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Letter From the Editor

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

Editing this journal has reacquainted me with I skill I learned during my 25 years in the Air Force – how to get by on four to five hours of sleep a night. In many ways, I don't think I ever lost many of the values I learned in the Air Force and one of the main one is the sense of mission. This journal, and ACEG, or a mission for me – an avenue to serve a population I love, while I still get to do another thing I love that being teaching the next generation of counselors. All this is just to say that this issue is late getting published and for that I apologize to the ACEG membership and the authors of the articles in this issue.

This issue is an eclectic collection of articles in practice, theory, and research. The lead article touches on the loss of war and the experience of the widow. I hope to get more articles that involve the after affect of combat on the survivors. The second article focuses on veteran students in higher education. Since I view the children as the "forgotten factor" in the dynamic of the military family, there has to be an article involving school counselors. The fourth article presents trends in rehabilitation with veterans with TBI. The graduate student article examines the current literature on the treatment of PTSD using EMDR.

I need more submissions for the JMCG – as of today, I have enough articles on-hand for one more issue. So, ask around where you work – or try writing yourself. I'm advertising for submissions through ACA channels. Now that I have two issues to present, I will be focusing on getting the *JMGC* listed in a database (such as ERIC, SocINDEX, or PsychARTICLES) and assigning Digital Object Identifiers. Once *JMGC* is established, I'll work to have us listed in databases such as PubMed.

Benjamin V. Noah, PhD
JMGC Founding Editor

How the Social Isolation Factor and Ineffective Counseling Theory are Impacting the Grieving Experience of Today's Young Military Widows

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Abstract

Grief has only begun to be researched. A preponderance of existing research has been conducted studying widows and the emotional impact of their grief. Most research on widows has been done with middle age to elder widows. This article considers a sample of young widows between 18 and 25 who lost their mates as a result of recent war casualties. Using a basic interpretive qualitative design this study examined the data yielded from interviews with young widows based on questions designed using the Dual Process Model (DPM) Theory of grief (Stroebe & Schut, 2005). Individuals tried many different counselors before feeling as if their experiences were being understood.

KEYWORDS: military, widow, grief, dual processing model

As of October 2011, the approximate number of casualties due to the current wars in Afghanistan and Iraq totaled 6,253 (Statistical Information Analysis Division, 2011). These figures represent all branches of the military that were killed as a direct result of the United States involvement in war. It is estimated these figures are rising daily. These deaths result in a tremendous number of military spouses left to grieve the deaths as well as forcing them to learn how to function without their partners. The military community provides some support to these spouses in the forms of assistance with notifications, assistance with funeral plans, assistance with burial plans, and immediate emotional support.

At some point, nearly everyone experiences the death of a loved one. Unfortunately, death often results in a plethora of emotional distress, and emotional distress may or may not resolve itself over time. In fact, grief has been known to result in an increased risk of psychiatric

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disturbances such as major depressive episodes (Donnelly, Field, & Horowitz, 2001; Gilbar & Ben-Zur, 2002; Utz, Reidy, Carr, Neese, & Wortman, 2004). The bereaved are seen as representing a large at-risk population with higher overall death and suicide rates than age-matched control individuals. The bereaved have also been found to have increased occurrences of depression, substance abuse, and medical ailments (Allumbaugh & Hoyt, 1999; Donnelly et al., 2001; Feigelman, Jordan, & Gorman, 2009).

Often the bereaved seek health care without necessarily recognizing that grief is the underlying cause of their physical conditions (Feigleman et al., 2009; Worden, 2002). These illnesses include manifestations such as headaches, heart palpitations, and a variety of gastrointestinal symptoms (Donnelly et al., 2001; Feigleman et al., 2009; Worden, 2002). Mortality is significantly higher for both men and women during the period of time shortly after the death of a spouse. Additionally, the death of a spouse is seen as an assault on the meaning system of the bereaved, requiring significant revision of identity and of coming to terms with the new life situation (Field, Gal-Oz, & Bonanno, 2003; Gamino & Sewell, 2004; Waskowic & Chartier, 2003). Working through the loss involves interplay between attempts to preserve the past and the demand to accommodate the reality of present life without the deceased. Since a significant amount of accommodation is required, resolution of grief can be understood at the level of the individual's meaning system, as constructing a new life narrative that carries forth aspects of identity, incorporating the past relationship with the deceased, into the meaningful future (Epstein, Kalus, & Berger, 2006; Gamino & Sewell, 2004). By incorporating various aspects of identity to include values and beliefs that are symbolized by the image of the deceased, a continuing bond provides the bereaved with a sense of meaning and continuity in his or her new life.

If this new meaning is not successfully accomplished, the result is that of internalization of the emotion, and lowered coping strategies, as well as an increase in unbearable affect, and a feeling of being out of control (Field et al., 2003; Gamino & Sewell, 2004; Huda, 2001). Life cycle psychologist R.S. Lazarus (2000) has posited past experiences can help one cope with future events. This utilization of past experiences is often referred to as "anticipatory coping." Skills learned through successfully coping with negative experiences, can help when encountering future events. Likewise, unsuccessful coping experiences can provide a basis for identifying behaviors that are better modified (Field et al., 2003; Fraley & Bonanno, 2004; Zunker, 2006).

Healthy expressions of grief include deep sadness, painful awareness of the loss, physical distress, and a mix of apathy, anger, and despair (Donnelly et al., 2001; Weiss & Richards, 1997). Previous research has demonstrated as many as one in three of the bereaved are suffering from pathological or complicated grief (Marwit, 1996; Prigerson, 1997). Since the overall objective of grief work is to reconstruct one's life without the loved one (Marwit, 1996; Worden, 2002), there is a need for more exploratory research to identify the contextual experience of grief (Greenstreet, 2004; Wright & Hogan, 2008). As new information comes to light as a result of studies such as this, mental health grief clinicians gain not only a more broad understanding of the grief experience, but they are then better equipped to tailor treatment approaches to more appropriately address those experiences. Since militarily grieved spouses or "war widows" embody a unique group of the bereaved, their treatment should be equally unique.

A study of the patterns of resilience and maladjustment during widowhood (Bonanno et al. 2004), examined whether or not an apparent absence of grief is indicative of denial, inhibition, lack of attachment, or resilience. By using a quantitative study, the researchers' demonstrated large numbers of individuals appeared to be highly resilient in the face of losing a spouse. The study called for further research to examine the traditional bereavement theory more in-depth (Bonanno et al., 2004; Wright & Hogan, 2008). Bonanno et al. stated there was a significant need to consider if there may be alternative pathways through which an individual may emerge from the period of bereavement following the death of a spouse. They stated future research needs to focus more attention on the contextual features of loss. For example, research is needed that considers what the experience of loss consists of, both helpful and unhelpful aspects (Bonanno & Kaltman, 1999; Wright & Hogan, 2008).

Another study, examined the grief experiences of widows who were widowed earlier in their lives (Bisconti, Bergeman, & Boker, 2006). By using a quantitative study design, Bisconti et al. considered a small group of widows between 18 and 42 days after the beginning of their periods of bereavement to determine whether or not social support was a predictor of the adjustment trajectories identified in the study group. It was hypothesized that understanding the components of the social support process would heighten the general understanding of what contributes to the regulation of resiliency in later life. However, Bisconti et al. failed to demonstrate social support significantly predicted components of the emotional well-being process. Other studies (Somhlaba & Wait, 2008; Zettle & Rook, 2004) demonstrated social support had a significant and positive influence on the recovery process of bereavement.

One result of such a gap in thick data being produced resulting from research is clinicians within the counseling profession only have a set of numbers to identify the various components of grief behaviors. Interpretations are given to these sets of numbers by the researchers who captured them. In order for mental health clinicians to be better equipped to treat the bereaved, there is a great need for not only a deeper understanding of the grief experience itself, but also for an understanding of what commonalities, if any, exist within the experience from widow to widow (Bath, 2009; Somhlaba & Wait, 2008; Zettle & Rook, 2004).

Another oversight in the existing literature is the majority of studies conducted were done utilizing a sample of older widows. Few studies exist (Caserta & Lund, 2007; Cooke, 2003; Donnelly et al., 2001) that have examined the experience of grief from the perspective of younger widows. The majority of existing research studied middle age widows and older widows (Donnelly et al., 2001; Guinther, Segal, & Bogaards, 2003; Sandler, Wolchik, & Ayers, 2005). While studies generating sets of numerical data are fairly generalizeable, they do not contribute to an understanding of the experience of younger widows. Even though the general population is aging in numbers greater than any other generation, there is still a need for rigorous research to consider grief among other age groups of widows (Bonanno et al., 2004; Wright & Hogan, 2008).

Research Problem

Currently the United States is actively involved in two large-scale wars. The vast majority of military personnel fighting these wars are of the younger generation with 58% of the

casualties occurring between the ages of 18 and 25 (The Washington Post, 2009). The counterpart of this fact is greater numbers of young widows and widowers are being created every day. There exists a lacuna in research regarding this population of the bereaved. Existing studies which examined this population were primarily conducted using the quantitative research design and, therefore, produced data that was not contextual, nor did the studies allow for individual experiences (Gamino & Sewell, 2004; Guinther et al., 2003). Until research is done among this population and thicker data is captured, mental health grief clinicians will remain unfamiliar with the components of bereavement that are or may be unique to this population of younger widows who lost a mate as a war casualty.

While a fair amount of research has been conducted studying the grieving process, there has been very little research conducted with widows under the age of twenty-five, and even less studying those widowed by a spouse having been killed in action in the Iraq or Afghanistan wars. The purpose of this basic interpretive qualitative study was to understand the common aspects of grief as experienced by spouses between the ages of 18 and 25 who lost a mate killed in action in Iraq or Afghanistan. A study such as this will provide insight about the grieving experience to mental health clinicians who do grief counseling (common aspects of grief as experienced by this group of spouses). A study such as this will provide insight about the grieving experience to mental health clinicians who do grief counseling.

This study was done utilizing a group of volunteers from a local military base where the Program Director of the Survivor Outreach Services contacted her list of widows who fit the research criteria (widowed no less than twelve months, between the ages of 18-25, lost their mates as a result of a war casualty in Iraq or Afghanistan) and solicited their participation. Those who were interested in participating then replied to the Program Director. She then, in turn, provided the researcher with their contact information and the researcher then made contact with each of them, explained the research further to each of them, answered any questions and went over the informed consent forms with them. Dates were then set up with participants for the taped phone interviews. On the dates of the interviews the researcher called each participant, put her on hold and called as a third party a licensed and experienced clinical social worker who was to act as a crisis evaluator after the interview to assess the mental health status of each participant prior to disconnection and to determine if any participant was being left in a precarious emotional state due to the interview.

During the interviews each participant was guided by a set of semi-structured interview questions, but each participant was encouraged to expand upon her answers as she felt led to do so. The set of questions was designed with the dual process model of bereavement in mind (Stroebe & Schut, 1999). The dual process model of bereavement (DPM) states there are two primary emphases when considering bereavement (Archer, 2008; Rubin, 1999; Stroebe & Schut, 1999). The first emphasis is loss oriented, which addresses the internal, emotional aspect of the loss. The second emphasis is restoration oriented and addresses the loss by turning away from the emotional aspects and engaging in new tasks and role definitions caused by the loss. It is believed oscillation between the two emphases enables a balanced approach to grief and yields better mental health (Malkinson, Rubin, & Witztum, 2006; Richardson, 2007; Rubin, 1999).

The DPM theory holds the emotions experienced by the bereaved reflect the response to the inability to protect oneself from the realities of death as well as the recognition it is not possible to maintain the pre-loss bond with the deceased. It also holds there is a fear of having to now face life and make decisions on their own, anger at the deceased for leaving them, and even their own mortality (Richardson, 2007; Rubin, 1999; Stroebe & Schut, 1999). The restorational focus addresses such things as familial relations, work, and investment in life tasks, most of which were formerly performed by the deceased. These tasks may include financial matters, household and automobile repairs, and even household chores not previously performed by the bereaved (Richardson, 2007; Rubin, 1999; Stroebe & Schut, 1999).

Rubin (1999) hypothesized the DPM theory of bereavement provided an effective and empirical method for conceptualization of the loss experience as well as an understanding of the totality of the period of bereavement. Research demonstrates the DPM provided a way to effectively measure which aspects of a loss are life-long, which are transient, and which are problematic for the bereaved. However, it also holds more empirical research needs to be conducted to thoroughly validate this theory, since it represents a fairly new perspective on grief (Richardson, 2007; Rubin, 1999; Servaty-Seib, 2004).

The task or goal of the first track of DPM involves the emotional components of grief, in which the bereaved attempts to return to a level of functioning that allows him or her to manage and live in a reality in which the deceased is absent. This task commonly includes resistance to change in the form of denial, avoidance, and admission of loneliness (Malkinson et al., 2006). The first track also involves that of confronting and managing the unique emotional bond with the deceased, and the impact that the loss has on the nature of the relationship. This track addresses the longing, sadness, and intense involvement with the things that link one with the deceased (Malkinson et al., 2006).

In the restorational, or second track, the bereaved is confronted with the day-to-day reality in which she must address such issues as attending to children on her own, working, moving, and even in some cases learning home repairs or financial management. The widow must address such issues as attending to life changes and doing new things. The concept of restoration is not an effort to return to life as it was with the deceased, but rather to adapt to the new world in which the bereaved finds herself without the deceased (Malkinson et al., 2006).

It has been concluded (Malkinson et al., 2006) the DPM is an effective method for evaluating the progression of a bereaved individual when learning to live without the deceased. It has been demonstrated the DPM provides enough flexibility to be effective across a wide spectrum of bereavement and covers various ages, genders, and circumstances of death (Malkinson et al., 2006). It would also, then, appear that the DPM would effectively work as a theoretical perspective of widows who lost their mates as a result of war casualties. Similarly, Richardson (2007) concluded the DPM yields a more healthy mental status while grieving.

