Vol 2, Num 2
May-Aug, 2014

ISSN: 2165-7726

Journal of Military and Government Counseling

Association for Counselors and Educators in Government

A Division of the American Counseling Association

THE JOURNAL of MILITARY AND GOVERNMENT COUNSELING

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The Journal for Military and Government Counseling (ISSN: 2165-7726) is published tri-annually in January, May, and September by the Association for Counselors and Educators in Government.

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Letter From the Editor

Welcome to the fifth 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.

The ACEG board has approved a name change – from the Association for Counselors and Educators in Government to the Military and Government Counseling Association. This moves the focus of our name from who we are to those we serve. I like that the new name is in line with the name of this journal. The hope is that the name will give the association more visibility as the military division of ACA.

This issue is an eclectic collection of articles in practice, theory, and research. The lead article touches on the father/son relationship during deployment. The second article is pure research toward developing an interview guide for non-fatal Veteran suicide. The third article focuses on the social support of caregivers of Veterans with dementia. The fourth article reviews culturally competent therapy with Veterans. The graduate student article examines the issue of PTSD and moral injury.

I need more submissions for the JMCG – as of today, I have enough articles on-hand for one more issue. I want to always have at least five articles for each issue. So, ask around where you work – or try writing yourself. I'm advertising for submissions through ACA channels. I hope to have the journal listed in Google Scholar by the end of the year and I will working 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

Gone But Not Forgotten: The Impact of Fathers' Military Deployment on Their Sons

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Abstract

Guided by the understanding of the unique problems faced by children of deployed military parents and boys who grow up with an absent father, this theoretical study examines their convergence. This study presents an understanding of the psychological, emotional, and psychosocial development of children with deployed parents and the current approaches utilized to address their problems. Current research treats military children as a singular entity and does not consider the gender of the child and the deployed parent. The areas of mental health, socialization, and masculinity of sons of absent fathers are examined. By incorporating additional theoretical orientations, mentor programs, and differentiated family systems counseling, many of the clinical inadequacies for this population may be addressed.

KEYWORDS: military, deployment, fathers, sons

Numerous studies and reports indicate that the military deployment of a parent impacts each member of a family in a myriad of ways (Kaslow, 1993; Richardson et al., 2011; Buddin, Gill, & Zimmer, 2001). Such impacts stem far beyond simply missing a loved one and worrying about his or her safety in a war zone. The absence of a parent due to military deployment presents numerous difficulties in the lives of children (Richardson et al., 2011).

Impact of Military Deployment on Children

Three crucial areas of impact stemming from a parent's military deployment are children's' emotional, psychological, and psychosocial wellbeing. Children of all ages with deployed parents experience more emotional difficulties when compared to nationwide samples, with adolescents and females experiencing the highest levels (Chandra et al., 2010). These difficulties include higher levels of anxiety as well as academic, familial, developmental, and social problems (Chandra et al., 2010).

High levels of anxiety stem from a variety of sources including a lack of understanding why a parent left, missing the parent, a fear of losing the deployed parent (Richardson et al., 2011), uncertainty regarding the possible extension of the deployment (Pincus, House, Christensen, & Adler, 2001), and

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© 2014 ISSN: 2165-7726

excessive worrying about the well-being of the parent who remains at home. This ongoing anxiety may lead to problems with children and adolescents' behavioral health (Richardson et al., 2011). Psychosocial problems, including problems in the development of platonic and romantic relationships and sibling and parental relationships are also evident, as one in three children are at psychosocial risk during a military deployment (Flake et al, 2009). Again, adolescents and females experience the greatest number of difficulties (Flake, Davis, Johnson, & Middleton, 2009).

A parent's deployment also appears to have a wide-reaching, negative impact on the family unit. Not surprisingly, the spouse who remains home to raise the children and manage the home often experiences increased levels of stress and anxiety (Casteneda, 2008). The remaining spouse's increased levels of stress and anxiety stem from conflict between competing parental roles such as disciplinarian and caregiver. Higher levels of stress may also stem from a decrease in income, as a reservist's military salary may be far less than the job he or she maintains during peacetime. Additionally, the remaining spouse's stress and anxiety may arise from losing an emotional partner, along with the demands of taking on the deployed spouse's day-to-day responsibilities (Everson & Camp, 2011).

The rank of the deployed spouse also lends itself to the amount of stress and anxiety experienced by the spouse on the home front, with the spouses of officers reporting fewer problems (Burrell, 2006; Castaneda et al., 2008), and spouses of reserve Soldiers reporting the most difficulties (Chandra et al., 2011). This may be related to the level of education attained by parents who are officers, as parents with more education tend to have children with fewer psychological problems during both deployment and peacetime (Flake et al., 2009). Officers receive higher salaries than their reserve counterparts. Their spouse on the home front may face lower amounts of stress when managing a household where adequate funds are available.

School counselors report that children tend to reflect the psychological wellbeing of their parents at school, and parental sadness and anger stemming from one spouse's deployment can hinder children's academic performance and peer relationships (Richardson et al., 2011). During a deployment, negative psychological indicators experienced by the parent at home tend to include high levels of stress, anxiety, and sadness (Richardson et al., 2011). Gibbs (2007) notes that parents on the home front have shown to have higher levels of neglect and abuse their children when their spouse is deployed compared to when the spouse is not deployed. Parental neglect and abuse infiltrate many facets of a child's life and compound the psychological and emotional stressors that are already present in a family as a result of a parent's deployment.

Academic performance problems for children as they relate to a parent's deployment tend to vary in accordance with two major factors: the age of a student and the length of the deployment (Richardson et al., 2011). Richardson et al. studied the impact of extended parental deployments on the academic performance and emotional and behavioral wellbeing of their children in an academic setting. While those children whose parents were deployed for 18 months or less experienced marginal decreases in standardized test scores, those with parental deployments of 19 months or more experienced significant decreases. In addition, any resiliency that children have to their parent's deployment appears to erode after roughly 18 months of deployment (Richardson et al., 2011).

Academic performance may be further impacted if the highly stressed parent at home is unable to meet the academic support needs of the children. An increasingly stressed parent's ability to attend school meetings, assist a child with homework, or serve as a needed emotional support for a child may dwindle and ultimately may become non-existent (Richardson et al., 2011).

Current Intervention Approaches

In order to provide assistance for military children, the Department of Defense and private service providers have utilized a number of approaches. Some of these approaches have been implemented within a school setting, while others have focused on individuals and families.

School-based Approaches

Support in the schools focuses on academic and mental health support, and is intended to benefit children within and outside of the school setting (Buddin et al., 2001; Richardson et al., 2011). One major form of school-based intervention comes in the form of Department of Defense Education Activity (DoDEA) schools. These schools, which operate both domestically and internationally, provide an education and school environment that is suited for the unique demands of military students and their families, including providing counseling for students living outside of their home country. This includes support for adjusting to new cultural and societal norms and support in navigating the college admissions process. These schools have proven highly successful, as demonstrated by a graduation rate of 97% (DoDEA, 2013).

In order to address academic issues in public schools, the Department of Defense allocates additional funding known as Impact Aid. This federal assistance ensures that military students are afforded a quality education in communities with military bases that do not otherwise support the schools through local taxes (Buddin et al., 2001). In addition, Child, Youth, and School Services (CYSS), a division of the Family and Morale, Welfare, and Recreation Command, has a presence in each military branch and offers before and after school programming, academic support, summer camps, and additional care for children whose parents are deployed (Richardson et al., 2011).

Public schools in conjunction with local military bases strive to achieve academic success by providing support to children through individual counseling and support groups with other children of military parents and their families (Richardson et al., 2011). Individual interventions often begin with an adolescent's behavioral problems and address emotional and familial problems stemming from deployment later in the therapeutic process (Everson, Herzog, & Haigler, 2011). School based support groups take many forms, including group counseling facilitated by school guidance counselors. School Liaison Officers (SLO's) are present in schools to help students with numerous problems, including those stemming from a parent's deployment (Richardson et al., 2011). SLO's often serve as intermediaries between schools and parents to ensure academic success for each student is within reach. SLO's also serve as an intercessor between schools and military commands to ensure that both parties are aware of problems faced by military children and that they are able to effectively coordinate solutions (DoDEA, 2013).

Individual Approaches

Assisting children of deployed Soldiers utilizing individual approaches may take the form of individual counseling for children and their parents as well as assistance for parents in child rearing and dealing with stress (U.S. Army CYSS, 2013). Mental health counseling is available to adolescents via school counselors as well as through counseling services provided through the Family and Morale, Welfare, and Recreation Command (Richardson et al., 2011; U.S. Army CYSS, 2013). Military Family Life Consultants (MFLC's) are Department of Defense (DoD) contract employees who engage in helping all members of the military family, not just children. They are counselors who focus on providing counseling support to children as they work to develop strategies and tools to overcome problems stemming from deployment such as stress, anger, and sadness (Richardson et al., 2011). Operation Military Kids (OMK) is a partnership between the army and local communities that emphasizes the importance of military children forming social relationships with other military children in order to be able to support one another during a parent's deployment (Richardson et al., 2011). OMK accomplishes this goal by providing children of deployed Soldiers (103,000 children in 2011) opportunities to attend residential camps, sports and recreational activities, academic support, and intervention services (OMK, 2013). This provides military children some of the social support required to mitigate the unique demands present in a military family.

