was one that we could include at the end of the interview, that you would like to promote most…

Meyer: Yeah, Dakota Meyer Enterprises.

Williamson: Okay. What message do you want to accompany that promo?

Meyer: I'm just trying to provide a place and give an example of accepting nothing less than being great. I'm just trying to set an example for how to stay on top.

Williamson: Okay. Let me ask you this: you mentioned kids…If there was a kid on the street who came up to you and shook your hand, what advice would you give to him?

Meyer: Never give up. Understand what is wrong and right and make your own decisions. That's one of my dreams, especially with the Leadership Institute, is to get kids at an age where they're more like play-dough, and if we can mold them and put powerful people around them, then we can help with the education system and raise education in America.

I truly believe that that's where it starts, and so that is my goal. But what would I do? I would tell him to never give up; never, no matter what, never give up. Everybody's so focused on "What do you want to be when you grow up?" Well once a kid says he wants to be great, everything will fall into place. Instead of trying to figure out if you want to be a fireman, a doctor, a nurse, a cook, whatever, if you'll decide and understand that you want to be great, then the rest of your life will fall into place.

Williamson: Who were your heroes as a kid?

Meyer: I've got to tell you, my dad and my grandfather are two huge heroes. They made me who I am. I always say I'm nothing. I am an example of the leaders who have been around me. I'm just the result of great leadership around me and great accountability. And so, I would say those are two of them. I think today, if you asked me, it's people like Gary Vernon from Rascall Flatts and that guy is a great guy, he's been there for me no matter what. The great Chris Schmidt, Toby Young, I mean, those

people are my core people to be there, so that's what I would say.

Williamson: What traits do your heroes have in common?

Meyer: You know, I say it a lot, but they hold me accountable. They're the voice of reason. They're the ones who are going to tell me when I'm wrong. They're not worried about hurting my feelings. They're worried about what's best for me. And they do it. We all come from different walks of life, and we don't always agree, but it's always that level of stability there.

Williamson: There's honesty and wisdom?

Meyer: Exactly.

Williamson: …and accountability…

Meyer: And accountability…and consistency.

Williamson: …and consistency…

Meyer: That's a huge one. Consistency.

Williamson: Do you have a motto?

Meyer: Yeah. "Whatever it takes." I know that's kind of a corny motto, but that's really it, "whatever it takes."

Williamson: What does that mean to you?

Meyer: It just really means that no matter what the situation, you do whatever it takes to come out the best person on the other side. It's not necessarily about winning or losing; it's

about being the best person that you can be for the situation. There are a lot of times that you've got to walk away. There are a lot of times you can only do so much, and that's the hardest part is understanding, with that motto, is knowing when to walk away.

Williamson: Right.

Meyer: But that's it. Whatever it takes. It really is what it says: whatever it takes, no matter what it is, whatever it takes. Don't worry about, I don't look at the motto of "I can, I think I can," as a coward motto; I think that the "I will" is the motto that you've got to go higher.

Williamson: You're like Yoda now. "There's no 'I can,' only 'I will.'"

Meyer: Yeah. [laughing]

Williamson: What else would you like for us to add to this?

Meyer: Pretty much got it all out of me.

Williamson: You have some powerful statements, and we're very appreciative of your time and insights.

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