Several common themes became visible from these interviews. It was difficult to distinguish which of these commonalities were due to the ages of the participants and which were due to the fact that the deaths of the spouses were due to the military losses. However, there were clearly similarities among these losses that made this population different from that of older

age widows. For example, while middle and older aged widows either didn't find themselves wrestling with questions about entering new romantic relationships or how soon to enter those relationships these younger age groups of widows found themselves confronting these questions very early on after the deaths of their spouses.

For this study the actual participants ranged in age from 21 to 24 at the time they were widowed. With this being a sample of convenience, all turned out to be Caucasian and none had remarried and only one had moved out of the area since having been widowed. All continued to live on or near a military base. As expected, each experienced fairly similar experiences to one another shortly after the deaths of their husbands as well as at the times of their interviews. As also expected, each widow's story had significant differences from most previous research studying an older group of widows. All widows had been married less than one year at the time they were widowed, though most had known one another significantly longer. Most had been married less than six months at the time of death.

While Bisconti et al. (2006) hold the social supports are significant predictors as components of the emotional well-being process of the bereaved, this study found that at least among this young group of conjugally bereaved, other factors also figured in to predict their emotional well-being. These factors included length of time they had been involved with their deceased spouses, plans that had been made with that spouse, whether or not children were produced from the relationship and personal perspective about the death itself. It did seem structural support did not predict components of the well-being process (Bath, 2008; Bisconti et al., 2006). Rank of the deceased spouses did not seem to influence the well-being, neither did birth order of the widows, nor the support system in place prior to the death of the spouse.

Where social networks were a factor, they tended to be substitutions in the area of other young widows more frequently than family members (Zettel & Rook, 2004). As Emily (pseudonym) stated:

> I'm in a whole different category now, a widow of a soldier rather than a wife of a soldier. Not only do I not feel comfortable with the spouses any more but they don't feel comfortable with me there. Suddenly, I'm seen as an outsider like I have some kind of disease or something.

Deborah (pseudonym) stated:

> I want to be around people who 'were there' or had been through the same kind of loss. Young widows, we're different. You can't compare this kind of loss to a loss from something like cancer. I've tried to talk to other friends and to family, but they just didn't get it. They seem to be thinking 'oh, you lost your husband, everybody does' but this is different. It was obvious they got tired of hearing me talk about (my husband's) death. They tried to lump me in with any other woman who had lost her husband, but my situation (my husband's death) is totally different.

As Zettel and Rook (2004) posited, the compensation aspect of the social networks held true among these participants, where alternative social ties enhanced the well-being of the participants once they dealt with their grief privately at first. Most of the widows went through a period of time where they felt the need to isolate and begin to come to grips with their new status

among the community. After that they began to seek solace outwardly. Betty (pseudonym) commented that:

> I literally wanted to die at first. Now, I've found other military widows around my age. We're a whole different game. The typical age of widows [are] different than we are. People keep expecting me to stop living or it's like I didn't love him. But I didn't die. It's not fair. I've spoken with many women my age and they're moving on with their lives but I'm not moving on. I just wanted to see someone who 'made it to the other side.'

The data garnered from this study also indicated there were not as many physiological symptoms seen as are seen among older widows (Donnelly et al., 2001; Worden, 2002). After the initial shock of being informed of the deaths most of the reactions seen among this group of widows tended to be emotional and psychosocial. The psychosocial behaviors tended to be more exocentric such as promiscuity, "retail therapy," and so forth.

This study also seemed to conflict with the parts of Bowlby's theory (Stroeve, 2002; Waskowic & Chartier, 2003), which holds that a conflict free relationship is more likely to display fewer grief symptoms than a relationship that had significant amounts of conflict. The participants in this study had been married a very brief amount of time, with the longest period being two years and most of that time the soldier had been deployed. This would seem to indicate the marriages had not yet lasted long enough to develop a pattern of conflict. Virtually all marriages begin with the experience of happiness and bliss with very little conflict. Every participant reported a great deal of love and respect for their spouses and every participant also displayed significant distress upon the loss of her spouse. This distress was displayed by vomiting when the Casualty Notification Officer appeared at the door, refusing to allow the Casualty Notification Officer entry into the home, asking a family member to tell them they had the wrong house, fainting, and several other signs of distress.

In several cases, participants displayed signs of not having severed the bonds with their spouses, but rather a changed bond with them (Waskowic & Chartier, 2003; Epstein et al., 2006). Eighty percent of the study participants reported some aspect of a changed bond with their deceased spouse. Participants reported "feeling like he's here with me," "I know he still watches over me," and "he can see me." One participant even mentioned she still talks to her husband. All participants expressed some sort of ongoing relationship with their spouses "spirit," perhaps in an effort to keep him alive to them in some way. However, this change in bond did not appear to prevent these women from progressing with and moving forward with their lives.

Zettel and Rook (2004) theorized about the loss of the social network also being grieved since the widow must deal with role adjustment. Compensation in the social network has a functional impact of minimizing the loss by utilizing other resources. The data produced by this study indicates these widows utilized other young military widows. Research indicates a positive relationship with an increase in loneliness and an increase in the formation of new social ties. The participants of this study all reported how many young widows groups help them, especially at times when they were feeling particularly lonely.

Only 60% of the participants (3 out of 5) sought counseling and even they reported it as being less than helpful. Alexis stated:

> I did talk to a counselor and it kind of helped. It mostly helped me understand how what I'm feeling now is related to all my stuff from childhood. I didn't stay in counseling long though. I just didn't feel it was doing much for me so I stopped going.

Carol remarked:

> I held off on professional counseling for awhile because I felt so ashamed because I wasn't able to handle it by myself. My friends and family got tired of hearing me talk about it so I saw a counselor a couple of times. It did help me get rid of the knot in my chest but that was about it. It really seemed to be more a waste of time than really helpful. I mean, it helped some but not all that much.

Deborah reported:

> I went through three different counselors before I found one that seemed pretty good. They kept telling me 'yes, you lost your husband but others lose theirs too' and I didn't feel they appreciated that I had lost my husband in such a horrible way. The way my husband died can't be compared to someone that loses her husband to cancer and the counselors just didn't seem to get that. They seemed more interested in playing with our baby than in what I was saying. I finally found one that really seemed like she was helping but not enough for me to see her for very long.

The Most Helpful Then

Initially after a death, the bereaved typically has no shortage of friends, family, and acquaintances for support. In this study, the data showed things to be somewhat different. Eighty percent of the participants reported feeling as if many people were avoiding them because they didn't know what to say or because of what they (the widows) represented to them. Most reported feeling a definite separation between them and the military spouses. Whether this separation was real or perceived, ultimately, the widows felt little support from those who had formerly been considered friends.

Deborah reported not knowing of any young widows in her home town in New England, so she has elected to remain in the general vicinity of the military base at which her husband was stationed. She states that she got more support from other young widows from the very beginning than even any of her family members provided.

Only 40% of the participants reported God or their faith as being a primary support for them initially after losing their husbands. Emily stated a belief that "God wouldn't have done this if I wasn't capable of dealing with it."

While Betty had mentioned having "lost her place in life" and that now she "would never be a mother," she also mentioned being raised in a very strong Christian household. She stated how much strength she drew from her faith from the beginning, but also mentioned being "angry at God" because she "had prayed for God to keep (her husband) safe." This type of vacillation was typical at such a time of loss when the emotions tend to alternate frequently.

The Most Helpful Now

As time progresses and the bereaved begin to feel slightly more sociable, the support system often begins to expand to once more include others. One hundred percent (5 out of 5) of the participants of this study specifically mentioned other young military widows as being their primary source of support. The Family Readiness Group and the Survivor Outreach Services were also mentioned as main sources of support for these widows. Whether taking part in activities as a consumer or as a leader these widows felt comfortable and helped by both of these groups provided by the military.

Forty percent of the participants have begun volunteering as a way of "giving back" to those who gave support to them. One widow volunteers to speak at the sessions held for the CNO/CAO training. She states that she wants them to see who it is they'll be giving the horrible news to and she tells them "if any of you don't want to be here (in this program), leave now." Another widow works diligently at fund raising for other military families, most often for a program called "homes for troops" that build houses for returning soldiers and their families. She states that she "tries to make others happy," and by doing so she feels she is contributing to those in the same or similar situations as that in which she is.

Deborah mentioned being very close to her sister and her husband's sister. She also stated that she talks a lot to her husband's best friends and that is another reason she has chosen not to move away from the area of the base where she had lived with her husband. She also volunteers for the "peer team" with the Family Readiness Group. This position means she helps prepare families in which the soldier is deployed or is in the process of being deployed. It was unclear what her role is in this group but it is a role from which she gets a significant amount of fulfillment.

Emily moved several states away from the base in order to be nearer her husband's family. She also lives near a military base, though a different one from which she and her husband had been involved. She is especially close to her husband's brother and his wife, who was stationed at the base Emily moved to, and they were some of the main reasons that is where she moved. She has since begun dating again and has dated several military men since moving there. She stated she is comfortable dating military men because that's what she has known. She also confided that it is a way she keeps (her husband) close to her. She tends to date men who are similar to the type of man her husband was.

Conclusion

Several factors are thought to contribute to the effects of conjugal bereavement such as the age of the survivor at the time of the loss of the spouse and the cause or suddenness of the death (Straub & Roberts, 2001). Most existing studies on early widowhood indicate the loss of a spouse may be more traumatic when experienced at a young age than when experienced toward later life. Excess mortality was found to be greater in younger widows than in older widows for virtually all causes of spousal death (Straub & Roberts, 2001; Stroebe, Hansson, Schut, & Stroebe, 2008). Sudden and unexpected death, such as that resulting from a war casualty, appears to produce excessive physical and emotional trauma on the survivor. It is thought to diminish the

capacity of the bereaved to cope not just with the death itself but also with normal day-to-day living (Johnson et al., 2009; Palmer, 2008).

Based on the interviews, it is concluded the grief experiences of these young widows are inclusive of several important differences than in previous studies with widows. It seems likely that this is due, in part, to the affiliation with the military and the manner of death by which these spouses have died. It also seems likely that these differences are to a greater extent due to the ages of the widows and the life stages in which they find themselves. Since their life stages are fuller of beginnings than endings it distinguishes them from the older groups of widows who have begun the stages with more endings.

The common themes included the fact that most of this sample population are extremely young and most had only been married a very short period of time prior to widowhood. The interruption of life progression has left these widows feeling extremely distressed about which direction their lives are going after becoming widowed. This is likely quite different than other studies of widows due to the fact that this group of participants had begun charting their lives when widowed while in other studies the widows are either in the midst of their lives or performing life reviews as part of the stage of elderly widowhood. In other studies, the deaths of the spouses more closely followed the natural progression of life roles. In this study the widows lost their mates when their lives were just beginning to take flight. They not only buried their spouses, they buried many of the dreams they had as well.

While the five participants experienced the common themes of young age, short duration of marriages, similar immediate reactions to the news of the deaths of the husbands, ongoing emotional distress, coping skills, and most pressing decisions; the grieving experiences of these widows were still as individual as they are. Additionally, some subthemes such as other young widow groups and issues such as new relationships and child-bearing were significant in that they indicated some of the key differences between the grieving experiences of widows in this study and those of other widows.

The data analysis indicated some significant similarities in grief experiences between participants in this study as well as indicators that regardless of age or situation the grief experience is highly unique to the individual. The study findings suggest that the grief theories currently driving the grief counselors trying to help young widows are not meeting their needs. The small number of widows that sought out counseling under these conditions is one thing that should be considered. Another important factor to be considered is that only one of the widows who did seek grief counseling reported a satisfactory working relationship with her therapist and it had taken three different therapists before she found the one with whom she now works. This has significant implications for counselors.

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Supporting Student Veterans: Current Landscape and Future Directions

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Abstract

The number of student veterans coming to institutions of higher education continues to increase as the Post 9/11 GI Bill enters its fourth year. With the unprecedented benefits for veterans, universities are asked to provide specific services to student veterans to meet their needs and experiences to increase retention and matriculation. This article outlines the issues faced by student veterans including relational challenges and isolation, student veteran combat-related injuries, unique considerations for female student veterans, and the reported needs of student veterans. In addition, specific suggestions are given for administrators and counselors to provide support for student veterans.

KEYWORDS: student veterans, transitions, support of student veterans

Student veterans are continuing to show their presence on college campuses across the nation. The Post 9/11 GI Bill, authorized by Congress in 2008, has contributed to approximately 550,000 veterans being enrolled in institutions of higher learning throughout the country (Sander, 2012). The number has the potential to increase as the American Council on Education (2008) reported that as many as 2 million students could access their educational benefits in the future. When authorized, the Post 9/11 GI Bill became the most extensive educational assistance since the original 1944 GI Bill was signed by President Franklin Roosevelt. Since its inception, universities and individuals received over 20 billion dollars from the government to fund veteran education (U.S. Department of Veteran Affairs, 2012).

With this influx of student veterans providing an increasing source of revenue for universities; many in post secondary administration, along with university faculty, and staff, are interested in learning more about this growing population. Many veterans, including those that have served in Iraq or Afghanistan, who have exited the military, or those still affiliated with the military have differing characteristics based on their experiences (DiRamio & Jarvis, 2011). Based on their these unique characteristics and needs, universities are seeking ways to

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incorporate useful information regarding developing initial steps to integrate the needs of student veterans into academic and social programming.