Family-based Approaches

Another prominent form of assisting children of deployed Soldiers comes in the form of working with the entire family as opposed to working with individual family members (Everson & Figley, 2011). Government support for families as a whole may take place through many approaches. Mental Health Net (MHN) Government Services (2013) provides counseling related to a Soldier's deploying and reentering the family unit as well as stress management. School Liaison Officers, though a school based resource, provide parents with support related to child rearing (DoDEA, 2013 & Richardson et al., 2011).

Family therapy stands as a common form of therapeutic intervention provided to military families (Everson & Figley, 2011). Organizations such as Give-an-Hour, a non-profit which provides free or low-cost counseling to Soldiers and their families provide such services at no charge (Richardson et al., 2011). When working within the context of a family system, support can be provided to the many players who are affected by the deployment of a loved one. During family therapy, topics such as family roles, boundaries within the family, family processes, separation, and sibling relationships are addressed (Everson & Camp, 2011). A family systems approach to families of deployed Soldiers is intended to benefit the family as a whole as well as its individual family members.

A Shortcoming of Current Approaches

The school, individual, and family-based approaches to assisting children in military families have proven valuable in helping adolescents cope with the many hardships posed by deployment. However, none of the current approaches appear to differentiate among the children served on the basis of gender; rather, they treat the children of deployed Soldiers as a singular

entity. This is cause for concern, given indications in the research that a parent's military deployment may have a differential impact on boys and girls (Chandra et al., 2010; Richardson et al., 2011). Reed, Bell, and Edwards (2011) conclude that adolescent males are more likely to have impaired well-being than their female counterparts, especially in the forms of lower scholastic performance and engagement in risky behaviors. It appears that the impact may be uniquely strong and pervasive on the mental health, masculinity, and socialization of boys whose fathers are deployed.

The Unique Impact of a Father's Absence on Sons

On Mental Health

One area where a father's involvement plays a critical role in the life of his son is with regard to his mental health. Boys who grow up with absent fathers appear to have problems with their psychological wellbeing and a greater likelihood of experiencing mental health problems (Lamb, 2010). These mental health problems may impact multiple aspects of a young man's life and continue to negatively impact him for the remainder of his life (Miller, 2013).

Specifically, it has been shown that adolescent males who grow up with inadequate or absent fathers are at a greater risk for depression (Balcom, 2002). Pleck (2010) citing Carlson (2006) has proposed that sons, whose fathers are not involved in child rearing, as is the case with deployed fathers, are more likely to internalize their feelings and have a negative outlook on life. The depression faced by young men who grow up without a father may also contribute to a fatherhood wound. Miller (2013) describes this fatherhood wound as a sense of longing and desire for a father that was either neglectful or not present.

Adolescent males who grow up in fatherless homes are also at a higher risk for problems with aggressive and violent outbursts. These problems with aggression and violence permeate into all other aspects of the boys' lives; they are more likely to face problems at school and in the home (Balcom, 2002).

On Masculinity

Fathers play a critical role in their sons' development of masculinity, because they serve as the first and, oftentimes, the strongest embodiment of what it means to act in a way that is appropriate for a male in a given societal context (Floyd, 2006). Kimmel (2008) asserts that fathers have the power to substantiate a son's sense of maleness or cause it to dissipate, further emphasizing the importance of paternal involvement in a young man's life. Without a present father, many men feel a sense of grief and loss over the relationship they lack (Diamond, 2006).

Beginning in the 1970's, a notion that manhood and maleness should become tamer and gentler began to permeate throughout American society. This shift in the understanding of masculinity seems to have stemmed from the growing women's movement along with the loss of numerous manufacturing jobs that had been typically held by men (Brown, 2012). Conversely, the military presents a unique culture that idealizes a hyper-masculine version of maleness, putting forth the image of a strong, heroic warrior (Hall, 2011). This idealized version of

masculinity, within and outside of the military context, includes a high value placed on violence and physical prowess, while other forms of masculinity (e.g., the sensitive, caring, male) are viewed as inferior and lacking and best suited for women or homosexuals (Brown, 2012).

Conflicts between society's and the military's notions of masculinity lead to inconsistent models of masculinity for boys in military families. As women are now allowed to serve in combat roles alongside men, traditional gender roles within the military are changing, thus even further obfuscating these boys' notion of masculinity. According to Pittman (1993), boys without models are likely to overdo their notions of masculinity, "like a masculine impersonator" (p. 34). Boys without present fathers find themselves seeking to understand their own masculine identity within the context of their father's absence (Miller, 2013). Developing a masculine identity within this context may have implications for how a young man sees himself in relation to his peers.

On Socialization

Within and outside of the military context, a father's absence plays an important role in his sons' social development (Allen & Daly, 2007; Lamb, 2010). Floyd (2006) purports that the father-son relationship stands as the most crucial relationship with another male in a man's life. Without a consistent model of appropriate male behavior in various types of relationships, young boys may not be able to effectively or appropriately enter into relationships with other children; whereas those with a consistent model of appropriate male behavior in differing types of relationships are likely to face fewer problems in their social roles and in the development of intimate relationships (Balcom, 2002).

Adolescent males who do not have a father present in the home have shown to be less likely to be able to work effectively with others (Balcom, 2002). In addition, they are more likely to build relationships with other adolescents who engage in delinquent behavior such as vandalism, illegal drug use, and school truancy (Everson, Herzog, & Haigler, 2011). Thus, the socialization problems of sons lacking the regular presence of a father in their lives are not simply limited to the contexts of their own lives, but may have impacts on greater society in the forms of sons' engagement in negative behaviors.

New Approach to Addressing Military Fathers and their Sons

In view of the unique problems that continue to be faced by sons of fathers away on military deployments, it seems that additional clinical perspectives and methodologies may be needed to augment current intervention approaches. Given their demonstrated effectiveness, expanded application of family systems interventions is recommended. In addition, the incorporation of mentoring, group work, and a feminist perspective into intervention programs for sons with deployed fathers holds promise for more comprehensively addressing their potential deficits in the three critical areas of mental health, masculinity, and socialization.

Expansion of Family Systems Interventions

As noted previously, the family systems approach has shown to be effective in addressing a myriad of issues and problems faced by sons of deployed military fathers. Rather than pathologizing the symptoms of a family with a missing member, a family systems approach seeks to empower remaining members to support one another in coping with and overcoming the challenges presented during the member's absence (Corey, 2013). As such, an expansion of family systems-based services to military families is recommended.

A family systems approach may be particularly useful in working to change well-established, stereotypical morays about masculinity in families where military service has become the family business; that is, where fathers, grandfathers, and other older male family members have also served in the military. Utilizing a family systems approach may also prove beneficial to military sons by providing them with a stronger sense of support and familial intimacy. Increased intimacy may prove helpful in mitigating risks of social delinquency.

Mentoring Programs

In addition to utilizing a family systems approach, mentoring and role-model programs have proven effective in mitigating mental health problems stemming from inadequate parenting and fatherlessness (DuBois, Portillo, Rhodes, Silverthorne, & Valentine, 2011). Children who have mentors have shown to have an increased ability to face and overcome obstacles (Woodland, 2008). Tierney et al. (1995) compared a group of 959, 10-16 year old students who had mentors and those who did not. It was found that having a mentor present in a child's life decreased first time drug use by 46%, decreased school absenteeism by 52%, and lowered violent outbursts by 33%.

In order to optimize the effectiveness of such programs for military children, it is imperative to have mentors who understand the culture of the military (DuBois, et al., 2011; Spencer, 2007). Potential mentors with such knowledge could include non-deployed soldiers, retired soldiers, ideally male, as well as adult males who grew up in military families and thus, have an understanding of the unique experience of having a deployed parent.

Having a mentor who is knowledgeable of a changing military culture can provide sons of deployed fathers a consistent, positive male role model in the father's absence. Having a mentor may also reduce the level of responsibilities and subsequent levels of stress on the remaining parent (e.g., through help with homework, getting sons out of the house on a Saturday, etc.), thus decreasing the stress of that parent as well as the stress experienced vicariously by the children in the home. Unfortunately, mentoring programs across the country lack qualified adults willing to serve as mentors for youth. Additionally, the quality of mentors and programs are widely varied throughout the country (Cavell, DuBois, Karcher, Keller, & Rhodes, 2009). Thus, increasing the availability and quality of training for mentors would be advantageous for sons of deployed fathers.

Group Work

Additionally, group counseling may assist with issues faced by sons of deployed military fathers. Hauenstein (2003) noted that group counseling for adolescents who suffer from social problems proves advantageous by providing them with a sense of community and an opportunity to reject the notion of a personal fable, or the idea that their situation is entirely unique. Mitigating such feelings of isolation and potentially developing platonic relationships may decrease the opportunity for delinquent behaviors for this population.

While group counseling and group services for children of Soldiers are already available, it would be important for these groups to develop appropriate curricula to address the specific needs pertaining to the deployment of a father and the specific impacts and stressors that arise for sons. Such group work opportunities, in conjunction with an effective mentor and family systems perspective, would provide these young men with the social support required during the absence of their father and is, therefore, recommended.

A Feminist Perspective

Effective intervention for this population may also benefit from a feminist theoretical orientation. The addition of a feminist theoretical perspective in both individual and family intervention programs would encourage boys to explore the problems that come from adhering to traditional gender norms and additional cultural expectations (Corey, 2013). The therapeutic goal in utilizing a feminist approach would be to remove the limits placed on boys by gender-role socialization (Corey, 2013). This perspective would prove especially useful due to the hypermasculine culture and narrow definition of masculinity purported by military culture (Brown, 2012).