Addressing Student Veteran Transition

Secretary of Veterans Affairs Eric K. Shinseki offered a point of focus related to military veterans when he stated, "veteran-students transitioning from active duty service to civilian educational pursuits face unique challenges entering the college setting" (U.S. Department of Veterans Affairs, 2011). Additionally, President Barack Obama recently signed an Executive Order to fully fund the Post 9/11 G.I. Bill in April 2012 (Cooper, 2012). With the increasing number of student veterans, the Order is designed to increase the amount of information available to veterans thus protecting the veteran and their family members from deceptive marketing practices some universities employ to recruit veterans (Stratford, 2012). These actions indicate the heightened level of awareness amongst our national leadership regarding veterans entering academic settings.

Veterans who enroll in higher education are a subgroup of nontraditional students (Cook & Kim, 2009; Ford, Northrup & Wiley, 2009; O'Herrin, 2011; Persky & Oliver, 2010; Rumann & Hamrick, 2009). The recent enactment of the Post 9/11 G.I. Bill, with the attractive benefits package for veterans and their families, will provide the catalyst for an increasing number of veterans to utilize the G.I. Bill over the next several years (O'Herrin, 2011). It has been noted that student veterans encounter similar transition issues to nontraditional students (DiRamio & Jarvis, 2011), but bring their own unique set of issues related to their military experiences.

Research by Rumann and Hamrick (2009, p. 440) identified that these issues range from role incongruities, maturity issues, relationships, and identity renegotiation. In particular, role incongruities consisted of "military and academic life, the incompatibilities of lingering stress and anxiety with returning to college, and enacting aspects of the student role during deployment and aspects of the military role during college." Maturity of veterans also seems a unique characteristic as student veterans appear more motivated to complete their degrees after they had returned from service (Green, 2012; Rumann & Hamrick, 2009).

DiRamio, Ackerman, and Garza-Mitchell (2008) examined the potential transition issues affecting veterans of the Iraq and Afghanistan conflicts. DiRamio et al., in their discussion on veteran's transition and their time during combat, utilized the "Moving In, Moving Through, Moving Out" model (Schlossberg, Lynch, & Chickering, 1989; Schlossberg, Waters, & Goodman, 1989) as a framework for considering the transitional needs of veterans.

DiRamio et al. (2008, p. 80) identified key elements of student veteran transition as follows: "connecting with peers, blending in, faculty, the campus veterans' office, financial concerns, disability services, and mental health." Connecting with peers emerged as an issue for most of the student veterans, despite being somewhat similar in age, felt an increased sense of maturity based on their military experiences. For student veterans, to blend in typically meant that they didn't want to be recognized as a veteran by their peers (DiRamio, et al., 2008). By blending in student veterans did not have to answer awkward questions their nonveteran peers often ask pertaining to their experiences in the military. Faculty and administrative

inconsistencies were also an issue for student veterans. They expressed frustration that faculty and staff members on campus did not understand the needs of the veteran students. The difference, for these veterans, was that the faculty misunderstood them as a cultural group, whereas veteran services offices were inconsistent with how student veteran benefits were managed. Lastly, veterans identified that both mental health and disabilities offices "were not ready for a large increase in clients" (DiRamio, et al., 2008, p. 91).

To ensure a successful transition for student veterans, Ackerman, DiRamio, andGarza-Mitchell, (2009), O'Herrin (2011), and Rumann and Hamrick (2009) suggest colleges and universities increase the tailored services, including counseling, to ease the transition of veterans to campus. In addition, universities are encouraged to provide "mental health staff who understand veterans' issues" (Radford, 2010, p. 5). It is vital that universities, especially the helping professional on campus, understand how a student's "roles, relationships, routines, and assumptions have changed as a result of his or her military experience" (DiRamio & Garza, 2011, p. 9).

Relational Challenges and Isolation

Relationship challenges provided insight into student veteran transition as Rumann and Hamrick (2010) found that veterans returning to the educational setting had difficulty in maintaining previous relationships due to the time lapse where nonveteran students had advanced several semesters in their studies than the student veteran. In addition to maintaining relationships, student veterans experienced difficulty initiating new relationships because of the emotional and social maturity that they had developed while being deployed.

Because some student veterans feel that they can only share their military experiences with very few, specifically other veterans, veterans have shown a tendency to isolate from others causing difficulty in initiating and maintaining relationships (DiRamio, Ackerman, & Garza-Mitchell, 2009; Rumann & Hamrick, 2010). Student veterans utilize the "interdependency and cohesiveness" (DiRamio & Jarvis, 2011) they learned in the military as a tool for their success in college. Many student veterans feel a sense of frustration because of the "daunting and unfamiliar bureaucracy of higher education" (O'Herrin, 2011, "Establishing specific points of contact," para. 1).

Student Veterans Combat-Related Injuries

In addition to transition and relational issues of student veterans, another area of interest for college counselors is managing "service-connected injuries" (Radford, 2010). Cook and Kim (2009) speculated that nearly 18 percent of those soldiers returning from "Operation Enduring Freedom and Operation Iraqi Freedom suffered or are currently suffering from psychological problems such as post-traumatic stress disorder (PTSD) and depression" (p. 22-23). In addition to veterans returning with issues of mental health, the number of service members returning with traumatic brain injury (TBI) is estimated at 244,217 (Department of Defense, 2012). Given the complexity of these issues and the degree they can impact student veterans' learning, college administrators and counselors play a vital role in providing aid to the student veterans' as they return to the classroom.

Female Student Veterans

Within the military veteran population, there are gender specific issues for female student veterans (DiRamio et al., 2008). DiRamio and Jarvis (2011) reported that more than "14 percent of active-duty military personnel, with 17.5 percent National Guard or Reserve and 20 percent new recruits" (p. 70) are female. Additionally, 200,000 of the 1.8 million troops in Afghanistan and Iraq are women.

Female student veterans experience higher levels of financial difficulty and are susceptible to being victims of sexual assault. PTSD is also a growing concern for female veterans. In a study, of 8,000 students of those 800 were veterans, published in the Chronicle of Higher Education found female veterans had a 14.1 percent incidence of suffering from PTSD compared to 5.4 percent of nonveteran students and 9.8 percent of male veterans (Killough, 2009). In addition, female veterans had an increased rate of sexual assault while serving in the military. Killough (2009) found that 43.7 percent of female veterans reported being the survivor of sexual assault or MST (military sexual trauma).

Female student veterans have long struggled to establish an identity in the military. DiRamio and Jarvis (2011, p. 69) suggest "the history of women in the armed forces in many ways parallels the devaluation of women as workers in American society in general." Despite the increased presence of women in the military, they continue to lag behind men in high-ranking leadership roles. Potential reasons for this are that women take time off to raise their children or are single parents. The gender difference also expands to perceptions of being too masculine or too feminine and the impact of that perception on a woman's military career. These perceptions could lead to the high number of sexual harassment and trauma experienced by female veterans (DiRamio & Jarvis, 2011).

These additional concerns for female veterans warrant attention from administrators, counselors, and staff at postsecondary institutions of higher learning to enable female veterans to find their voice and searching out help (DiRamio & Jarvis, 2011). Intentional programming including mentoring and learning communities, support female veterans in the establishment of a subgroup within a veterans organization, encouraging involvement with the counseling center, connecting women with organized study groups, and establishing professional development opportunities for faculty to assist female veterans are all ways that the university community can facilitate a successful transition to college for female veterans (DiRamio & Jarvis, 2011).

Reported Needs of Student Veterans

The American Council for Education detailed a report of a focus group designed to determine how universities and colleges were structuring their various services for student veterans in transition (Cook & Kim, 2009). The purpose of the focus group was to increase the knowledge base and determine the level of preparedness of institutions of higher education in educating student veterans. Of the institutions that responded, more than half of the institutions, 57 percent, had some type of veterans' program (Cook & Kim, 2009; O'Herrin 2011). Many of the campuses were considering veteran friendly changes within the next five years of the survey

that included professional development and exploration of state and federal funding sources (Cook & Kim, 2009).

Cook and Kim (2009) found that student veterans were concerned with currently available campus services and programs including a lack of flexibility of some campus programs with respect to military students' sometimes unpredictable deployment schedule in the armed forces, uncertainty about campus recognition of civilian courses taken while in the military or formal training or college courses obtained as a service member, and lack of strong guidance about navigating the maze of G.I. Bill education benefits.

Regardless of military branch or geographic location, these issues resonate amongst student veterans. Cook and Kim (2009) commented that the frequency at which the focus group respondents expressed these concerns indicated that campuses could increase the depth and breadth of services that were being offered to veterans and service members.

College and University Student Veteran Support

Previous discussion on supporting student veterans (Cook & Kim, 2009; Ford, Northrup & Wiley, 2009; Livingston, 2010; O' Herrin, 2011; Persky & Oliver, 2010; Rumann & Hamrick, 2009; Van Dusen, 2011) has highlighted the need for colleges and universities to be leaders in raising awareness of the needs of student veterans as a first step in developing effective support services. Persky and Oliver (2010) suggested that in addition to student affairs staff members, trained counselors serve a critical role in helping veterans in their transition back to college (DiRamio & Jarvis, 2011; Persky & Oliver, 2010; Rumann & Hamrick, 2009). Persky and Oliver (2010, p. 115) continue by emphasizing "counselors and advisers should be trained to recognize, understand, and address problems that are unique to veterans and that thought that veteran-specific counseling should replace the generalized counseling that veterans currently receive." In consideration of counselors' assistance of student veterans, the increasing amount of veterans taking advantage of their Post 9/11 G. I. Bill, presents the potential for counselors to become overwhelmed and over-extended.

Benefits of Supports

Though there exists unique concerns related to student veterans, supports designed to address these issues appear beneficial and reasonable in terms of energy and resources. There is evidence targeted supports appear beneficial for student veterans with many outperforming their civilian peers in classroom performance and graduation rates (Lang & Powers, 2011). Student veterans seem to thrive when necessary attention is devoted to the concerns of this population within colleges and universities. Administrators, counselors, and staff are able to assist student veterans in successful degree attainment thus, positively impacting the transition from military to civilian life.

Student Veteran Supports

Student veterans have long been a part of the university setting; however, the roles of student, service member, and veteran have become "less clear cut and bonded and are often

experienced simultaneously as well as sequentially" (Rumann & Hamrick, 2009, p. 32). To address concurrent roles and stressors, Rumann and Hamrick (2009, p. 32) suggest "establishing proactive and working partnerships to help create a more seamless environment for students who need to successfully navigate multiple agencies, organizations, and bureaucracies to help create or find supportive individuals and environments to facilitate the transitions of student veterans."

DiRamio et al. (2008) identified recommendations for student affairs administrators related to supporting student veterans. Administrators should aid veterans through the implementation of a personalized, holistic approach. Institutions can train veteran-friendly mentors across campus. These advocates would meet with students to direct participants to appropriate services such as: financial aid, counseling, student organizations, disability services, academic advising, faculty members, and institutional research. In addition, DiRamio and Jarvis (2011, p. 24) suggest "encouraging involvement in other areas of campus life such as student employment, counseling, tutoring and transfer, and adult student programs not only helps student veterans but also offers global insights for nonveterans."

In addition, Schlossberg (as cited in DiRamio & Jarvis, 2011) outlines three specific steps to ease the transition of student veterans to campus. First, she indicates universities provide an individual to act as a 'socializing agent' to help veterans understand the expectations and culture of the campus community. This would assist student veterans who often encounter difficulty based on confusion relating to the campus community in addition to past military experiences that could serve as a distraction (DiRamio & Jarvis, 2011). Second, she states colleges and universities "establish a group situation with weekly meetings" (DiRamio & Jarvis, 2011, p. 18). The weekly meetings could serve as a forum where new student veterans could interact with those veterans who have successfully integrated into the campus community. Within these interactions, the experienced student veteran could provide guidance and insight into the components of a successful transition. Lastly, Schlossberg (as cited in DiRamio & Jarvis, 2011) suggests that a college or university establish group meetings that include the veterans' family unit. Often family members are unable to relate to the college experience of the student veteran. By including the family, the student veteran is able to expose them to the requirements and expectations of college, as well as his or her feelings about the transition.

Collaborative Support

Counselors in postsecondary settings play a key role in assisting student veterans. Counselors in various settings such as counseling centers and career centers are ideally positioned to assist student veterans especially those who may have issues of functionality due to a disability. Burnett and Segoria (2009) offer recommendations for providers in postsecondary educational settings to support student veterans with and without functional limitations. They indicate a need for providers working with student veterans to establish relationships with a university's VSO or Veteran Service Organization (U.S. Department of Veteran Affairs, 2011). Student veterans often are dealing with various mental and physical injuries requiring collaboration between civilian and military providers. While they primarily focus on disability student service providers; academic, career, and mental health counselors are able to facilitate and maintain this relationship to ensure the continuity of care.

Burnett and Segoria (2009) also suggest a university-wide, interdepartmental committee designed specifically to address the needs of student veterans within the institution. The committee is ideally called to form by the university president and/or the academic senate to ensure the work is a high-level priority. The committee consists of representatives from the counseling center, office of student disabilities, career center, the admissions office, veteran's office, faculty, students, and those from the veteran community. The directive of the committee is to create a campus climate conducive to the success of all military transition students especially those with disabilities.

Collaboration with entities in the community is another means of connecting resources to assist student veterans (Burnett & Segoria, 2009). Various veteran-centric organizations such as the local veteran centers and hospitals, the American Legion, Veterans of Foreign Wars (VFW), and others provide services and support for this population. These organizations offer several services and can be a useful way to access the population. Interacting with these organizations can also prevent duplication of effort and keep all parties informed of the work being done both in the community as well as at the college or university. Devoting time to establishing relationships with these organizations can create useful partnerships both on and off campus.

Supportive Campus Environments

Ensuring student veterans have a voice on campus is another critical piece. While academic institutions are intellectually-open environments designed for the free exchange of ideas, many discussions with other students and faculty fall outside the realm of respectful discourse and can be a barrier to student veterans engaging the community (Burnett & Segoria, 2009). While it is important not to curb open dialogue, student veterans, like other distinct groups, are worthy of considerate and respectful treatment by students and faculty.

Faculty and staff training related to the unique needs of military veterans is one way to enlighten professionals of the necessary steps to ensure student veterans are supported in the university setting. Specifically, Texas Tech University provides a training educating interested advocates through the completion of the training related to the needs of military personnel and their families. The goal of the training is to provide a welcoming environment to military personnel and their families through the gained knowledge and insight. This training is currently presented as a classroom workshop, but could be offered through online formats to encourage greater participation. The information presented at these workshops enhances participants' understanding of the military and the unique needs of student veterans. Upon completion of the training, participants receive a decal to designate being an advocate for military veterans in the college or university. In addition, participants are contacted for future involvement in campus activities associated with veterans on campus.

Enhancing Voice and Profile

Groups for veterans in colleges and universities are one way to connect with others with a similar experience and collectively advocate for the needs of student veterans. Student Veterans of America, created in 2008, is a national organization with affiliated chapters at several institutions across the nation. Ensuring this kind of organization exists at your university and

taking the time to create the student group if one is not present can be the work of administrators and providers in a college and university.

In addition to student groups, on-campus mentors can be linked with individual student veterans to provide one-on-one support (Burnett & Segoria, 2009). Faculty and advanced students who have experienced combat can be an invaluable resource connecting with student veterans in a meaningful manner to assist in the transition from military to civilian life. The mentor can also offer resources both on-campus and in the community when appropriate. This is another method for creating a web of support for veterans in postsecondary educational settings.

Advocacy

Advocating for the needs of this population at the state and federal level is important in keeping those in power abreast of the needs of student veterans (Burnett & Segoria, 2009). Your state government and the US Department of Veteran Affairs are organizations that create policy that directly impacts this population. Continual communication with these entities and tracking progress and utilization is important to secure fiduciary support for various programs and initiatives for student veterans. Administrators, counselors, faculty, and staff are able to provide tangible evidence related to the experience of veterans in student organizations and the efficacy and effectiveness of these supports.

One such governmental program is Complete College America which is a tangible support with the goal of increasing young adult postsecondary degree attainment. This program is unique in that it has specific partnerships with various states focusing attention on the needs of traditionally underserved populations within each state. This program advocates for increase degree completion by young adults and by extension student veterans highlighting the need for collaborative advocacy efforts for increase graduation rates. This program in addition to others provides means in which to enhance the likelihood of student veterans completing their postsecondary education.

Research

Finally, there seems a paucity of tangible research related to student veterans and their experience and graduation from postsecondary institutions. Examining the efficacy of supports to determine appropriate methods of intervention would significantly benefit helping professionals who assist this population. Administrators, faculty, and staff of colleges and universities possess a useful skill set related to program evaluation and research. Assessing for need, implementing various programs, evaluation their effectiveness, and disseminating this information would significantly benefit those who serve student veterans.

Given the significant fiduciary resources allocated for supporting veterans and specifically those in college and university settings, it is important to examine efficient and effective methods of support. Harnessing the research infrastructure and mission of college and universities to develop new supports or revise and improve existing interventions will benefit both funding sources of student veteran support programs and those receiving services.

Conclusion

Student veterans are engaging postsecondary settings both now and in the future in a significant manner. Given their sacrifice, it is essential colleges and universities focus on creating supportive environments for successful attainment of degrees. Given the apparent need to consider effective methods for ensuring degree attainment for student veterans, critical questions related to the effectiveness and efficiency of current interventions and programs of support are worthy of consideration. Administrators, faculty, and staff are entrusted with the personal and professional development of students. A willingness on the part of various constituents within university settings to collaborate to support this population provides an opportunity for remediating student veterans' struggles in higher educational settings. Thinking in unique ways and listening to the voices of student veterans are essential elements in generating initiatives and programs of support.

While student veterans do have unique concerns, they are entitled the same opportunity for success as any student. Making sure we are doing all we can to honorably serve those who have served is a guiding question for all professionals in postsecondary educational institutions. Ensuring a successful transition from the military to civilian life benefits both the student veterans and our society as a whole.

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School Counselors' Observations of OEF/OIF Children and Families: Identifying Opportunities for Assistance

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Abstract

Over the past decade 15-20% of veterans report symptoms of post-traumatic stress disorder (PTSD), anxiety or depression post-deployment. Children experiencing parental deployment have reported depression, anxiety, relationship issues, behavior problems, and poor academic performance. These consequences to service families have gained the President's attention and led him to develop the Strengthening Our Military Families: Meeting American's Commitment program (2011), to bring federal resources to bear on identifying opportunities to create support across all public and private sectors. This manuscript describes the results of a military family survey that was conducted by the Arkansas Counseling Association, which indicate that school counselors have identified distress in children and families experiencing parental deployment.

Keywords: PTSD, school counseling, military family

Nearly two million children in the United States live in military families, with nearly half experiencing combat-related parental deployment since September 11, 2001. Changes in life stressors for military families include deployment separation, injury, mental health concerns, and reunification (Chandra, Martin, Hawkins, & Richardson, 2010; Lester et al., 2010; Sayers,

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Farrow, Ross, & Oslin, 2009). Over the past decade around 15-20% report symptoms of post-traumatic stress disorder (PTSD), anxiety or depression post-deployment (Lester et al., 2010; McNulty, 2010; Milliken, Auchterlonie, & Hoge, 2007; RAND Center for Military Health Policy Research, 2008). Research confirms the link between parental stress levels and negative parenting behaviors (Coyl, Roggman, & Newland, 2002; McNulty, 2005; Ritchie & Holden, 1998). Children experiencing parental deployment have reported depression, anxiety, relationship issues, behavior problems, and poor academic performance (Chandra et al., 2010; Chartrand, Frank, White, & Shope, 2008; Lester et al., 2010; McFarlane, 2009).

The consequences of deployment to service families have attracted the attention of President Obama and he has responded with the Strengthening Our Military Families: Meeting American's Commitment program (Obama, 2011), a government-wide review to bring federal resources to bear on identifying opportunities to create support across all public and private sectors. As part of this effort, First Lady Michelle Obama and Dr Jill Biden kicked off the national Joint Forces campaign to create awareness and build collaborations between organizations (Sherr & Murphy, 2011). The belief is that building strong supportive communities that engage military families will, in turn, help to strengthen the resilience of the family that is faced with the stressful transitions involved in deployment.

Harrison and Vannest (2008) explained how deployment of a parent can negatively impact children emotionally, academically, and behaviorally, and that separation may cause children to act out in reaction to feelings of loss, anxiety, and anger. Additionally, without family and community support, National Guard and Reserve spouses may emotionally withdraw from their children (Harrison & Vannest, 2008). Families of National Guard members and reservists are particularly vulnerable because they are scattered in communities across the US and do not have as many military support services as active-duty service families have (Lamberg, 2008; Harrison & Vannest, 2008; Rodriguez & Green, 1997).

This movement validates the agenda of many counselors, who had previously identified the need for community support in assisting these families and had believed that counselors could play a role in that support. In 2009, members involved in the Arkansas Counseling Association, a branch of the American Counseling Association, began collaborating with VA researchers and the Arkansas Department of Education Guidance and Counseling Unit to identify military children as well as train school counselors to better identify, assess, and assist the families. Descriptions of these earlier efforts have been published in the *Journal of Rural Health* (Waliski, Kirchner, Shue, & Bokony, 2012). Results of this collaboration indicated that although strategies and level of assistance varied, school counselors were providing support for both children and parents to help them plan for and cope with the significant stress that families experience during the transitions through predeployment, deployment, reintegration, and redeployment.

The current manuscript describes the results of a study employing the Military and Veteran Children and Family Questionnaire, that was conducted by the Arkansas Counseling Association (ArCA) at their 2011 Annual Conference, entitled *Going into Combat for Arkansas Children and Families*. Many of the educational sessions at the conference focused on providing continuing education credits on topics concerning the mental, social, emotional, and academic

success of OEF/OIF family members as well as identifying and promoting available resources within the state and on a national level.

Methods

Purpose

This is an exploratory study guided by three research questions:

1. What are school counselors observing in Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) children and families?
2. What are school counselors currently doing to assist these families? and
3. What services needed for OEF/OIF military families fit into the scope of practice of school counselors?

Procedures

This study is a secondary data analysis of a military family survey that ArCA conducted at its annual conference. The instrument used was a modified version of a questionnaire that researchers from Central Arkansas Veterans Healthcare System (CAVHS) had used with school counselors in 2010 to gain exploratory pilot data about military children and families. ArCA leadership gained permission to use the instrument during their 2011 Annual Conference, which focused on creating awareness and providing continuing education for the mental health needs of military and veteran families. Their intent was to understand what continuing education would be needed in the future. CAVHS researchers later requested from ArCA the data gathered from respondents attending the conference to conduct the secondary data analysis that would identify their perceptions of the needs of military and veteran children and families. The study protocol and instrument were reviewed and approved by the CAVHS Institutional Review Board (IRB) prior to data analysis. Data were originally collected from individuals during the two keynote presentations of the ArCA 2011 Annual Conference. No identifying information was included, and respondents were asked to put the evaluation in a manila folder outside the door as they left the conference hall.

Instrument

The Military and Veteran Children and Family Questionnaire is a single page, front and back, survey that solicits counselors': (a) demographic information about their professional status and expertise, (b) experience in assisting military and veteran children during deployment (c) observations about the needs of these children, and (d) their opinions about what school counselors can do to support military and veteran children and families. The questionnaire comprises multiple-choice and short-answer options.

Participants

Of the 650 people who attended the ArCA 2011 Annual Conference, 171 (20.9%) completed the survey. The number of people attending the two keynote presentations was not collected. The majority of the respondents were school counselors (136); therefore, we chose this

subgroup to include in the final analysis. Their primary objective is to identify and assist children with stressors that may prevent successful learning. The members of the organization were all over the age of 18. They were predominately female, and the majority resided in rural areas.

Data Collection and Analysis

Volunteers were asked to complete the anonymous survey and place it in one of several manila folders outside the main conference hall. The conference staff then collected the surveys and gave them to the organization's president-elect to be entered into an Excel database. In many cases the participant was able to write in a response. Data were categorized and entered twice for accuracy. Researchers from CAVHS received written permission from ArCA to conduct a secondary data analysis of de-identified data, and this study was approved by the CAVHS IRB. The database was transmitted electronically and saved on a secure CAVHS server. Data were uploaded and analyzed using SAS Analytics software.

Results

Respondents were seven males, 113 females, and 16 who did not indicate their sex. Sixty identified themselves as elementary school counselors, 60 as secondary school counselors, 13 as counselors assisting children kindergarten through 12th grade, and three who did not respond. Sixty-six indicated that they worked in urban counties and 55 in rural areas. To further understand and describe the responses, the investigators decided to compare the data based on elementary or secondary school counselors and urban versus rural locations. No significant differences appeared within either of these two variables; therefore, we have reported the results in percentages.

School counselors were asked to identify needs they have observed in their daily interactions with children of military families. Because there was the possibility that children of different ages had different needs, we analyzed these data by identifying the variation between elementary and secondary school counselors and separating the responses into urban and rural categories. Table 1 displays these results. The majority of respondents indicated the need for individual and family counseling and for referrals for services or mental health treatment.

Volunteers were asked to identify all the services they were providing to OEF/OIF children and families. The majority of school counselors indicated that they provided some service to military children and families in their schools. Most counselors (urban 58%; rural 68%) reported providing individual counseling, and several provided family counseling (11% urban, 12% rural) and group counseling (18% urban; 17% rural). In addition, academic assistance (36% urban; 33% rural) and resources (29% urban; 47% rural) services had been provided by school counselors. Forty-seven percent of rural counselors and 29% of urban counselors reported that they have organized school activities to create awareness and support military families.

School counselors were asked to identify barriers to assisting children and families of veterans and military personnel. Three were highly reported:

1. School counselors felt that children experiencing parental deployment are not easily identified (45% urban, 57% rural) unless the child or family communicates the information to a teacher or counselor and agrees to allow that information to be shared.
2. Counselors indicated that time ((47% urban, 48% rural) and class schedules (28% urban, 26% rural) comprise barriers to providing needed services.
3. Counselors did not feel they had the knowledge and training (44% urban, 57% rural) to assist these children and families. Fifteen percent of urban counselors and 12% of rural counselors indicated they did not have the administrative support to provide the services, and 21% of urban and 16% of rural counselors felt there were no barriers to providing services.

Table 1
Needs Identified by School Counselors

	Rural		Urban	
	K-5 (n=24)	6-12 (n=31)	K-5 (n=37)	6-12 (n=29)
Individual Counseling	70.8%	58.0%	56.7%	44.8%
Referral Information	50.0%	45.1%	51.3%	34.4%
Family Counseling	70.8%	19.3%	37.8%	48.3%
Communication w School	45.8%	51.6%	27.0%	44.8%
Academic Assistance	16.6%	32.2%	21.6%	37.9%
Financial Assistance	12.5%	16.1%	5.4%	24.1%
*Respondents were able to answer more than once				

School counselors were asked to identify services that would support military children and families and that were within their scope of practice. Table 2 shows that the majority thought they should be providing resource information, communication between school and military leaders, individual counseling, and academic assistance.

To gain an understanding of the resources needed by school counselors to provide services to these children and families, participants were given a list of various resources and asked to indicate which would be most helpful for them in their practice. Results are listed in Table 3.