Future Research

In order to provide effective services for the sons of deployed military fathers, further research is needed. First, it is recommended that the specific impact of military culture on the development of sons living in military families be further studied. Suggested specific areas for inquiry include understanding the differential impacts of a mother or father's deployment on sons. Additionally, the hypermasculinity promoted in the military (Brown, 2012) and its impact on military sons' development also warrants further research. It may also prove advantageous to understand how are problems with young men's mental health impacted by the length of the deployment. Additionally, more information is needed regarding how the rank and job of a military father impacts a son's relationship with his father. For example, would a son whose father is a cook in the military see notable differences from a father who is an officer leading other Soldiers into combat? Though beyond the scope of this paper, there is clearly a need for similar research examining the impact of parental deployment on girls. By answering these questions, future research may help to improve the effectiveness of support services for children of both genders who must confront the difficulty of a deployed parent.

Conclusion

A Soldier's deployment takes a severe toll on many different parties; however, his or her children are especially hard hit. Appropriately caring for these young people is crucial as the absence of a parent may have significant impact on the child's development. It is important to note that children of Soldiers should not be treated as a singular entity, but rather in groups beyond gender in order to serve them most effectively. The relationship between father and son is unique and warrants special attention when examining the three critical areas of mental health, development of masculinity, and socialization. This unique relationship merits utilizing new clinical approaches to address the unique issues facing young boys with deployed fathers.

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Volume 2, Number 2 2014

Developing an Interview Guide to Evaluate Non-Fatal Suicide Attempts in Veterans: Use of a Modified Delphi Method

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Abstract

An estimated 22 Veterans die from suicide daily with approximately 67% of those deaths occurring by means of firearms. In order to better understand the process by which Veterans attempt suicide by means of firearms, an interview guide for qualitative evaluation of the contexts and characteristics of Veterans after a non-fatal suicide attempt or serious suicidal ideation was developed. An email based modified Delphi method was used to evaluate the content and structural validity of an initial draft of the interview guide and to inform further development of interview questions. The review panel consisted of six individuals, three Veterans with experience dealing with soldiers in active duty and/or Veterans, and three academic experts. In contrast to the traditional Delphi Model where 6-7 experts in the field of suicide prevention would be queried regarding the development of an interview questionnaire, this modified Delphi method utilized Veterans to inform the language and tone of the interview questions. A total of three rounds were performed to achieve a minimum consensus level of 80%. The resulting interview guide contains open-ended questions that are easily understood by Veteran participants, follows a natural flow of questioning, and follows the Theory of Planned Behavior conceptual model.

KEYWORDS: Delphi method, suicide, Veterans, suicide prevention, interview guide

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© 2014 ISSN: 2165-7726

The purpose of this article is to describe the process used to develop a qualitative interview guide to be used in a future study entitled *Context and Characteristics of Non-Fatal Suicide Attempts Involving Firearms*. When submitting this qualitative research proposal for grant funding and Institutional Review Board (IRB) review, some reviewers expressed the need to ensure that the interview guide would gain enough information to answer the research question, and questioned whether the guide would be too intrusive or lengthy to participants, given the sensitivity of this topic. Because qualitative interviews are designed to gather information regarding a specific event through individual interviews, this interview technique is not validated in the same way that a quantitative approach would be. The Delphi method is commonly used to determine the validity of qualitative questions during the development of survey instruments. This paper describes the use of a modified version of the Delphi method in developing a valid qualitative interview guide to assess suicide ideation with firearms to be given to a U.S. Veteran population residing in a rural southern region.

Background

Approximately 36,000 to 38,000 deaths occur by suicide in the United States each year (Office of Patient Care Services [OPCS] and Office of Mental Health Services [OMHS], 2011) with a case ratio strongly related to the availability of household firearms (Miller, Azrael, & Barber, 2012). An estimated 22 Veterans die from suicide daily (Kemp & Bossarte, 2012) and approximately 67% of those deaths occurring by means of firearms (OPCS & OMHS, 2011). Data available from the Department of Veterans Affairs (VA) Suicide Prevention Applications Network suggest that more than 1,250 Veterans who receive care at facilities of the Veterans Health Administration attempt suicide each month and 15% of all Veterans who survive a suicide attempt will make a repeat suicide attempt within the next 12 months (OPCS & OMHS, 2011; Bossarte, 2012).

This article describes the use of a modified Delphi method, instead of the more commonly used Delphi method, to assess and validate survey questions when developing a qualitative interview guide to measure factors associated with suicide ideation/attempt involving the use of firearms. The final interview guide will be used to gather information from Veterans who recently reported serious suicide ideations involving firearms or interrupted or aborted suicide attempts by firearms. This interview guide will aim to identify the context of suicide events involving firearms and the process for obtaining access to the firearm, including timeframe of firearm acquisition relative to suicide attempt, location of firearm within the home, and the use of safety devices (e.g., safety locks). To our knowledge this is the first study either within or outside of the VA that endeavors to directly engage suicide attempt survivors in order to understand the context of risk associated with firearms and seeks information on how to prevent future loss of life. Given that there is limited research on suicide by firearms, this exploratory study assumes that to gain overall understanding of the suicide phenomena and ultimately prevent suicide, it should be observed from a holistic perspective, which includes a description and understanding of a person's social environment as it is perceived by the individual. Therefore, an understanding that individuals are guided by the stressors and support experienced from within their environment is paramount in conducting research on suicide prevention.

The Theory of Planned Behavior

Prior research studies have used the theory of planned behavior (TpB) to gain a general understanding on factors directing individuals to choose suicide. TpB provides a theoretical framework within which suicide events can be understood and prevented. This model is an extension of Fishbein and Ajzen's (1975) theory of reasoned action (TRA). In TpB a person's behavior (e.g., use of firearm or other lethal method in a suicide event) is guided by his/her intention, which in turn is influenced by three factors. The first is the individual's attitude toward the behavior, which has three components: attitudes related to the behavior (use of lethal method), beliefs about the consequences of the behavior (suicide and suicide by the chosen method), and the acceptability of those consequences. The second is the person's estimate of the social pressure to perform or not perform the behavior or the subjective norm. The third is the extent to which a person feels able to enact the behavior which is determined by how much a person has control over the behavior and how confident the person feels about being able to perform the behavior (Francis et al., 2004). These three factors influence one another and their outcome can be mediated by actual (rather than perceived) behavioral control.

The Delphi Method

The Delphi method uses the opinions of subject matter and research process experts and combines this into a group consensus (Keeney, Hasson, & McKenna, 2001). The Delphi method originated in the 1950's through an experiment conducted by the RAND Corporation and was used to inform policy and military strategies (Dalkey & Helmer, 1963). The method repeated individual questioning of seven experts on a central topic without allowing direct contact or discussion within the group. After each round of questioning, the policy or strategy under review was revised, based on available data previously requested by a member of the panel or by relevant suggestions of panel respondents. This method was continued through five rounds of interviews and the respondents were given the opportunity to change their answers based on the information provided (Dalkey & Helmer, 1963). Although this method has been modified in its use since its origination in the 1950's, it has been used extensively in research within the social sciences (Keeny, 2001). In a critical review of this methodology, Keeny, Hasson, and McKenna (2001) explain that the Delphi method has much to offer in terms of gaining consensus from a wide range of experts on a specific topic.

This study used a modified Delphi expert panel method to develop and validate the content and structure of an interview guide to be used in a study researching the contexts and characteristics of Veterans residing in the region served by the Central Arkansas Veterans Health System (CAVHS) of Veterans Integrated Service Network (VISN) 16 (which includes Arkansas, Oklahoma, Louisiana,, Mississippi, and parts of Texas, Missouri, Alabama, and Florida), after a non-fatal suicide attempt or serious suicidal ideation using firearms. The demographics of this population as a whole are summarized in Table 1 (State and County Quick Facts, 2014; National Center for Veterans Analysis and Statistics, 2014; VHA Office of Rural Health, 2014). VISN 16 and the Central Arkansas Veterans Health System in particular serve a predominantly rural Veteran population. Several issues arise when formulating interviews for this demographic: language needs to be at an appropriate educational level without seeming condescending; many

rural Veterans live in areas where the possession of firearms for hunting is an acceptable lifestyle activity; and as a whole this demographic holds to a strong belief of self-sufficiency.

Table 1. *Demographic Composition of Veterans Residing in Arkansas*

	Arkansas	**Nation**
	250,000	21,886,671
Veterans-Gender		
Male (%)	225,955 (90.4%)	19,623,813 (90%)
Female (%)		
Age		
17-44	49,923 (20%)	4,440,594 (20%)
45-64	89,992 (36%)	7,774,254 (36%)
65-84	95, 070(38%)	8,265,725 (38%)
85+	15,107 (6%)	1,406,098 (6%)
Ethnicity		
Caucasian	209730 (84%)	17,190,937 (78%)
African-American	32,400 (13%)	2,618.046 (12%)
Latino/Hispanic	5,702 (2%)	1,757,837 (8%)
Native American	1,790 (0.7%)	151,474 (0.7%)
Asian/Pacific Islander	357 (0.1%)	306,661 (1.4%)
Geographical Residence (%)		
Rural	53.9%	29%
Urban	40.6%	71%
Service		
Wartime	185,596 (74%)	16,475,283 (75%)
Vietnam era only	79,250 (32%)	6,787,916 (31%)
Gulf War: pre 9/11	29,652 (12%)	2,717,512 (12%)
Gulf War: post 9/11	25,714 (10%)	2,179,706 (10%)
Peacetime	64,499 (25%)	5,497,681 (25%)

Thus, while the Delphi model would utilize six to seven professionals within the social sciences to inform an interview guide that adheres to the TpB model or other theoretical models, this method might yield questions that might not be easily understood by our patient demographics, might be deemed as patronizing, and would not validate the respondent's past military experience. Our modified Delphi procedure thus included a panel that was composed 50% of social science experts and 50% of evaluators who had past military experience as well as extensive work experience serving active military personnel and/or Veterans. We term the latter panel participants "Military/Veteran Experts" in that their job on the Modified Delphi model was to inform the interview guides with our rural Veteran population in mind. Knowing that we would be interviewing participants who had attempted or had serious ideations of suicide and who might have had prior combat experience, we wanted to develop a guide that not only captured relevant information regarding suicide ideation but was also respectful of the Veteran and his/her past experience.