Table 2
Services that Should be Provided by School Counselors

	Rural		Urban	
	K-5 (n=24)	6-12 (n=31)	K-5 (n=37)	6-12 (n=29)
RESOURCE INFORMATION	79.1%	80.6%	78.3%	72.4%
COMM WITH SCHOOL	83.3%	77.4%	72.9%	72.4%
INDIVIDUAL COUNSELING	83.3%	64.5%	70.2%	72.4%
ACADEMIC ASST/CHILD		70.9%	64.8%	72.4%
FAMILY COUNSELING	58.3%	38.7%	40.5%	44.8%
FINANCIAL ASSISTANCE	20.8%	32.2%	18.9%	27.5%
NONE	0.0%	3.2%	2.7%	6.8%
*Respondents were able to answer more than once				

Table 3
Resources

	Urban	Rural
Counseling Techniques for Children	57.5%	39.6%
Referral Information	30.3%	48.2%
Training	28.7%	34.4%
Group Counseling Curriculum	36.3%	17.2%
Assessment Instruments	27.2%	25.8%
Toolkit for Family Resilience	22.7%	22.4%
Counseling Techniques for Families	21.2%	17.2%
Videos	10.6%	12%
Current Literature	3%	15.5%
Access to Evidence Based Practices	9%	6.8%
*Respondents were able to answer more than once		

Discussion

This study addressed three research questions:

1. What are school counselors observing in Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) children and families?
2. What are school counselors currently doing to assist these families?
3. What services needed for OEF/OIF military families fit into the scope of practice of school counselors? Results indicated that counselors detect a need for services and are trying to provide them within their scope of practice.

Individual and family counseling were most often indicated as services that school counselors thought children in military families needed. This was followed by resource information and more communication with the school. School counselors are master's-level professionals with training in individual and group counseling skills, crisis intervention, parent consultation, and behavior management (American School Counselor Association, 2005). School counselors are trained to provide prevention counseling for children and families in distress and, if an individual is experiencing symptoms that indicate a mental health need, to make referral for treatment with an appropriate professional. Results indicate that, given appropriate resources and referral information, school counselors could assist OEF/OIF children and families more effectively provided parents would communicate the changes and stressors experienced from military deployment.

Barriers to Services

Problems with providing needed services to military children and families most often concerned the identification of these families, knowledge of counselors, and the time needed to provide services. Military families are not required to tell school personnel about their military involvement or about parental deployment. This may be because some families choose to deal with deployment privately or may fear that knowledge of parental absence will cause additional stress.

The second most reported barrier was the school counselor's lack of knowledge and training about military life and the deployment experience. Counselors who feel inadequate in their abilities to assist may not be as proactive in identifying students, promoting school activities that honor military personnel, or encouraging children and families to seek support. Additionally, if school counselors are not supported by their administration or are too overloaded to provide counseling and support, students may not receive the attention needed to transition through the changes of parental deployment and reintegration.

Resources

Consistent with the responses that indicated most participants provide counseling services to OEF/OIF children and families, they were interested in resources providing them with education, techniques to use, and referral information for those individuals needing more intensive treatment. Surprisingly, the resources did not have to be evidence-based practices or current literature. Counselors may not be interested in reading current literature due to time

constraints or may not view it as easily transferable to practice. Further research is needed to identify factors in their lack of interest.

Limitations

This is one of very few studies addressing the needs of military children and the services counselors provide for them. Being an exploratory study, several limitations should be noted. First, with 650 attending the conference, the number of participants was low. A change in design could be made to improve recruitment. One option would have been to have surveys available in all sessions. Not all people registered for the conference attended the keynote session so opportunities to garner participants may have been missed.

The survey asked for respondents to rank the top three needs of military children and families, but many of the respondents just checked the box, thus we were not able to rank the importance of each identified need.

Finally, this study does not capture how much time counselors are spending with military children and families. An estimated 47% of school counselors indicated that time was a factor in providing services to military children and families. Further research is needed to determine if school counselors' overall responsibilities proscribe his or her providing additional attention to this population or if the child's schedule plays more of a role in the time factor.

Conclusion

The Department of Defense, Department of Veterans Affairs, and Department of Education are key government stakeholders in providing support to military families. School counselors are key personnel within the public school setting. Collaboration between larger departments of the public sector and community organizations and members could play a role in building the support needed to create and maintain resilience in military families.

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Trends in Quality of Life Enhancements for Veterans with TBI: Implications for Rehabilitation Counselors

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Abstract

Veterans living with traumatic brain injury (TBI) experience challenges in coordinating health and mental services, as well as securing and sustaining social and economic supports. Accordingly, quality of life enhancements which promote community reintegration and vocational outcomes are of great import in the current times. As more service members return from conflicts in Iraq and Afghanistan, the need to normalize and reintegrate veterans into local communities is increased. Federal, state, and private agencies have invested considerable time and resources in the development and evaluation of treatment programs that promote postmorbid psychosocial recovery. This article will examine trends in postmorbid psychosocial service provision, propose greater triangulation of services between public and private service providers, and discuss practical implications for rehabilitation counselors.

KEYWORDS: TBI, quality of life enhancements, vocational and community rehabilitation

TBI can result from visible and non-visible injury to the head that can directly or indirectly impact brain functioning. Recent studies reveal that in the last decade, mental health providers have seen a marked increase in the number of individuals diagnosed with TBI (Faul, Xu, Wald, & Coronado, 2010; Resnik, Bradford, Glynn, Jette, Hernandez, & Wills, 2012; Stiers et al., 2012). This statistic is especially visible in the veteran subpopulation, particularly amongst service members returning from the current conflict in the Middle East. In an effort to meet the physical, mental health, cognitive, psychosocial, and vocational needs of veterans diagnosed with TBI, the Veterans Affairs (VA) offers extensive restorative services to promote greater independence in living and an overall improved quality of life (Faul et al., 2012).

According to the Defense and Veterans Brain Injury Center of the Department of Defense (DVBIC), a total of 253,330 active duty service members from all branches of the military have been diagnosed with TBI in the last 12 years (2012). The DVBIC indicates that brain injury is an

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invisible war trauma that is often difficult to diagnose because it is not marked by immediate changes in behavior post-injury. In addition to the inherent challenges involved in diagnosing TBI, many symptoms of TBI can be masked by other commonly co-occurring conditions, such as post traumatic stress disorder (PTSD), anxiety, and substance abuse. As a result, treatment of this signature injury of veterans wounded in Iraq and Afghanistan has become all the more complicated.

Of the three levels of injury that characterize the severity of TBI (mild, moderate, and sever), mild TBI is the most difficult to diagnose, as the symptoms are often undetected and subsequently not reported. Therefore, many service members do not realize that they have sustained a mild brain trauma and continue to proceed as usual in their daily military functions, which increase their likelihood of sustaining multiple insults to the brain. The VA reports that the cumulative effect of multiple mild insults to the brain results in more pronounced cognitive, social, emotional, and physical deficits, which are in turn, better able to be detected and reported (Department of Veterans Affairs, 2010).

Blast injuries account for a major percentage (75%) of TBI cases amongst veterans who have served in active war zones. However, other occurrences such as a falls, motor vehicle accidents, and struck by/struck against events account for the remaining percentage of TBI cases (Defense and Veterans Brain Injury Center of the Department of Defense, 2012). While females do sustain brain injury, males ranging in age from 18 to 40 years are almost twice as likely than females to sustain TBI because they are generally more likely to be involved in high impact activities (Ivins, 2003). Finkelstein, Corso, and Miller (2006) reported that direct medical costs and indirect costs associated with loss of productivity due to TBI, incurred from 2000 to 2006, were in excess of 60 billion U.S. dollars. Since 2006, an additional 162,688 veterans have been diagnosed with TBI. As a result, the current direct and indirect cost of TBI has an actual economic burden that is significantly greater than 60 billion dollars. Therefore, the need to explore viable rehabilitation strategies that promote quality of life enhancements and lead to community and vocational integration is heightened.

While the federal government has invested significant resources in the training of personnel and development of medical, mental health, and psychosocial programs, there are not nearly as many trauma and brain injury centers to meet the needs of the growing number of veterans with TBI. Therefore, gaps in service provision continue to highlight the importance of triangulation of services between public and private agencies. As both public and private sectors explore avenues for partnerships, more veterans will begin to receive timely and seamless medical, mental health, and psychosocial services, which will promote successful community integration and vocational outcomes.

The intention of this paper is to review literature about current methods in of quality of life enhancement that are typically provided by public and private sector service providers. This paper will also examine current trends in quality of life enhancement and their impact on vocational and community rehabilitation. As well, this paper will discuss strategies for triangulation and coordination of services between both sectors, so that resources can be pooled and veterans' community integration and vocational rehabilitation needs can be met in timely manner. Additionally, this paper will discuss factors which limit the achievement of rehabilitative success amongst veterans with TBI and the subsequent implications for rehabilitation counselors. Lastly, the intention of this paper is not to present an exhaustive review of TBI related literature, but rather to discuss several treatment options in an effort to enhance awareness and stimulate ideas about further research on this topic.

Public and Private Sector Trends in Quality of Life Enhancement

Community integrated rehabilitation programs provide quality of life enhancement services along a continuum comprised of four models that range from inpatient to outpatient milieus in both public and private sectors. The most controlled setting to provide community integration services is the nonhospital inpatient neurobehavioral program, which generally treats patients with co-occurring mood, behavior, and cognitive disorders by using behavioral and cognitive remediation principles to promote skill development (Trudel, Nidiffer, & Barth, 2007). Residential programs are less controlled than neurobehavioral programs and they provide 24-hour homelike supervision and community integration, which is similar in scope to assisted living facilities. Day treatment programs, also known as the comprehensive holistic model, offer an even less controlled setting than residential programs. These programs provide milieu-oriented multimodal services which promote psychoeducation, cognitive rehabilitation, social skill development, and vocational preparation through individual and group participation. The least controlled setting, which is akin to outpatient services, is known as home-based rehabilitation. This treatment option is not comprised of a treatment team, but offer a broad spectrum of individual and group services that are primarily self-managed or monitored by family members and visiting paraprofessionals. A limitation of this option is that it requires the veteran to coordinate services, have knowledge of service providers, and reimbursement procedures. This treatment option is generally best for individuals who are technically savvy and can make use of telecommunication, electronic case management, and internet access (Degeneffe et al., 2008; Trudel et al., 2007; Wehman, Gentry, West, & Arango-Lasprilla, 2009).

Trudel et al. (2007) explain that even though there are four main models of community integration, there is great diversity in the format in which services are delivered in each of these models. Thus, research findings from one program cannot be easily applied to another program, even if both programs are developed according to the same model. Since there is no standardized procedure according to which services are rendered, generalizability and replicability of findings across different demographics and geographic areas is challenging at best. While there is some diversity in service provision across the different military hospitals and veterans' medical centers, private hospitals and rehabilitation agencies tend to have programs that are even more diverse in structure, thereby making application of research findings problematic (Degeneffe, 2008).

Federal Service Providers

Federal service providers are largely comprised of military hospitals and veterans' medical centers (Wehman et al., 2009). In light of the fact that service members and veterans with TBI diagnoses are reaching historic numbers, the DOD and VA have invested significant efforts in the development of national trauma centers that specialize in providing rehabilitative services which aim to either restore premorbid functions that promote return to active duty or restore quality of life to levels that promote optimal return to civilian life (McNamee, Walker, Cifu, & Wehman, 2009). In comparison to private hospitals and rehabilitation agencies, trauma centers housed in military hospitals and veterans' medical centers tend to have a somewhat homogeneous structure such that all basic services are provided according to standard operations of procedure and can be replicable form one medical center to another. While there is diversity in the provision of adjutant therapies, federally funded trauma centers, such as the DVBIC model, are still more uniform in structure and thus provide a viable model to be studied and replicated.

The DVBIC model. The DVBIC model is of particular interest because it is comprised of 15 military hospitals and VA medical centers, of which 14 are located in the US, and one in

Germany. Of the 14 locations, 8 are concentrated in the Mid-Atlantic region, with the remaining being dispersed across the continental US (Defense and Veterans Brain Injury Center of the Department of Defense, 2012). The DVBIC locations offer subject matter experts (SMEs) who provide seamless and comprehensive medical, mental health, and adjunctive therapies that promote successful outcomes in physical, social, and vocational rehabilitation. However, this model is also limited in replicability, as many city, state, federal, and private hospitals do not have access to all of the same medical and adjunctive programs in one geographical location. Thus, veterans are unable to receive seamless rehabilitative services and must travel a significant distance in order to access medical, mental health, adjunctive therapies, or vocational programs that are imperative for successful outcomes (Hynes et al., 2007).

Several factors serve to demotivate veterans in accessing proper medical, mental health, and rehabilitative care that leads to successful social and vocational outcomes. One major factor is the inability to drive or travel long distances due to symptoms associated with TBI. Other factors include the economic burden of having to travel long distances, inability to coordinate services and low frustration tolerance due to cognitive deficits associated with TBI, and inability to understand the importance of adjunctive therapies in the treatment of TBI. As a result, many veterans do not follow-up in accessing services that are located outside of the immediate medical facility (Haynes et al., 2007).

State and Local Service Providers

State hospitals and rehabilitation agencies are somewhat similar in structure to federally-run medical centers, but they tend to be limited in the scope of services they provide. In response to the 1963 Community Mental Health Act, which initiated the deinstitutionalization of state hospitals and led to the expansion of community mental health centers, very few state-run hospitals remain in existence (Pratt, Gill, Barrett, & Roberts, 2002). As a result of the deinstitutionalization movement, not many hospitals have funds to develop the extensive infrastructure necessary for the provision of community reintegration services to individuals with TBI. While, most state hospitals provide services to individuals with severe persistent mental illness and other co-occurring disorders, only a handful of specific programs exist for persons with TBI diagnoses (Pratt et al., 2002).