Methods: Delphi Process and Procedures

Development of Initial Interview Form

In an effort to gain a greater understanding of the context in which attempts of suicide by firearm occur, the authors applied the theoretical framework of TpB when developing their qualitative interview guide. Individual characteristics to be investigated include attitudes related to firearms, perceived connectedness to their family and environment, and attitudes about help seeking. Contextual factors to be examined in the interview guide include the Veterans access to firearms in the home, cultural beliefs about firearm ownership, patterns of use, significant life events preceding the attempt, and home environment (i.e., factors that would promote or restrict access to firearms). The role of the expert panel was to review the interview questions to ensure that they would answer the research questions, would in no way harm the Veteran participant, and respectfully inquire about the details related to this sensitive subject.

This study used an email-based modified Delphi method to validate the content and structure of the qualitative interview guide. The following procedures were used:

1. Review of relevant literature: Researchers performed a comprehensive search of the literature relevant to the TpB conceptual model and Veteran suicide by firearms before drafting the initial interview guide. This initial interview guide contained a total of 16 questions (Appendix A).
2. Review of draft instrument: Subject matter experts, not involved in the Delphi process of validation, reviewed a preliminary draft of the interview guide for the wording and overall readability of the instrument. Revisions were made to the interview guide as suggested. The initial interview guide contained 16 questions; six questions dealt with personal attitudes towards firearms and use of firearms in the suicide attempt/ideation, two questions dealt with subjective norms regarding the how the potential interviewee as well as those close to him feel about suicide and whether anyone close to the interviewee had attempted suicide before, and the remaining eight questions dealt with perceived behavioral control (e.g. perceptions regarding control of actions in the current or past attempts/ideations, Appendix A).
3. Selection of expert review panel: We chose to recruit a review panel consisting of Veterans, suicide prevention providers, and experts in qualitative analysis. The panel was made up of six people all of which work in services to assist Veterans. Combined expertise consisted of three Veterans, two qualitative experts, and two suicide experts. Individually the panel consisted of
   - three Veterans, with collectively two years of work experience Veterans Healthcare.
   - one anthropologist (PhD level) trained in qualitative interviewing methods;
   - one mental health professional (PhD Level) post-doctoral training in qualitative interviewing methods and suicide; and
   - one suicide prevention specialist (RN), with over a decade experience in suicide prevention with Veterans in crisis.
4. Round 1 of Delphi: In this round of the study the experts were individually emailed a draft of the interview guide (See appendix A), explanations of TpB and of study objectives, and were asked to answer nine general questions about its content and structure. The questions asked were:

- Do you feel the overall flow of the guide is appropriate for Veterans?
- Do you feel the overall tone of the guide is appropriate for Veterans?
- Do you feel the questions asked gather enough information about the Veteran's suicide attempt/ideation?
- Do you feel the questions asked gather too much information about the Veteran's suicide attempt/ideation? In other words, are the questions too personal or offensive?
- Do you feel the questions asked follow the TpB (as described in the attached study description)?
- Are there other questions that you would include?
- Are there questions that you would remove?
- Would you change the order of questions?
- Do you have any additional comments about this interview guide?

Once all feedback from the expert panel was received by the authors for the first round, the suggestions of the reviewers were compiled, each question was checked for consensus, and revisions to the initial interview guide were made as suggested.

5. Round 2 of Delphi: In round two of modified Delphi evaluation, the same panel of experts were emailed a draft of the revised interview guide as well as the comments from round one, and asked to answer the same nine questions about its content and structure. Once all feedback from the expert panel was received for the second round, researchers compiled the suggestions of the reviewers, checked the responses for consensus and made revisions to the interview guide.
6. Round 3 of Delphi: In round three of the study the same experts were emailed a draft of the second revised interview guide, containing all of the comments from round two, and asked to answer the same nine questions about its content and structure. Additional comments and suggestions for further evaluation were considered.

Results

Three rounds of data collection were employed to reach at least 80% consensus for the first four questions and less than 20% expressing need to change wording of the interview guide as expressed by the last five questions (e.g., 80% consensus that the wording was not offensive and that there were no other changes or comments to be made). All six participants provided feedback for all three rounds. Table 2 displays the questions asked and includes the percent of participants responding "Yes" to each question during each round. As evident in Table 2, the level of consensus increased for each question from one round to the next with all questions reaching a consensus level of at least 80% by round three.

Round 1 Recommendation

In round one, the panel of experts reviewed the first draft of the interview guide and provided feedback on its contents and structure. After initial review, consensus was reached by the panel in terms of the overall tone of the interview guide being appropriate for Veterans (Q2, Table 2) and the adherence of the interview guide with TpB principles (Q4, Table 2). However, half of the respondents had problems with the flow of the questions and suggested changing the order in which certain questions were asked (Q1 and Q8, Table 2). Specifically, the qualitative

experts and one of the Veterans suggested opening the interview with general questions regarding suicide and then delving into the specifics of attempt by firearm and attitudes about firearms. Half of the reviewers felt the interview guide was not informative enough and specifically that questions pertaining to perceived behavioral control were too limited in quality and needed to be broader or more open ended. A third (two of the Veterans) felt that some of the questions were too personal or offensive. Most of the reviewers felt the other questions needed to be included in the guide, specifically regarding history of ownership and use of firearms. Four of the six reviewers suggest removing several questions. Specifically, question 2 of the interview guide was thought to be redundant with question 1 regarding history in gun ownership and question 3 regarding factors in choosing a particular firearm for the current suicide attempt/ideation (see Appendix A).

Table 2. *Level of Consensus for Rounds 1-3*

Question	Round 1	Round 2	Round 3
Do you feel the overall flow of the guide is appropriate for Veterans?	50%	67%	100%
Do you feel the overall tone of the guide is appropriate for Veterans?	83%	83%	100%
Do you feel the questions asked gather enough information about the Veteran's suicide attempt/ideation?	50%	67%	83%
Do you feel the questions asked follow the Theory of Planned Behavior (as described in the attached study description)?	83%	100%	100%
Do you feel the questions asked gather too much information about the Veteran's suicide attempt/ideation? In other words, are the questions too personal or offensive?	33%	17%	0%
Are there other questions that you would include?	83%	0%	0%
Are there questions that you would remove?	67%	17%	0%
Would you change the order of questions?	50%	17%	0%
Do you have any additional comments about this interview guide?	33%	17%	0%

Note. Numbers represent the percent of "Yes" responses.

In addition to answering the questions listed in Table 2, some experts provided general recommendations throughout the draft instrument. These recommendations included:

Suicide prevention expert. The suicide prevention specialist described the interview guide as "not containing anything insensitive or inappropriate" and stated that the questions followed the TpB model.

Qualitative experts. Both of the qualitative experts voiced their concerns that the interview guide was too structured, particularly those questions dealing with perceived behavioral control (questions 9-16; Appendix A) and did not represent the open-ended nature of a qualitative interview. One expert suggested that the interview guide "needed to contextualize behavior/attitude with firearms within a larger context of suicide." They made suggestions to change some of the wording and order of the questions to reflect a more qualitative interview and suggested that some of the more specific questions be embedded within the more general ones.

Veteran experts. Overall, the Veteran expert responses to the evaluation questions (Table 2) did not differ from those of the qualitative experts, with the exception of whether they thought some of the wording was too personal or offensive. The overall agreement with the qualitative experts was regarding order of questions in context of firearm use and qualitative aspect of the interview guide. One Veteran stated that the questions should "be more open-ended and not elicit simple yes/no or specific date answers." Another Veteran suggested adding the question "What makes you want to attempt suicide?" again reflecting the qualitative experts' suggestions that the specifics of firearm attempt be imbedded within more general questions regarding suicide. One Veteran stated a were concerned that the wording used sounded too "clinical in nature" and offered suggestions on how the authors could make it sound better. Two Veterans had issues with appropriate wording regarding some of the questions in the Attitudes Related to Behavior section or the Perceived Behavioral Control section. One Veteran reminded the authors of the likelihood that these individuals might have grown up in households were guns were commonly owned and used for a variety of purposes (e.g., hunting, recreation, collection, protection) and that questions in this section needed to address this history and use but also be sensitive to the fact that gun ownership is an accepted norm in this region of the country. Both Veterans reminded the authors that all Veterans have been trained in the use of firearms in their military training and that: (a) experience within the military needed to be embedded in the attitude section of the interview guide and (b) question #13 in the interview guide was possibly offensive. The qualitative experts or the suicide prevention experts did not raise these same concerns.

Round 2 Recommendations

The revised interview guide for Round 2 presented questions under two main categories rather than three. The language of categories specific to TpB (e.g., Attitudes, Subjective Norm, Perceived Behavioral Control) was omitted and the category headings were changed to Suicide and Firearms. The revised guide consisted of seven major and general open-ended questions with more specific probes embedded within the seven questions. These questions remained from the initial guide and were rephrased to reflect a more open-ended quality. Other more specific questions from the initial guide were inserted as specific probes. Consensus was reached for all but two of the evaluation topics. Two panel members continued to have problems with the flow of the interview guide and with the order in which questions were asked. One of these was a qualitative expert and the other was a Veteran expert. In particular, these evaluators had suggestions regarding the flow and order of the section regarding the specifics of the attempt with a firearm and history of firearm use. They also had suggestions for streamlining the wording of some of the questions. In addition to answering the questions listed in Table 2, some experts provided general recommendations or comments throughout the draft instrument:

Suicide prevention expert. No suggestions offered for further improvement**.**

Qualitative experts. One of the qualitative experts on the panel voiced continuing concern that the guide was too structured and needed to contain more general questions to represent a true open-ended qualitative interview. The other qualitative expert was satisfied with the edits performed from the first round and had no further edits or suggestions.

Veteran experts. One respondent suggested that some of the wording added to or changed for some questions during the first round sounded "too clinical and research oriented" and that the Veterans participating in the interviews may be confused on what the question is really asking. They provided suggestions for editing these questions to more clear for the Veteran population. None of the Veterans felt that the language in the revised second draft was too personal, offensive, or intrusive.

Round 3 Recommendations

Consensus was achieved for all evaluation questions by round three. After completion of the third round, the reviewers had reached 100% consensus on eight of the nine of the questions asked and 83% on the remaining question: "*Do you feel the questions asked gather enough information about the Veteran's suicide attempt/ideation?* The final Interview Guide accepted by consensus is found in Appendix B. The final guide is similar in many respects to the Round 2 guide; the two sub-headings and seven general questions from round 2 remain. Probing questions also remain but were streamlined in order to sound less "clinical." The order in which the questions under the Firearms section are presented was changed so that the first question asked probes the factors and considerations leading to choosing a firearm for the current suicide attempt/ideation followed by history of firearm ownership and use. Comments on the third round were as follows:

Veteran experts. No suggestions offered for further improvement.

Qualitative experts. One qualitative expert suggested conducting at least two mock interviews to test the interview guide for general understanding and flow of the questions asked. The second qualitative expert had no further suggestions for improvement.

Suicide prevention experts. No suggestions offered for further improvement.

Testing the Interview Guide

It was suggested that the authors perform at least two mock interviews. The purpose of these mock interviews was to ensure the questions were easily understood by Veterans who were naïve to the purpose and process of the study design, that all needed information was captured, and to determine the amount of time needed to complete the interview in planning for the actual study. In both mock interviews, respondents were able to give enough information needed to answer the questions on the interview guide and provided the qualitative information needed to assess the contextual nature of firearm use in suicide attempts or ideations.

Discussion

Although there has been increased literature published about Veterans' suicide involving firearms, little is known about the context and characteristics of the suicide event. When interviewing Veterans that have had recent ideations or suicide attempts, it is imperative to gain the information while maintaining the Veteran's well-being and sensitivity to the Veteran and his/her past experiences. For that reason the questions used for key informant interviews must be

pertinent to the subject and worded in a way that will encourage the Veteran to share valuable personal information. The interview guide developed and described in this article will be used in a future pilot study which seeks to advance knowledge of perspectives about and processes of suicidal behavior among Veterans, specifically about non-fatal suicide attempts by firearms. The information to be gained includes: (a) help-seeking behaviors and thought patterns in times of suicidal crisis, (b) reasons why Veterans choose firearms as a suicide method, (c) relationships between military service and suicide, and (d) suicide prevention strategies from the perspective of the Veteran.

The results from this pilot study will inform recommendations for reducing access to firearms during periods of extreme emotional distress for Veterans who survived a suicide attempt and further efforts in suicide research by providing information needed to develop a comprehensive suicide prevention program. Since the future pilot study will involve interviews of Veterans who reside within a region of VISN16 that contains both urban and rural components, development of an interview guide must keep in mind the demographics of the general Veteran population in this Southeastern U.S. region. Ownership and use of firearms in both rural and urban regions may be an accepted norm that is informed by similar or different purposes (e.g., protection vs hunting/recreation). Furthermore, knowledge that Veteran demographics include a majority of Veterans who have had military combat experience is important when developing an interview guide. Thus for the purposes of the future study, a valid qualitative interview guide will need to contain language that is not only understood and accepted by the Veteran (e.g., not too clinical in nature) but that also acknowledges and respects the Veteran's past and current experiences.

Traditionally, the credibility and dependability of qualitative interviews depends on rigorous techniques and methods used for gathering and analyzing the data (Patton, 1990; Rubin & Rubin, 2005; Speziale & Carpenter, 2007). The interviewer becomes the instrument and the quality of the data rests on his/her ability to build rapport with the participant and be an active listener (Gordon, 1994). Thus in qualitative studies, the integrity of the data are determined by the rigor of the operational techniques in which the interviewer collects and analyzes key information (Speziale & Carpenter, 2007). Furthermore, the quality of the data is greatly dependent on the skills of the individual interviewer, reflecting his/her professional training and content expertise, prior experiences, and ability to guide, but not lead, a conversation (Patton, 1990). Therefore, the validity of an interview guide cannot be fully determined prior to the interviews but must be measured through the quality of the outcome after a trained interviewer has followed several rigorous techniques to establish rapport with participants and has collected and analyzed the data. However, this technique could be interviewer dependent and interview guides developed by this technique could yield different questions or wording depending on different trained interview training.

The Delphi Method, which was developed as a means by which policy or procedures could be evaluated, modified, and/or validated in a more objective manner, can be used to develop qualitative interview guides in a way that incorporates expert feedback, including potential participants. By using an iterative procedure by which a panel of 6-7 qualitative experts anonymously evaluates an interview guide, the Delphi Method assumes that the end product will be the result of a systematic process that yields a strong, valid, and reproducible instrument. This

process has been used widely in a variety of clinical and psychological research studies (Burnman, 2005; Timble, Damberg, Scheider & Bell, 2012; Ryan, et al., 2014).

The current study deviates from the Delphi Method in that it employed three Veterans in addition to three qualitative experts in reviewing and assessing the interview guide development. While the Veteran experts on the panel were not experts in qualitative methodology or in behavioral science fields, they none the less had other expertise to lend to the development of a valid interview guide. The authors believe that by using the modified Delphi Method described in this article, the final interview guide contains a better structure than the initial draft, captures the pertinent information needed to complete the future study, is broadly and directly worded, and fits the demographic for which the guide is intended.

This modified Delphi approach which incorporated members of a demographic (e.g., Veterans) for which the interview guide was intended in addition to behavioral and mental health experts yielded consensus in only three rounds. The use of Veteran experts helped inform an interview guide that was not too clinical or academic in wording. All participants, including the Veteran experts, were apprised of the TpB methodology and study objectives for which this interview guide was developed prior to review of the initial draft. Both the Veteran experts and Qualitative experts agreed that the initial and subsequent drafts of the interview guide adhered to TpB principles. Both the Veteran expert and qualitative expert responses to the initial and subsequent drafts of the interview guide were congruent in terms of flow, order of questions, and overall tone. Both sets of experts independently suggested that the order of the interview guide be phrased with open-ended questions about suicide first followed by specific questions regarding firearms. Thus, the use of non-mental health or non-social science experts (e.g., Veteran experts) did not hinder or alter the Delphi process.

The use of Veterans enhanced the final interview guide in that it involved information regarding wording from a Veteran or soldier point of view. While one Veteran reviewer found the question about practicing loading a weapon problematic and potentially patronizing in the initial interview guide, it no longer became an issue when the order of that particular question was placed after the general questions regarding suicide and suicide intent in the second draft. Presumably, the context of the question (even though the wording remained the same) had changed from that of practicing using a weapon to rehearsal of suicide method. Another Veteran expert comment following the first Delphi round informed the authors and other reviewers of the need to inquire about the participant's military experience as well as the general acceptability of firearms for various purposes within this demographic in general. Thus, inclusion of Veteran experts in the Delphi process was a benefit in developing this interview instrument.

Strengths and Limitations of Using a Modified Delphi Method

The main strength of using a modified Delphi method to develop the interview guide described in this article was that it allows researchers to anonymously solicit feedback from a diverse group of content experts. Using anonymity provides objectivity to the outcomes of the process based upon the panelists' ability to provide and react to uninhibited feedback they might not provide if in a group setting (Keeney, Hasson, & McKenna, 2001; Lindeman, 1981). The anonymity of the Delphi process allowed the non-research Veteran experts to freely give their

opinions regarding the wording and order of the interview guide without feeling intimidated by the more academic participants (e.g., the qualitative experts). The use of non-clinical personnel in this modified Delphi procedure helped develop a research instrument that delved into contexts of suicide by firearm and that would be suited for our patient population. The wording of the final interview guide contains language that can easily be understood by the general population of our state (in which less than 20% hold a college degree and more than 50% reside in a rural community; State and County Quick-facts, 2014) and avoids clinical or research language that would inhibit a Veteran from freely speaking from his/her point of view. A final strength is that this process utilized a systematic approach to the development of a robust instrument that proved to be adequate when field tested on two Veterans naïve to the process and study objectives.

The main limitation of using the modified Delphi method to develop and test the interview guide was the time required to gather feedback from and gain consensus among the panelists. This process took a total of three months from initial review to consensus of the final interview guide. This length of time, while seemingly short given that consensus is trying to be attained among six disparate individuals with busy work schedules in addition to their being part of the Delphi panel, is none the less a significant amount of time when framed in the context of preparation for research, internal review board submissions, and yearly continuing review within an academic or government setting. However, while more traditional methods of developing qualitative interview guides are less time consuming, this approach has its merits in that it uses a collective, systematic approach rather than an individual approach for validation of procedural methods and may lead to a quicker acceptance of the interview instrument by a Research Committee or Internal Review Board Committee in the long run.