The National Institute for Disability and Rehabilitation Research (NIDRR), a Division of the US Department of Education's Office of Special Education and Rehabilitative Services, supports research, training, and development disability services. NIDRR has developed a state-of-the-art TBI Model that provides short- and long-term treatment. This model has been used to establish 14 brain injury recovery centers nationally, and while these centers are comprehensive in scope, they are not enough in number to be accessible to all individuals living with a TBI (National Institute on Disability and Rehabilitation Research, 2002).

State rehabilitation agencies are better equipped to provide services to individuals with TBI; however, their staff often have large caseloads, and thus cannot provide direct services. In an effort to use federal and state funding judiciously, most state rehabilitation agencies operate according to the order of selection, such that they provide services based on severity of disabling conditions. As a result, state rehabilitation counselors tend to service their large caseloads by

coordinating services via individual and state contracts with private rehabilitation agencies (National Institute on Disability and Rehabilitation Research, 2002).

Private Service Providers

Private hospitals and rehabilitation agencies tend to be very varied in the scope of services they provide. While many private hospitals and rehabilitation agencies specialize in providing comprehensive services to individuals with TBI, they continue to be diverse in the breadth of services they offer. A common variable that impacts both private hospitals and rehabilitation agencies is that they are both driven by funding streams. Thus, the vast majority of private hospitals and rehabilitation agencies have active contracts with city and state rehabilitation agencies, thereby extending their expertise to individuals being served by city and state providers (Pratt et al., 2002).

Brown, Gordon, and Speilman (2003) examined the extent of engagement in social and recreational activity amongst individuals with TBI engaged in a private hospital rehabilitation program. Of the 279 persons who participated in the study, they found that those individuals who were single, had access to more disposable income, were less depressed, and had greater time since injury, were more likely to be involved in social and vocational activities. As a result, they concluded that variables such as depression, fatigue due to recency of injury, and economic support played an integral role in community reintegration and vocational outcomes. Brown et al. further recommended that mitigating these variables would promote greater participation in community and vocational outcomes for persons with TBI.

Triangulation and Coordination of Services

While each geographical area may have its own unique set of service providers, a prevailing need in all areas is the coordination of services with private and public sector providers. Additionally, since VA hospitals serve vast geographical areas, the need to connect with other public and private outpatient centers is immense, as this link can meet the gaps in service provision by affording veterans with mental health, adjunctive, and rehabilitative options that may be located closer to home. Even though connecting public and private providers may be easier to achieve in large metropolitan cities that offer a multitude of medical and allied health resources, it is feasible to develop working relationships with individual service providers in rural areas, so that veterans can access medical and rehabilitative services without having to travel long distances.

Persons with TBI have not historically used quality of life enhancement services. Traditionally, these services have been used by persons with developmental disabilities and mental illnesses, so most psychosocial programs were originally designed with the intent of meeting the needs of these subpopulations. However, with the return of veterans with severe TBI, ranging in age from 20 to 50 years, the need to re-think quality of life enhancement services has arisen (Girard, 2007). Typically, due to the shortage of comprehensive psychosocial programs that specialize in providing services to veterans with TBI, service providers have to know how to triangulate information from a variety of different local resources that can promote recovery, community reintegration and vocational exploration (i.e., nursing homes, libraries, zoos, schools, community colleges, museums, department stores, etc).

Girard (2007) asserts that in the face of increasing need for rehabilitation, coordination of services becomes the onus of mental health providers, who must teach veterans about how they

can manage their health via a variety of electronic tools that can allow them to schedule appointments, communicate with staff (nurses and physicians) and access referrals for orthotics, prosthetics, and adaptive technology. Common devices that can assist veterans in managing memory, medication schedule, and navigation of physical and domestic environment include PDAs, medi-minders, iPods, reachers, grab bars, canes, GPS systems, and GuardianAlert (also known as a MediPendant). Services that are specific to VA hospitals include access to electronic medical records, ability to interact with physicians and nurses via telemedicine, also known as interactive video teleconferencing, and increased reliance on online training to enhance psychoeducation about living with TBI (Darkins, 2006).

Need for Psychosocial Rehabilitation

Results from numerous studies converge and lead to a simple conclusion that TBI is associated with vast challenges that impact physical, mental, emotional, domestic, economic, and social aspects of life (Degeneffe et al., 2008; Trudel et al., 2007; Wehman, Gentry, West, & Arango-Lasprilla, 2009). What makes the psychosocial outcomes so challenging to quantify is that there is no singular gold standard in measuring the domain of participation. In order to define the areas that need to be measured in psychosocial integration, the VA sponsored State of the Art (SOTA) Working Group on Community Reintegration identified key dimensions of participation. The key elements of psychosocial participation include social, vocational, educational, personal (spouse/significant other), spiritual/religious, parental, leisure, domestic life, civic life, self-care, and economic life (Resnik et al., 2012). The SOTA Working Group also indicated that while assessment tools can be objective, subjective, self-report questionnaires, or surveys, program evaluations need to primarily focus on ways in which veterans can be engaged for services that promote psychosocial participation throughout the lifespan, not only during a acute episode (Resnik et al., 2012). Results from this study further indicated that while several VA medical centers offer medical care for acute and serious persistent physical and mental illnesses, they do not play a very central role in the psychosocial rehabilitation of the very same veterans. Resnik et al.'s (2012) recommendation that federal service providers should develop links with private rehabilitation service providers in the community in order to promote psychosocial participation throughout the lifespan have been further supported by Brown, Gordon , and Spielman (2003), who suggested that reciprocal relationships with local resources may be beneficial in yielding successful psychosocial and vocational outcomes.

One strategy that is well-received by researchers and practitioners is the need to develop better working relationships between pre-existing public and private rehabilitation service providers. By developing more fluid referral sources between the two sectors, clinicians will be better able to promote social integration and vocational readiness of veterans with TBI. The development of special initiatives which link community involvement and mental health stabilization has been supported by both federal and private service providers, but thus far, these initiatives are largely autonomous.

A review of available VA data reveals that each state offers its own unique set of psychosocial support services at VA medical centers, as provision of many services is dependent upon the availability of resources offered in a given geographical area. Nevertheless, most VA hospitals in each state have access to enough supports such that veterans with TBI can access similar psychosocial support services throughout the nation. However, a limiting factor that impacts timely and continued use of necessary resources is availability and accessibility to these very resources. In states with large rural areas, access to

psychosocial support services can be limited. Accordingly, linkages with private rehabilitation providers in these areas can serve to fill gaps in service provision.

Community Reentry

Findings from recent studies have revealed that TBI is associated with several co-occurring disorders such as PTSD, depression, anxiety disorder, substance abuse, and adjustment disorder (McNamee et al., 2009; Wehman et al., 2009; Resnik, Gray, & Borgia, 2011; Stiers et al., 2012). Since these disorders are collectively marked by diffuse deficits in social functioning, it is reasonable to conclude that veterans with TBI and co-occurring disorders will be at greater risk of experiencing social difficulties when resuming civilian life. As a result, their readjustment is punctuated by substance abuse, automobile accidents, suicide attempts, economic hardship, marital difficulties, homelessness, poor parenting, and acts of aggression (Trudel et al., 2007; Stiers et al., 2012). Other contributing variables that can impact social and community functioning include survivor's guilt and feelings of grief and bereavement associated with physical injury, which in turn lead to perceived low self-esteem (Burke, Degeneffe, & Olney, 2009).

Helping individuals adjust to participating in major life roles within the community is known as community reentry or community reintegration. Traditionally, the concept of community reintegration has been studied when examining the readjustment of individuals upon discharge from mental institutions or incarceration (Lew, 2005, McNamee et al., 2009). However, the community reintegration of veterans with TBI is a poor studied concept that remains to be explored at depth. Further examination of this concept will assist researchers in enhancing veteran participation, assessing treatment efficacy, identifying best practices, and tracking program success.

As per the Department of Labor (DOL), persons with disabilities represent the greatest subpopulation of individuals who are unemployed (Wehman et al., 2009). Of those individuals with disabilities who are unemployed, a large percentage is comprised of those who have sustained TBI. These findings indicate that postmorbid community reentry is essential for readjustment to civilian life, a hallmark of which is successful employment. While premorbid cognitive and vocational functioning are generally good predictors of postmorbid cognitive and vocational functioning, an important variable that maximizes successful outcomes is timely and early access to social and vocational activities (Resnik et al., 2011).

Commonly identified essential elements of community integration include the ability to operate as an independent, autonomous person; ability to function as a friend, student, worker, spouse/significant other, parent, and family member, and a civic or community member (Resnik et al., 2011). However, Resnik et al. (2012) assert that community integration is multifaceted and all elements cannot be measured in all persons, thereby making the assessment of community reentry all the more complicated. Therefore, in an effort to clarify key dimensions of community participation for veterans, the SOTA Working Group on Community Reintegration proposed the following role functions: social, work, education, parental, spouse/significant other, spiritual/religious, leisure, domestic life, civic life, self-care, economic life. Resnik et al. (2012) concluded their study by stating that further examination of the behaviors associated with successful completion of these roles will be necessary for program development, but they indicated that measuring such varied elements would be formidable, as no assessment tool can measure all key elements of community reintegration.

Strategies for Return to Work

Strategies that support vocational success include functional capacity evaluations, diagnostic vocational evaluations (DVE), pre-vocational and vocational counseling, and vocational exploration. These services support the overall goal of returning to work because they prime the individual with thoughts about working, allowing him/her to entertain ideas about work preferences, and the manner in which work would impact disability management. Wehman et al. (2009) suggest that the efficacy of supported employment for use with veterans with TBI, much as it is used with persons with DD and mental illness, should be examined. They also indicate that time of intervention may play an integral role in vocational success, thus they recommend that early intervention strategies such as prevocational counseling and vocational exploration with the veteran and his/her family may key the individual to consider vocational reentry as an essential and foremost part of rehabilitation, rather than a terminal goal of rehabilitation. Additionally, McNamee et al. (2009) proposed that early vocational intervention strategies that have been used for other disability groups may lead to the same level of vocational success for veterans with TBI, such that with appropriate levels of support, they may be able to return to premorbid employment in the same or related position. They also recommended that rehabilitation professionals need to espouse the approach that all individuals are employable by making viable efforts to match veterans with positions that suit their skills, interests, and abilities, while providing reasonable accommodations.

Resnik et al. (2012) and Wehman et al. (2009) also recommended that employment should be viewed as a process that includes both successes and failures. Following this logic, they propose that involuntary termination should be viewed as a mismatch between the employee and employer, not a failure on the part of the particular veteran. Degeneffe et al. (2008) also recommended that nontraditional employment such as telework, self-employment, temporary posts, and independent contracting work may play an integral role in exposing the veteran to work while allowing him/her to conduct disability management. Lastly, for veterans who are not interested in working or are unable to work, other means of promoting vocational integration should be provided, such as the opportunity to volunteer or participate in peer-run job clubs – groups that introduce the concept of work.

Discussion

A major benefit of providing psychosocial services to veterans with TBI is that not only will these services help to stabilize mental health, reduce social isolation, improve body image, and enhance interpersonal relationships, they will inherently make the veteran more capable of participating in vocational rehabilitation and will eventually promote successful vocational outcomes, such as volunteerism or employment. Additionally, these services will reduce long term costs associated with serious pervasive mental illness (SPMI) because socially engaged individuals are less likely to decompensate and relapse.

Limiting Factors and Implications for Rehabilitation Counselors

Several limiting factors impact the community integration and vocational outcome success of veterans with TBI. The most pronounced variables include the lack of proper infrastructure, need for continuing education amongst professionals, and lack of awareness due to limited research and outreach efforts. While several trauma and brain research centers are in existence nationally, they are still small in number and cannot meet the increasing needs of veterans in various geographic regions of the US. As a result, the gaps in services that are imposed by geographical distance can only be met by developing partnerships with state, city

and private hospitals, which can work together to ensure that veterans can access essential rehabilitative care closer to home.

Reduction in funding for health programs is cause for concern in the current economic times, but can be counteracted by developing working coalitions amongst rehabilitation service agencies so that veterans can access services via an extensive infrastructure. As well, limited placement options and inadequate funding streams for job development services pertaining to veterans with TBI highlight the fact that there is a viable need for expanded placement options. Additionally, a marked increase in the number and nature of TBI diagnoses warrants the need for clinical considerations for rehabilitation counseling professionals, who will have to stay abreast with developments in research and best-practices pertaining to TBI and co-occurring disorders.

Lack of public awareness about the symptoms, signs, and treatment needs of veterans with TBI poses a challenge to the treatment and normalization of persons with this condition. Since TBI associated with war assaults still remains to be studied in depth, knowledge about the challenges that this subpopulation faces has not reached community awareness. Therefore, subsequent barriers in transitioning from living with TBI to resuming civilian responsibilities remain in place. In an effort to reduce stigma, increase public awareness, and promote networking amongst veterans, community outreach regarding the impact of TBI on social and vocational aspects of functioning should be supported.

The various limiting factors that impact the study and normalization of persons with TBI hold practical implications for rehabilitation counselors. Specifically, rehabilitation counselors will need to be aware of the changing demographics of veterans and the challenges they face when transitioning to civilian life. As a result, rehabilitation counselors will benefit from continuing education in order to possess a comprehensive grasp of the complex nature of war-acquired TBI. Additionally, in light of the limited funding available for job placement and outreach activities, rehabilitation professionals would be wise to recognize the benefits of having extensive working relationships with stakeholders, which can subsequently assist in coordinating services across public and private sectors.

It is also recommended that rehabilitation counselors become advocates of additional funding for TBI-related projects that support community reintegration and vocational outcomes. By promoting enhanced funding for community integration, rehabilitation counselors will also help to raise political awareness of an issue that has become a silent epidemic of the current veteran population. Furthermore, it is also recommended that rehabilitation counselors develop working relationships with the family members of veterans with TBI. Unlike some other disability subgroups, individuals with TBI can rely heavily on the natural supports of their family, friends, and fellow veterans. As a result, it is expected that these very individuals will impact the treatment plan development process.