A second limitation involves the difference in interviews informed by a review Delphi panel versus traditional approaches involving a qualified researcher in the mental health or behavioral sciences. In qualitative research, semi-structured interview guides include open-ended questions and follow a script covering a list of connected topics. Qualitative expert(s) and/or interviewer(s), who become the instruments of data collection, are tasked with developing the interview guide, which often involves drawing on existing literature or informal data collection techniques (e.g., informal, unstructured interviews with participants) to formulate initial questions and probes. The initial guide is tested among a small sample of participants (e.g., n=2 to 3) and revisions are made based on the participants' recommendations and the interviewers' experiences (Bernard, 2002). Furthermore, semi-structured interview guides are intended to be flexible and while the interviewer follows a series of related questions, the conversation often strays from the topic, thus probes (they may or may not be on the interview guide) are often asked. Additionally, in studies using inductive and grounded theory techniques, interviewers seek to research theoretical saturation, which means that no new themes or relationships among them emerge from the textual data (Strauss & Corbin, 1990). Thus, when new themes emerge from the participants' narratives, interviewers conduct subsequent interviews to saturate the data, which can involve asking related but new questions (questions that were not on the original guide). The interview guides developed in this manner are flexible and adaptable to the interview process and data collection strategy.

Because qualitative interviewers become the instrument of data collection, we believe that an experienced qualitative interviewer who has expertise in the content area, and can

synthesize the information, as well as ask open-ended appropriate questions and probes, can develop semi-structured interview guides with the same level of efficacy and accuracy as using a Delphi panel. A limitation is that an interview guide using the Delphi method in the construction of semi-structured interview guides is that the guide might become too rigid and not have the flexibility needed for the participant to lead the interview. That said if a qualitative expert serves on the expert panel during the Delphi process then it is likely that the expert will emphasize the need for open-ended questions and probes to allow for the needed flexibility. Thus, the decision to use one technique over the other for developing or validating a semi-structured interview guide rests on the individual researcher, the nature of the research study, and the context of the organization within which the research or interview will be conducted.

Conclusion

In an effort to strengthen the methods of a qualitative study that will be conducted by the Department of Veterans Affairs Department of Health Services Research concerning the context and characteristics of Veteran suicide by firearm, we used a modified version of the Delphi method to develop and test a proposed interview guide. This modified Delphi panel consisted of a 50/50 composition of qualitative researcher experts and Veteran experts. The Delphi method is a useful technique to obtain consensus among expert panelists and has yielded important insights in the interpretation of findings for policy research in health research (Bloor, Sampson, Backer, & Dahlgren, 2013). However, we also recognize that on inter-disciplinary studies, qualitative experts may not possess both content and methodological expertise. This is what we found in our study: the qualitative experts were not as nuanced as the Veteran experts on the context by which firearms might have been used in a Veteran's past or present history, not including the suicide attempt/ideation involving the use of firearms. We also understood that while the Veteran experts had the expertise in informing a guide from a particular demographic point of view, they might not have the methodological or theoretical expertise that the qualitative experts would have. Thus, we found if useful to supply information regarding the aims of the research and the theory informing the research to the individual members of the modified Delphi team when presenting them with an initial interview guide. We found that the Veteran experts were as competent in addressing the tone, order, flow, and theory behind the interview guide as the qualitative experts. We also found that the Veteran experts were invaluable in informing nuances in wording of the interview guide from a Veteran point of view.

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Appendix A: Initial Interview Guide

Contexts and Characteristics of Non-Fatal Suicide Attempts Involving Firearms

**Note to interviewer: Main questions are numbered, and possible probing questions are indented underneath.*

Attitudes Related to the Behavior

1) Tell me about your history with firearms.
   Did you grow up with firearms in the house?
   When did you acquire your firearms?
   What firearm safety measures do you use? (gun locks, gun safes, gun safety courses)
   Did you have firearms in your home prior to the attempt/ideation?
      Do you currently keep firearms in your home?
         If yes: What firearms are currently in your home?
2) What factors led to choosing a firearm?
3) What made you choose the particular firearm that you used/considered using in your suicide attempt/ideation?
4) Had you considered other methods to take your life?
         If yes: What other methods did you consider?
5) Tell me a bit about what you thought would happen after your suicide attempt?
6) Do you remember having any concerns that caused hesitation in the attempt/ideation? (family, religion, responsibilities).

Subjective Norm

7) How do those close to you feel about suicide?
      How does your family feel about suicide?
      What about your friends?
   Did the feelings these people have about suicide and suicide by firearms impact your decisions?
      If so, tell me about that
8) Has anyone close to you ended or attempted to end their life by suicide?
   If yes, was it using a firearm?
   If yes, was this a family member?
      If no, what was your relationship with this person?

Perceived Behavioral Control

9) Prior to your suicide attempt/ideation, did you try other behaviors to avoid hurting yourself?
   If yes: What did you do?
10) Did you believe that you could stop from hurting yourself if you wanted to?
11) Did you believe that the use of your firearm would lead to your death?
12) How confident were you that you would be able to complete the attempt?
13) How did you know what to do? Did you practice loading and unloading the firearm?
14) What is your opinion of gun locks and off-site storage?

15) Was your suicide attempt or ideation an impulse or had you been developing a plan?
16) Was there a specific event that triggered suicidal thoughts or a combination of life events?

Conclusion

I appreciate the time that you have taken to answer these questions about what must have been a very difficult time in your life.

Is there anything else that you would like for us to know?

Appendix B: Final Interview Guide

Contexts and Characteristics of Non-Fatal Suicide Attempts Involving Firearms

**Note to interviewer: Main questions are numbered, and possible probing questions are indented underneath.*

Suicide: Some Veterans - consider taking their lives and some commit suicide. I'd like to talk to you about your thoughts on suicide.

1) Can you tell me about your thoughts on suicide? *Possible probes:*
   - How often would you say you've thought about suicide?
   - What about attempted suicide?
   - What were the methods you had considered, and what helped you get through those times?
   - How do those close to you (e.g. family and/or friends) feel about suicide?
   - Has anyone close to you EVER died by or attempted suicide?
2) What happened when you attempted suicide? *Possible probes:*
   - Was your attempt or ideation an impulse or had you been developing a plan?
   - What do you recall were your initial thoughts and what did you do in response to this/these event(s)?
   - Did you try anything to avoid hurting yourself? If yes, what did you try?
   - How did you know what to do and did you practice loading and unloading the firearm?
   - How confident were you that the use of a firearm would lead to your death?
   - Did you consider methods other than a firearm during this attempt?
   - Where you drinking or using any drugs at the time?
3) Do you remember having any concerns that caused hesitation or made you think twice about attempting or committing suicide? (e.g., family, religion, responsibilities).
   - Tell me about what you thought would happen after your attempt/ideation? What did happen?

Firearms: I'd like to talk about the ways that people go about committing suicide, and specifically about using firearms.

4) What factors or considerations did you think about that led to your choosing a firearm for your suicide attempt/ideation?
   Follow –up question: How did you choose the particular firearm that you used/considered using in your suicide attempt/ideation?
5) How have firearms played a role in your life? *Possible probes:*
   - Were there firearms in the house when you were growing up?
   If yes: What type, how many, and what was their main purpose/use (*recreation, hunting, home protection, collecting*)?
   - When did you own your first firearm?
6) Did you have firearms in your home prior to the attempt/ideation?
7) Do you currently keep firearms in your home? *If yes:*

- What are these mainly used for (*e.g., security, hunting, collecting, recreation, or etc.…*)?
- What firearm safety measures do you currently use? (*e.g., gun locks, gun safes, gun safety or hunters education courses*)
  If no to locks or safe: What measures do you use? (e.g., *Are they out of reach for children, bullets separate from guns, locked ammo, loaded firearms or generally are they uncontrolled and accessible?*)
- How do your family and friends feel about you having firearms (*if individual does have firearms*)?
- How often (*do you currently or did you previously)* handle your firearm(s).
  Follow-up question: Has that changed?

Conclusion

I appreciate the time that you have taken to answer these questions about what must have been a very difficult time in your life.

Is there anything else that you would like for us to know about the use of firearms or about your suicide attempt/ideation?

The Influence of Social Support in Caregivers of Veterans with Dementia

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Abstract

This study examined social support and its relationship to quality of life among caregivers of community-dwelling dementia patients who are Veterans of the U.S. military. The author examined the relationships of caregiver burden, social support, and quality of life in caregivers with and without respite services in a community-based dementia caregiver program (N=98). An assumption that having the support of respite services would alleviate at least some caregiver burden was not upheld; those with respite services did not perceive greater support and enhanced quality of life. Surprisingly, we found that those with formal interventions from a social service agency equally perceived adequate support despite the presence or absence of respite care. Respite services were seen as "helpful" only.

Keywords: social support, caregivers, dementia, Alzheimer's, quality of life

Caregivers of persons with dementia frequently believe that they "have things under control" and should not call upon other people for help. The post-World War II generation has particular concerns about being a burden to other people and wanting to handle life events and life crises without having to call upon others (Bradley, Whiting, Hendricks, & Wheat, 2010; Nuttman-Schwartz, 2007). Within the project described here, the evaluators and clinical staff often heard such comments as "I'm too tired and worn out to participate in any help such as support groups" or "I have health issues of my own and I'm just hanging on with taking care of my husband." The knowledge gained from this study, however, appears to have implications for clinicians and health personnel working with Veterans' caregivers and points to ways in which health services and social services workers can be of greater help in alleviating at least some of the burden of caregiving, enhancing social support, and generally guiding Veterans' families toward a greater quality of life.

NOTE: This project was supported in part by grant number # XQ098, from the U.S. Administration on Aging, U.S. Department of Health and Human Services. Grantees undertaking projects under government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official Administration on Aging policy.

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The purpose of this quantitative study was the examination of any relationships among social support, quality of life, and caregiver burden in a population known to have difficult social and emotional adjustment: those caring for spouses or partners with dementia. We focused here primarily upon dementias of the Alzheimer's type or Alzheimer's disease and related dementias (ADRD), as the diagnosis is known in the *Diagnostic and Statistical Manual of Mental Disorders-IV-TR* (2000). Caregiver burden is a key measure in research about dementia caregivers, and is often used as a baseline measure in intervention studies.

In one study specifically focused upon Veterans with dementia, their caregivers were found to endure "caregiver burden" due to several prominent factors: the degree of cognitive impairment of the Veteran with dementia, behavior problems, personal care dependency, and the number of conditions needing attention (Bass et al., 2012). The most common problems that produced "burden" in these caregivers were social isolation and depression. Thus, the chronic and unremittent nature of the Veteran's dementia care seem to suggest that one solution would be respite care for the caregiver, to allow her (in the Bass study, all caregivers were also female) to get out occasionally and to alleviate the isolation and possibly improve the depressed mood. Even telephone support programs for Veteran-family caregivers are known to lessen anxiety about isolation and to offer a greater perception of social support (Bormann et al., 2009), and behavioral interventions have been shown to reduce caregiver stress and the sense of having to go it alone (Nichols, Martindale-Adams, Burns, Graney, & Zuber, 2011). Such caregivers are also known to abdicate their own self-care in the process of making sure all needs are met for their loved ones (Thorpe et al., 2006), so it seems likely that any process that alleviates some of that burden of care will be useful and welcomed by caregivers. The high financial cost of caregiving is also known, although less costly in comparison with formalized nursing home care; an analysis of the National Longitudinal Caregiver Study estimated caregiving costs of $18,385 annually per patient in 1998, undoubtedly more fifteen years later.

Prior research has found many social and relational factors associated with caregiver burden, such as the relationship quality among family members of the caregiver, the patient's cognitive ability, behavioral symptoms exhibited by the dementia patient, and demographics such as caregiver gender (Papastaurou & Kalokerinova, 2007). Research on Veterans and family treatment considerations specifically found that the frailty of Veterans was especially problematic to witness by family members (Sherman, Fischer, Sorroco, & McFarlane, 2011), and that patient-centered care is worthwhile as a treatment methodology in that Veterans' personal and professional experiences vary and each situation needs to be examined uniquely and treatment planned accordingly (Rose et al., 2007). It is well known that dementia caregivers have a high level of burden compared with caregivers of patients with other disabilities or diagnoses (Gonzalez-Salvador, Arango, Lyketos, & Barba, 1999; Ory, Hoffman, & Yee, 1999). Authors of a prominent book on caregiving described the caregiver role as a *36-Hour Day* (Mace & Rabins, 1999). If only to enhance the daily experience of the Veteran, or any individual with dementia, caregiver burden has been cited as needing improvement (Brodaty, Whiting, Hendricks, & Weat, 1993; Mittelman, Ferris, & Schulman, 1996). However, the author asserts that a caregiver in such circumstances warrants examination of (and alleviation of) the depth of burden in his or her own right, in keeping with social work and other professional counseling ethics to preserve individual dignity and choice, to do no harm, and to alleviate human suffering whenever possible.

According to the Alzheimer's Association *Facts and Figures* (2010), there are an estimated 5.3 million individuals living with Alzheimer's disease in the U.S. and more than 10.9 million unpaid family, friends, and neighbors who provide care to those individuals. The *2009 Florida State Profile* estimates that more than 500,000 Floridians suffer from Alzheimer's disease (Department of Elder Affairs, 2009). With more than 3.3 million Floridians 65 or older, the number of people who will develop Alzheimer's disease or related disorders (ADRD) and the number of families directly impacted with providing care within that state alone will reach an estimated 640,000 by 2025. Thus, Florida reflects the anticipated aging of the U.S. in many ways. There are estimated to be 300,000 Veterans with dementia, with dementia in that population predicted to peak within 2018-2020 (Kunik, 2010; Office of the Assistant Deputy Under-Secretary for Health, 2004).

Within the Veterans Administration, there are educational and research centers founded specifically to address the knowledge about and needs of aging veterans; these are known as "GRECC's", the Geriatric Research Education and Clinical Centers (USDVA, 2014. Each GRECC offers a research component, an education component, and a clinical component blending current knowledge about Veterans' geriatric needs with ways to address those needs. The GRECC's conduct basic laboratory research on the origins of aging and the conditions commonly associated with geriatrics, and their researchers study the utility and effectiveness of the care delivery as well. Veterans and their families can find many resources on the GRECC website and because there are nineteen across the country, there is likely to be a GRECC within a reasonable distance. GRECC researchers have currently noted that there are 1.7 million Veterans of World War II still living today; approximately 39,000 of those have received the benefit known as Aid in Attendance, largely associated with caregiving in the home. Although this benefit could be of great assistance to caregivers dealing with dementia, relatively few of the eligible Veteran families know of the benefit, according to a *New York Times* article on the subject (Seliger, 2012).

Two organizations in Sarasota County have taken the lead in assisting caregivers of people with ADRD, currently intervening in more than 1,500 families of people with ADRD, and they participated in this federally-funded study. One of the agencies annually serves more than 70 people with ADRD and 80 caregivers of people with ADRD through individual counseling, family counseling, caregiver support groups, wraparound case management services, and respite care. Additionally, approximately 300 caregivers per year receive telephone counseling and support through these service agencies. Another 1,000 people attend educational workshops for caregivers each year, although only approximately 300 of those workshop participants are caring for people with ADRD.

Sarasota County, one of the "oldest" counties in the U.S., with areas of population consisting of 35% over the age of 65, is served by one of 15 Florida designated memory disorder clinics which sees approximately 350 patients per year. This clinic directly serves more than 400 caregivers by providing information and referral to community resources; this clinic was a major referral source for study participants. Professional staff currently are certified by the State of Florida to provide Alzheimer's training to professional and non-professional caregivers and in the last fiscal year provided training to more than 2,500 people on issues related to care and

aging. These two entities, therefore, partnered to provide the New York University Caregiver Intervention (NYUCI; Mittelman, Roth, Haley, & Zarit, 2004) model and to enroll caregivers into the study. Because many caregivers also receive formal agency help or other relative assistance, they did not meet the study inclusion criteria, and thus, approximately 200 families eventually ended up in the study. Of the 200 families, 98 included caregivers of Veterans. Only spouses or adult caregivers were admitted to this study.

Research has suggested that interventions often offer only moderate relief to caregivers (Brodaty et al., 2003), and some have called for greater assessment of caregiver burden simply for the sake of caregiver relief (Schultz et al., 2002). Existing literature also lacks attention to variability among caregivers studied, and attention to variability among caregivers as a factor in caregiver burden (Carretero et al., 2007; Mittleman et al., 2004). Many studies have, in fact, focused upon the impact of the cognitive deficits in the care recipient, help with everyday functioning and level of care needs, and behavioral and psychological factors more generally (although without considering individual factors in the caregiver). However, relationships outside the marital or partner dyad have typically been neglected as objects of study (Pearlin et al., 1990). This study sought to add knowledge about the role of social support from family members and others, as well as the influence of respite services that might alleviate some of the burden of caregiving.

The caregiver intervention study was funded by the U.S. Administration on Aging (now the Administration for Community Living) over a three-year period in which a demonstration project could take place in order to evaluate the effects of a specified intervention protocol that assessed social support as well as caregiver burden, caregiver depression, quality of life as perceived by the caregiver, and physical well-being of the caregiver during the study period. Although the study of Veterans' traits and characteristics was not the main focus of the overall study, the evaluators realized that a significant subset of the 213 dementia patients under study in the larger project did happen to be Veterans; this ability to study the Veterans' situation in caregiving appeared to be a fortuitous opportunity. Thus, the author has extracted project participants' Veteran-related data from the overall project database. Depression and caregiver physical health are not the subject of this particular article, as depression scores have not yet been evaluated over time and because physical health of the caregivers appears to have no great variability in the sample. Rather, we have focused upon social support, caregiver burden, and their relationship to quality of life.

Thus, this study endeavored to note relationships among several variables that include attention to the individual caregiver's aspects of support as well as the social and emotional variables of perceived social support and quality of life. A note: in homage to the idea that the number of social contacts does not equal a quality of social interaction, we acknowledge the difficulty of using only a quantitative numeric to describe social support in terms of contact with relatives. The author is more interested in the quality of the contact as perceived by the caregiver, as well as the relief of caregiver burden or stress resulting from contact and perceived social support from relatives, especially in relation to their geographic locations. Unfortunately, the numeric reporting of social support contacts is the longstanding measure of perceived social support (see greater discussion in the limitations section).

Methods

The Alzheimer's disease caregiver study was designed to use the New York University Caregiver Intervention (NYUCI) counseling and support intervention to assess the well-being of caregivers. NYUCI elements consisted of an initial assessment of the family system and problems, a first individual session followed by four family sessions for counseling and problem-solving, as well as teaching dementia caregiving suggestions and answering family questions, ad hoc contacts to the agency for the following 18-month period if the caregiver wished for individual or group counseling, and follow-up assessments at quarterly intervals during the two-year enrollment period (Mittleman et al., 2004).