Recommendations for Psychosocial Support Strategies

The aim of psychosocial support services is to assist veterans in acquiring necessary tools to improve their quality of life and socialization needs, thereby promoting vocational readiness that can lead to participation if vocational training and subsequent acquisition and retention of employment. A few public and private hospitals in the Northeast have started to use promising measures which entail the provision of support services via the use of computer aided psycho-educational training that promotes reduction in social isolation, enhancement of computer knowledge to improve technological independence, and increases community involvement via volunteer opportunities at local community centers and other free or low-cost venues such as community colleges, parks, zoos, gyms, libraries, and so forth. This model is based on the

premise that mental health providers function as service coordinators who promote social integration and vocational readiness via special initiatives that link community involvement and overall health stabilization.

Generally, the computer aided psycho-educational model provides veterans with the following adjutant services: transitional inpatient rehabilitation, housing assistance, neurobehavioral services (i.e., cognitive remediation), occupational therapy, physical therapy, speech-language therapy, therapeutic recreation, as well as computer aided psycho-educational groups that promote social skill development with peers, family members, and general public. These services aim to restore physical health and mental stability, while also working to reduce social isolation via face-to-face interaction and enhanced computer knowledge to improve technological independence and promote increased community involvement. Other services include neuropsychological evaluations, functional capacity evaluations, and medication management via private or VA hospitals, pre-vocational and vocational counseling, vocational exploration, and DVE (diagnostic vocational evaluation) services.

Further exploration of the efficacy of the computer aided psycho-educational model needs to be conducted. Results from this model will need to quantified, and reliability across different veteran subpopulations will need to be assessed. While this model relies on the use of computer aided psycho-educational training and can be beneficial in serving veterans situated in rural areas via the use of telecommunication, the generalizability of this model across different geographical regions remains to be seen.

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Eye Movement Desensitization and Reprocessing (EMDR) Treatment with Combat Veterans: A Review of Current Literature

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Abstract

Eye movement desensitization and reprocessing (EMDR) has been a noteworthy treatment approach for 20 years. However, there are mixed reviews regarding the efficacy of EMDR with combat veterans that have been diagnosed with posttraumatic stress disorder (PTSD) indicating a gap in current knowledge and literature. This review sought to answer whether current literature supports the efficacy of EMDR with combat related PTSD. Several quantitative and qualitative approaches were reviewed. The studies selected compared and reviewed EMDR from several difference perspectives. While the majority of the studies selected support EMDR with combat veterans, there are several methodological concerns. Overall, EMDR appears to be a beneficial treatment approach; however, further research is recommended in this area.

KEYWORDS: EMDR, PTSD, military, combat veterans

With anywhere from 9% to 24% of deployed military service members returning with symptoms of posttraumatic stress disorder (PTSD), it is necessary to develop effective treatments for these veterans (Renshaw, 2011). Eye movement desensitization and reprocessing (EMDR) has been suggested as an effective treatment intervention for civilian cases of PTSD; however, there is limited support for combat related cases (Spates, Koch, Cusack, Pagoto, & Waller, 2009). Spates et al. (2009) reported "EMDR is set against a theoretical backdrop referred to as 'adaptive information process'" (p. 282). The theory proposes individuals with PTSD have incomplete information processing in terms of how they process and store the traumatic memories (Spates et al., 2009). EMDR uses physiological interventions to desensitize the client to the distress of the memories while also correct the faulty processing of the memory (Spates et al., 2009). Several studies have been conducted regarding EMDR as well as its usefulness and efficacy with combat related PTSD; however, there appears to be mixed results. If current literature of EMDR could adequately suggest this treatment as an effective intervention for combat related PTSD, this approach could potentially help thousands of men and women in the military that have combat related PTSD.

Statement of the Problem

Eye movement desensitization and reprocessing (EMDR) has been a popular intervention for posttraumatic stress disorder (PTSD) and acute stress disorder (ASD) for over 15 years (Spates et al., 2009). Since its inception, it has been a highly researched and highly debated

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topic. Several studies fully support its use and efficacy with PTSD (Rogers, Silver, Goss, Obenchain, Willis, & Whitney, 1999), while others find the intervention reveals results of no significant difference to other empirically supported treatments (Ironson, Freund, Strauss, & Williams, 2002). In addition, research regarding the efficacy of EMDR has been localized on particular traumatic events such as sexual abuse or rape, natural disasters, or acts of war (Carlson, Chemtob, Rusnak, Hedlund, & Muraoka, 1998; Ironson, et al., 2002; Spates et al., 2009). Backed by empirical support, albeit it mixed results, the Department of Defense recommends this treatment intervention, among others, for military members suffering from combat related posttraumatic stress disorder (Russell, Silver, Rogers, & Darnell, 2007).

Several studies have been conducted related to EMDR and its efficacy with combat related PTSD (Carlson et al., 1998; Rogers et al., 1999; Silver, Rogers, & Russell, 2008). The general consensus of the literature is that EMDR is an effective treatment; however, it does not appear superior to other trusted approaches such as prolonged exposure or trauma focused therapy. Therefore, a review of current literature will best determine the level of empirical support for EMDR efficacy with combat veterans diagnosed with PTSD.

Description of EMDR

Eye movement desensitization and reprocessing (EMDR) is based on the theoretical concept of the adaptive information processing (AIP) model. This theory proposes, in very basic terms, that the memories of trauma including visual and auditory components become dysfunctional and are filed away in the brain and cause recurring traumatic flashbacks and other symptoms associated with PTSD (Albright, Thyer, Becker, & Rubin, 2011). Therefore, the goal of treatment is to reprocess and restore the traumatic memories in a healthy and more adaptive way. “It involves using a dual attention/bilateral stimulation procedure that aims to reprocess the disturbing emotions and cognitions associated with the traumatic incident” (Albright et al., 2011, p. 4). Using body and sensory awareness, EMDR clinicians during treatment ask clients to recognize and track the sensations in their body as these indicate where the memories may be stored within the body (Albright et al., 2011). EMDR is both an exposure therapy and a physiological intervention. Albright et al. suggest the treatment may be tolerated better than other exposure or trauma focused treatments because of the bilateral stimulation and body awareness.

Research on EMDR has been inconclusive on many levels. First, while controlled treatment studies have noted EMDR has been effective in reducing PTSD symptomology it has not been recognized as more effective than another noteworthy treatment approach. Also, dismantling studies have not been able to conclusively identify the eye movement or bilateral stimulation as necessary components of the treatment nor do they exclusively lead to symptom reduction (Albright et al., 2011). Finally, research on EMDR applied to active duty military members with combat related PTSD has yet to be systemically reviewed to analyze if the findings have been consistent (Albright et al., 2011). Therefore, this review of popular EMDR literature is essential to begin the process of performing an extensive systematic review of EMDR and its efficacy with active duty military members.

Literature Review

Quantitative Approaches

Rogers, Silver, Goss, Obenchain, Willis, and Whitney (1999) conducted a true quantitative experiment of 12 Vietnam veterans "to compare the effects of a single session of EMDR or exposure on traumatic combat memories within the context of an inpatient PTSD treatment program" (p. 121). The current climate of psychotherapy prefers treatments that provide rapid results. Rogers et al. (1999) were interested in the improvement of combat related PTSD patients after only a single session of EMDR, or exposure therapy. The authors argue that although "long term efficacy is certainly the primary consideration in treatment selection, [when] given two treatments of comparable efficacy, clinicians might be interested in such factors as speed, ease of application, comfort for the client, and safety" (Rogers et al., 1999, p. 120). These results are applicable in the case of the active duty service member whose mission requirements might require redeployment into combat situations.

All study participants were administered the Clinician Administered PTSD Scale (CAPS) then randomly assigned to two groups, those receiving EMDR intervention and the other group receiving exposure therapy treatment, by a clinician blind to their CAPS results (Rogers et al., 1999). Following the CAPS assessment, all participants were asked of their most distressing combat related memory. Additional assessments included physiological measurements of heart rate and blood pressure, and subjective rating of the intrusive combat related memory on the Subjective Unites of Disturbance scale (SUDS) on a scale of zero to 10. Following these assessments, each group received a single session of their respective treatment. A post-test follow up assessment was conducted one week after treatment. The authors note this "study was designed to examine the process, rather than long-term efficacy of two treatments" (Rogers et al., 1999, p. 125). They acknowledge that this focus of rapidity as opposed to long-term efficacy may lead to potential limitations.

There are several threats to the validity of this study; however, the authors acknowledge several of them (Rogers et al., 1999). The authors acknowledge that their intended focus of immediate results as opposed to long-term efficacy may limit the interpretation of their results. Houser (2009) explains that if the results of a treatment are "short term and the novelty does not have a chance to wear off" (p. 157) this may skew the reported results. Also, the authors acknowledge that two different therapists administered the two different treatments. This may lead to questionable results in reference to "interaction between personological variables and treatment" (Houser, 2009, p. 154). For example, the participants in the EMDR treatment group may have responded to the therapist more positively than the exposure therapy group.

This true quantitative experiment has few concerns with validity due to the random assignment, the pre and post-test follow up, and the use of a control group (Rogers et al., 1999). The conclusions of the study were that the participants of the EMDR treatment group showed a significantly greater decrease in their SUDS scores after a single session of treatment as opposed to the exposure therapy group (Rogers et al., 1999). The implications of these findings support that EMDR is an effective treatment for combat related PTSD and also a treatment with potentially rapid results (Rogers et al., 1999).

In another true quantitative experiment, Carlson, Chemtob, Rusnak, Hedlund, and Muraoka (1998) studied 35 male veterans, ages 41-70, which were selected from Veterans Affairs hospitals and clinics in Honolulu, Hawaii. In order to ensure these men selected were representative of the combat veteran population they were compared to 114 consecutive outpatient admissions at the same VA hospital. There were no significant differences between these two groups aside from age (Carlson et al., 1998); the group selected for the study was older than the outpatient population. This was attributed to one particularly older veteran (70 years old) who participated in the study.

The authors' research proposal was to address whether combat related PTSD could be successfully treated with a moderate number of sessions of EMDR (Carlson et al., 1998). Various standardized instruments were used throughout the course of study including the Clinician Administered PTSD scale (CAPS), Mississippi Scale for Combat related PTSD, Impact of Event scale, PTSD Symptom scale, and others (Carlson et al., 1998). In addition, to measure the individual's biofeedback in response to treatment or control intervention the participants were hooked up to an electrophysical monitoring and feedback system (Carlson et al., 1998). There were four periods of the study including pretreatment (assessment and evaluation), treatment or control conditions (participants were randomly assigned to one of three groups; control, EMDR treatment, or relaxation treatment), post-treatment and reassessment, and finally a three month follow up assessment (Carlson et al., 1998). The exception was the CAPS assessment as it was administered in the initial assessment and the three month follow-up so not to over-burden the participants with this length assessment (Carlson et al., 1998).

Carlson et al. (1999) conducted a true experiment as characterized by the presence of a control group as well as random assignment (Houser, 2009). There is a pre-test and post-test assessment. Houser (2009) suggests this type of research method and design allows for very little concerns in terms of internal validity. In addition, the authors implement several other defenses against validity concerns by ensuring the therapists were trained in EMDR and those administering standardized assessments were trained, yet unaware of the participants' group assignment. As for external validity, or "the extent to which the researchers can replicate the actual events occurring in the natural environment and thus can generalize results back to the population" (Houser, 2009, p. 147), there are minimal concerns. Carlson et al. used a chi-square statistical reference to assess group equality and there was a concern regarding the overall age of the study participants. The mean age for participants was 48.0; this is higher than the outpatient population they compared to and much higher than the average active duty military service member. For example, 80% of the current active duty Air Force enlisted population is 18 to 35 (Air Force Personnel Center, 2011). This indicates an area of future research; does EMDR prove an effective treatment intervention for younger combat related PTSD sufferers?

The findings in Russell's (2006) observational design study may have indicated a similar question whether there was a "difference between acute and chronic stress" in terms of treatment (p. 11). Russell (2006) selected four difficult cases of PTSD and ASD from a field hospital in Rota, Spain. The participants were selected from 1,400 casualties evacuated from the Iraq war. Their cases were selected because of their serious nature. The goal of Russell's (2006) study was to discern if an abbreviated version of EMDR would be effective in treating combat veterans of

the Iraq war. In addition, he wanted to describe EMDR through specific illustrations of serious cases.

Russell (2006) selected several standardized instruments to triangulate the results of his case reports and observations; measures included Subjective Units of Distress Scale (SUDS), as well as the Structured Clinical Interview for PTSD (SCI) and the Impact of Events scale (IES). The use of triangulation in this case helps to support what the author observed in his participants (Houser, 2009). There was no control group or manipulation of a variable; rather the results were gathered through self-reports and observation.

In terms of validity, there are a few concerns present in this study. First, due to a limited number of participants there is a possibility the favorable results of this study are not so much an indication of the EMDR treatment but rather than interaction between client and therapist (Houser, 2009). The small sample size also effects the statistical power analysis (Houser, 2009). This is described as the "numbers of subjects needed to reject the null hypotheses" (Houser, 2009, p. 135). A limited number of test subjects mean limited support for the hypothesis. Also, there are no long term results reported and the results reported by Russell (2006) were observed immediately following treatment. Therefore, there is a concern regarding the "interaction between time of measurement and treatment effects" (Houser, 2009, p. 158). The intended purpose of Russell's (2006) study was to describe EMDR treatment; he does this very well through the four case illustrations. However, due to the concerns of validity and reliability, the conclusions regarding the efficacy of EMDR should be used with caution in this case.

The final quantitative experiment, conducted by Ironson, Freund, Strauss, and Williams (2002) involved 22 individuals being treated at a specialty clinic for trauma related disturbances. The participants in this study were not combat veterans; rather, they were mostly survivors of abuse. An immediate question of transferability of results is valid. The purpose of the study was to compare EMDR and prolonged exposure (PE) therapy in a community based setting. Also, the authors were interested in differences between EMDR and PE in terms of drop-out rates during the course of treatment, sustained results at a three month follow up assessment, and the level of distress or discomfort during treatment (Ironson et al., 2002). The authors hypothesized that EMDR would result in less distress to the patient. Though Ironson et al. outlined several different hypotheses, they were successful in testing all of them.

Ironson et al. (2002) first administered several tools to gain pre-test information; these instruments included the PTSD Symptom Scale (PSS-SR), the Beck Depression Inventory (BDI) and the Distressing Events Scale (DES). The results of the PSS-SR were validated against the Structured Clinical Interview for DSM Disorders (SCID). The authors noted that primarily self-report measures were used; however, they also implemented several standardized instruments. Houser (2009) notes an advantage to self-report measures include "ease and time of administering them" (p. 173). However, a disadvantage is the possible bias involved with self-reports (Houser, 2009). Self-report questionnaires can produce biased results as the participant may not report accurately.

After random assignment, the groups received their respective treatment; either EMDR or PE. One slight modification to standard EMDR protocol was the use of homework; this was an

attempt to keep the variables between groups as similar as possible so the focus was on the process in the therapy session (Ironson et al., 2002). Results indicated that "EMDR was more likely than PE to result in a 70% reduction of PTSD symptoms following three active treatment sessions" (Ironson et al., 2002, p. 123). There were no significant differences in the three month follow-up assessment; results appeared to remain stable for both groups. As for the distress and tolerance of treatment, there was a higher drop-out rate in PE treatment which supports the hypothesis that PE is more distressing to go when compared to EMDR. The final conclusion of the study was that neither treatment was more effective than the other (Ironson et al., 2002).

Qualitative Approaches

There are limited qualitative studies on the efficacy of EMDR (Silver, Rogers, & Russell, 2008). The purpose of this study was to "describe and illustrate the use of EMDR with combat veterans" (Silver et al., 2008, p. 948). Their research design was a case study approach; "case studies were selected for their typical nature" (Silver et al., 2008, p. 952). Houser (2009) reports case study subjects typically are observed in their natural setting. It is unclear how these cases were selected, though they appear to be patients of the authors. In addition to describing EMDR and the eight phases of therapy, Silver et al. report on the case of a 22 year old male and a 73 year old male. Both are combat veterans; however, the combat experience of the 22 year old was very fresh and recent as opposed to the 73 year old veteran who served in Vietnam many years ago. The conclusion of the study, as supported by these case studies, is that EMDR is an effective treatment for PTSD (Silver et al., 2008).

While Silver et al. (2008) present an excellent summary of EMDR standard protocol, "case studies have limited generalizability" (Houser, 2009, p. 68). There are several other concerns in terms of validity in this study. The authors do not provide any additional information to support their conclusion (Silver et al., 2008). The results of this case would have been better supported through triangulation or the use of "multiple methods to focus on particular phenomena or events" (Houser, 2009, p. 77). Finally, there is a concern over bias. The participants were selected through convenience sampling (Houser, 2009); therefore, the treating therapists appear to be reporting on their own patients and their success (Silver et al., 2008). Without any direct observation by a third party, there is a concern regarding credibility and verifiability of the results (Houser, 2009). Overall though the experiences reported by the case studies may prove useful; however, the results and conclusions should be used with caution.

In a unique case study approach, Schmuldt, Gentile, Bluemlein, Fitch, and Sterner (2013) apply their unique clinical perspectives to the case study of a single soldier's combat experience and his struggles with PTSD. In their remarks about EMDR, the authors suggest that this treatment approach would be effective with this particular case study in helping him to reprocess the painful traumatic memories and "moving them to adaptive resolution" (Schmuldt et al., 2013, p. 8). The authors address the concept of body sensations which is an integral component of EMDR treatment. As related to the case study, Schmuldt et al. (2013) propose that the body sensations experienced by the client represent "unprocessed information related to target memories" (p. 8) and during the course of treatment these body sensations can be limited or even completely eliminated. The authors in this qualitative review of combat related PTSD seem to hone in on the physiological elements of EMDR. Their goal is clearly not to argue the validity or

the reliability of EMDR as a treatment approach but rather address one of the core components of the method which would be beneficial if applied to active duty military members.

The final qualitative approach does not involve combat related PTSD; rather, the test subjects are therapists and the purpose is to discover "how they integrate EMDR with their typical approach, changes they make to standard EMDR protocol, and their thoughts on why they think EMDR works" (DiGiorgio, Arnkoff, Glass, Lyhus, & Walter, 2004, p. 232). The authors utilized a demographic questionnaire and a structured interview. The questionnaire was simply to obtain background information on those selected for the study. DiGiorgio et al. selected three psychotherapists from different theoretical backgrounds including cognitive-behavioral, psychodynamic, and humanistic approaches. There were no standardized instruments used in this approach. The questions of the interview examined the psychotherapists' experiences with EMDR, including training and number of patients treated as well as the therapists' theoretical orientation, its influence on EMDR, and how the therapist deviates from standard protocol for EMDR treatment (DiGiorgio et al., 2004).

In order to reduce bias and increase levels of credibility within the research, the authors subscribed to the consensual qualitative research (CQR) method (DiGiorgio, 2004). This is a team approach to review the data to reduce inferences and bias when compared to only one researcher or reviewer (DiGiorgio et al., 2004). In addition, CQR is used "to have researchers arrive at a consensus about meaning, significance, and categorization of the data" (DiGiorgio et al., 2004, p. 233). Hill, Knox, Thompson, Williams, Hess, and Ladany (2005), the original researchers of the CQR method, explain this approach is ideal because it involves a rigorous method that allows several researchers to examine data and come to consensus about their meaning, thus reducing the biases inherent with just one person analyzing the data" (p. 204). This approach is similar to peer debriefing which is an approach to help enhance credibility and trustworthiness in qualitative research methods (Creswell & Miller, 2000).

The results of the study supported DiGiorgio's et al. (2004) hypothesis that therapists of different theoretical orientation integrated EMDR treatment differently. In addition, the study revealed the therapists did differ from standard protocol of EMDR treatment in various ways and to varying degrees (DiGiorgio et al., 2004). There were only three therapists interviewed and they were all from different orientations. Further research should be conducted to see if there is a difference in EMDR integration among therapists subscribing to the same theoretical orientation. Also, the number of interview subjects is defended by the authors as smaller sample size often "enable[s] researchers to gain an in depth understanding of each of their cases" (DiGiorgio et al., 2004, p. 250). They defend that increasing the sample size would not be a realistic solution.

Summary

EMDR, as a treatment for PTSD, has received significant empirical attention. The results of current literature seem to indicate it is an effect treatment for PTSD, more specifically for combat related PTSD (Russell et al., 1999). While there are similar treatments that may produce similar results, EMDR appears to be better tolerated by veterans (Ironson et al., 2002). Several studies support the hypothesis that EMDR is a rapid treatment approach with significant improvement after a single session (Rogers et al., 1999; Russell, 2006), a moderate number of

sessions (Carlson et al., 1998), or when compared to other treatments such as PE (Ironson et al., 2002).

Further research to support these hypotheses is recommended. Further research should be conducted in the area regarding acute and chronic PTSD; is there a difference in EMDR efficacy between fresh or immediate traumatic events or combat exposure that occurred 10 to 20 years ago? Similarly, is there a difference in improvement of PTSD symptoms after EMDR treatment with respect to age of participant? Finally, is there a difference in EMDR efficacy with respect to therapist variables in theoretical orientation and adherence to standard protocol?

These various studies appear to be moderately supportive of EMDR as an effective treatment for combat veterans diagnosed with PTSD. However, the support is not overwhelmingly significant. Each study focused on a different angle of EMDR which makes comparing these studies difficult. While one study focused on single session efficacy (Rogers et al., 1999), another study compared EMDR to another popular PTSD treatment, prolonged exposure (Ironson et al., 2002). Also, there are moderate concerns regarding validity (Russell, 2006), generalizability (Carlson et al., 1999), and small sample size (Russell, 2006).

Discussion

Eye movement desensitization and reprocessing (EMDR) has been a recognized treatment for posttraumatic stress disorder (PTSD) for over 20 years. Albright and Thyer (2010) explain “EMDR purports to access and process traumatic memories and facilitate the desensitization of emotional distress, the reformulation of associated cognitions, and relief of accompanying physiological arousal” (p. 2). Research has yielded mixed reviews regarding the efficacy of EMDR; however the International Society for Traumatic Stress Studies recommends EMDR as an effective treatment approach for PTSD (Spates, Koch, Cusack, Pagoto, & Waller, 2009). Limited research is available to support the efficacy of EMDR with combat veterans with PTSD. Regardless, the Department of Defense (DOD) and the Department of Veterans Affairs (VA) have recommended EMDR as a treatment option for combat veterans diagnosed with PTSD (Russell & Silver, 2007). While these organizations support the use of EMDR, does current literature support EMDR as an effective treatment intervention for combat veterans diagnosed with PTSD?

Albright and Thyer (2010) suggest that combat exposure represents a unique exposure that should be addressed separately from other stressors and traumas. The limited research conducted on combat veterans and the use of EMDR produces mixed results. Maxfield and Hyer (2002) suggest these results may be an error in methodological approaches rather than the therapeutic intervention itself. The literature review reveals studies dedicated to combat veterans and PTSD; however, several studies have serious threats to validity and reliability that suggest the results should be interpreted with caution. There are limited qualitative approaches specifically related to combat exposure and EMDR; those selected have limited reliability due to lack of triangulation and confirmability. As for the experimental approaches, the randomized control trials selected do not measure the long term effects of EMDR. Most post-test follow-ups were conducted between one week and three months (Rogers et al., 1999; Carlson, Chemtob, Rusnak, Hedlund, & Muraoka, 1998). Also, the sample sizes of the studies are small ranging

from four participants to 35 (Russell, 2006; Carlson et al., 1998). With limited participants and a lack of long term follow ups, the current literature examined does not provide sufficient evidence to conclude EMDR as an empirically supported treatment for combat veterans diagnosed with PTSD.

Special Populations

In addition to sample size and short term results, the quantitative approaches that specifically focus on combat veterans are comprised mostly of men. While the majority of service members in the military are men, women are not immune from developing posttraumatic stress disorder from combat exposure. Without further study into the success of EMDR with treating military woman, there is not empirical support for this treatment approach. However, there has been research regarding the efficacy of EMDR with sexual assault victims that were mostly female (Ironson, Freund, Strauss, & Williams, 2002). Further research should be conducted in this area to provide empirical evidence that supports EMDR specifically with female combat veterans.

Another consideration from current research is the lack of racial diversity in study participants. Most studies do not specify the racial or ethnic makeup of the participants and those that do are majority Caucasian. In addition, the literature reviewed did not study EMDR exclusively on certain racial or ethnic types. One of the core components of EMDR is how the body internalizes and experiences the physical sensations of the traumatic memories. Further research could be used in this area to explore various cultural considerations related to the physical experiences of trauma. In addition some of the studies suggested that EMDR had lower dropout rates and was tolerated better than other treatment approaches. Therefore, further research should explore how EMDR could be used in breaking the barriers that some military members feel when reaching out for help for mental health issues. The stigma of receiving mental health care services within the military community has been well documented (Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009); therefore, if EMDR is effective and easily tolerated it would be beneficial to see if there are ways to apply those components to this stigma.

Recommendations

In addition to further research for women and minorities, there are other areas for further research in EMDR efficacy for combat veterans. One topic of further research is in the area of acute versus chronic PTSD. While several of the studies reviewed participants that were veterans of the Vietnam era (Rogers et al., 1999); several of the studies selected participants from recent conflicts including the Iraq war (Russell, 2006). Could EMDR be more effective in processing recent combat exposure and acute cases of PTSD as opposed to more chronic traumatic stress from less recent combat exposure? Also, another theme that appears in current literature is the rapidity of EMDR when treating combat veterans. This may indicate another area of further research.

In an effort to explore this area of research, a true experimental design with a sufficient sample size of both Vietnam veterans and recently returning Operation Iraqi Freedom or Operation Enduring Freedom (OIF/OEF) could be utilized. Unfortunately, it would be difficult to

randomly assign participants as their age would be an indicator of their military status; "random assignment protects against problems with internal and external validity" (Houser, 2009, p. 147). The researchers should be diligent to ensure that proper precaution is taken to ensure both internal and external validity. The purpose of the research would be to measure the improvement of symptoms following a course of EMDR treatment and compare the Vietnam veterans against the Iraq veterans.

Conclusion

Posttraumatic stress disorder has been affecting combat veterans for decades; thousands of Vietnam and Korean War veterans have struggled with the symptoms associated with this psychological disorder (Price, 2007). Many treatments have been proposed as being effective for reducing PTSD symptoms. This includes eye movement desensitization and reprocessing. However, little empirical research has been conducted on a large enough scale to provide conclusive evidence of this treatment approach's efficacy with combat veterans (Maxfield & Hyer, 2002). While the limited experimental studies suggest EMDR as being effective in symptom reduction, these results are best taken with caution (Russell, 2006).

There are several areas for further research including efficacy with younger versus older veterans, efficacy with acute versus chronic stress disorders, and true experimental studies with larger sample sizes. With continued research into this approach, there may be substantial evidence to strongly suggest EMDR as a front runner in the treatment approaches for combat veterans suffering from posttraumatic stress disorder.

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