A pre- and post-survey design was used; the instruments were administered by licensed social work clinicians who assumed case management of the family's needs upon enrollment of each participant. As a demonstration project, the research method incorporates ongoing services targeting resolution of perceived needs followed by measurement of the behavioral and psychological outcomes of those services. The overall measures are designed to assess caregiver physical health, evaluate caregiver depressive symptoms, and to note caregiver social support and caregiver appraisal of patient memory and behavior. Veterans with Alzheimer's disease were specifically recruited from a Veterans' community service program in order to fully assess this demographic.

The university researcher, a specialist in gerontological social work, maintained close contact with all study partners to implement each facet of the research. The researcher achieved approval by the institutional review board and conducted a comprehensive evaluation of all phases of the program. At the conclusion of the 36-month project, the researchers now have an easily replicated program of interventions for people/families affected by ADRD.

Participants and the Sample Frame

The participants were 58% female in the overall project's caregiving sample, concomitant with the general population of U.S. caregivers. However, among the subset of Veterans' caregivers reported here, 100% of the caregivers were women, largely due to the era in which the sample Veterans entered military service (generally World War II). Although that population obviously contains female Veterans, the individuals in our sample happened to be men. Thus, this subset of caregivers was all female.

The caregiver ages ranged from 58 years to 101 years, with more than one care recipient over the age of 100. All but three of the caregivers are partners or spouses of the care recipient (98%); three (2%) are adult relative (daughter) caregivers. The initial study's inclusion criteria called for only spouse or partner caregivers, and two years into the study the lead funding agency allowed adult child caregivers to participate; an amendment was requested and granted by the Institutional Review Board. None of the caregivers are formal or paid help; this was also specified in the original study protocol and this requirement has been adhered to throughout the study.

Quantitative inquiry was chosen to determine the effects of this project's interventions due to the availability of good established measurements for the outcomes of interest: social support, caregiver burden, and quality of life. The Stokes Social Support Scale was used to determine the extent of social support perceived by the Veterans' caregivers; the Zarit Caregiver Burden Scale assessed such issues as understanding the dementia patient's motives and the caregivers' anxieties about abilities in caregiving; and the quality of life scale was derived from a measure developed by gerontologist Sarah Qualls in age-related aspects of life satisfaction perceptions (Qualls & Anderson, 2009). Similar studies of caregiver burden and quality of life have also used quantitative measures (Pearlin, Mullan, Semple, & Skaff, 1995; Sherman, Sorocco, Fischer, & McFarlane, 2011; Thorpe et al., 2006).

Once an interview was arranged and the participant enrolled in the program, a licensed clinical social worker (LCSW) made an assessment visit and began the protocol of visits, both in-person and by telephone or electronic message if more feasible for the participant. Especially with distant relatives, the alternative methods were often utilized. At the first in-person visit, regardless, the participant signed an informed consent form outlining the nature of the research and the duration and content of the study. The scales and other instruments of measure were described, explained if needed, and made available to the participant for leisurely review. The caregivers (deemed the "participants" in this study) completed a psychosocial assessment and demographic information pertaining to age, gender, relationship status, and the like was gathered within that instrument as well. Detailed information about social support and social relationships was a major part of the data collection.

Sample

The sample (N=98) was drawn from the Sarasota County, FL, elder population, which approaches 35% of the total population in some areas of the county, (in contrast to approximately 18% of the total U.S. population presently). The majority of program participants were White (94%), 2% were African-American, and 4% were Hispanic or Latino. Although socio-demographic characteristics were obviously skewed toward White participants, other demographic characteristics such as urban/rural residence, number of family members, social support resources, and quality of life perceptions were essentially similar.

As a community-based, cross-sectional study of older adults in caregiving situations, eligible individuals were drawn from two large referral sources: the Jewish Family and Children's Services program and a Sarasota hospital system and memory disorder clinic. Eligible individuals between 50 and 101 became the sample frame. Among the 250+ individuals contacted to offer the no-cost demonstration project's services, 213 eventually accepted the offer to participate in the interviews, assessment, counseling sessions, groups, and instruments of measure. The present analysis used cognitively intact caregiving participants. The size of the resulting sample completing the social support, caregiver burden, and quality of life scales in their entirety was 98 (the results reported here pertain to the 98 female caregivers).

Participant Assessments and Instruments

The Social Support Scale, Geriatric Depression Scale, Caregiver Burden Inventory, and a quality of life measure were administered at baseline (initial visit) and for subsequent months thereafter at a six-month interval for a pre-and post-measure design. If participants preferred, instruments were mailed to them at the home address rather than brought physically to the home. Response rate was 62%, considered a high rate of return by Dillman's (1978) standards and other estimations.

Social support. The Social Support Scale tallies the number and type of social relationships perceived by the caregiver to be offering support, defined as being available for consult or companionship, making the caregiver feel less isolated, and helping the caregiver realize that he or she is not alone in caregiving. The measures included six items assessing the number of relatives or friends considered to be a part of the support system, frequency of contact, and the degree of emotional closeness experienced, as well as geographic distance or nearness. Reliability was satisfactory (α=.77).

Although caregivers in this study did consider themselves to be essentially self-sufficient and capable in their caregiving duties, 68% of respondents report that they do not live close to family members. Anecdotally throughout the patient records kept for this study, caregivers all noted that mobility and transportation are problematic issues as they age. In fact, 85% have considered their options in regard to continuing to maintain independence and their ability to be effective caregivers if unable to drive.

Caregiver burden. The Caregiver Burden Scale is a 21-item measure of perceived stress within the caregiving role, with such items as "I don't have enough time for myself" and "I fear what will happen to my relative in the future." The scale is essentially a rating of the degree of stress or burden encountered by the caregiver in his or her role with the person with dementia. Participants all scored in lesser ranges at the completion of the post-test. The caregiver burden scale showed significant difference from pre-to post-test, with a mean overall decrease in caregiver burden score of 14.9 points, with both men and women reporting significantly fewer indicators of caregiver burden (12.1 in men and 13.9 in women of a possible total score of 45).

Quality of life. A five-item measure of the participants' perception of change in the quality of their overall life experience reveals low to high satisfaction with life events and life processes. Respondents were asked to report whether they agreed with such statements as "Things seem better than they were a few months ago" or "These are the best years of my life." All items were positively worded; that is, no reverse-scoring was necessary on the 3-point Likert-type scale ranging from 0 (strong disagreement) to 2 (strong agreement). Reliability was shown to be high in the present sample (α=.77).

Other variables. Demographic information included age (in years), gender (0=male, 1=female), marital status (0=not married, 1-married or partnered), educational attainment (actual years of education), and financial income status (numerical range). Although not a measurable instrument, the presence of respite services was also noted and entered into the stepwise

regression analysis. Respite services were offered to all participants in the study, although all of the participants did not accept the service.

Results

Data were analyzed with SPSS Version 12 (SPSS, 2008). Descriptive analyses, including frequencies, mean values, chi-square, and analysis of variance (ANOVA) were conducted on the demographic and pre-test items. ANOVA was used to test for statistically significant differences by gender. Paired-sample *t*-tests were used to compare pre- and post-test results on respite use, social support measures, caregiver burden, and caregiver's perception of the quality of life.

For continuity of data analysis and to attend to all possible configurations of the relatives' geographic status, initially the sample was divided into three potential groups: (a) caregivers with no relatives to provide social support, (b) caregivers with both social support and respite services, and (c) caregivers with social support but no respite. Because no respondent fell into the first category (N=0), only the last two groups were used in the analyses (caregivers with relatives and either respite or no respite services). Independent samples *t*-tests and chi-square analyses were conducted to assess differences between these groups. Correlation coefficients among study variables in the last two groups were compared using Fisher's *r-to-z* transformation, which allows a statistical determination of the difference between independent correlation coefficients (Steiger, 1980). In multivariate analyses, a hierarchical regression model of quality of life scores was estimated in each group. After controlling for demographic variables, the relative contact frequencies, social support, and quality of life measures were entered in the model of individuals receiving respite. Secondly, social support and quality of life measures were added for both groups to assess the independent effects of respite service use on quality of life.

Associations among study variables. Descriptive characteristics of the sample and study variables include an examination of Groups 2 and 3 (recall that we excluded Group 1); the two groups consisted of 98 older adults with exactly similar gender distributions (100% female). On average, participants were 74.2 years of age (SD=6.14) and more than 94% were married. The average years of education were 14.2, and the large majority was White (98.5%). The author notes that this sample was biased with regard to a slightly higher educational level than the general national population and it included few non-White participants; however, that is reflective of the region's ethnic disposition, which is 92% White. In the group of caregivers with respite services, women (obviously, due to the gender percentage) and those with more years of education had higher levels of perceived quality of life. Individuals with relatives but no respite services had a stronger association between social support and quality of life (r=.34, p<.001) than did caregivers with both social support and respite care (r=.11, p=.02). It appears that caregivers who have only social support without respite may seek (or may somehow receive) more contact and more frequent activities even in the local area than those who have both social support available as well as the respite care. Both groups showed a significant effect for social support and quality of life, suggesting that with or without respite, social support still has a significant impact upon quality of life.

Regression model of perceived quality of life. The results of the hierarchical regression model suggest that social support and social activity relate to life satisfaction in the presence of certain demographic variables. In the regression model for individuals with social support only, demographic variables explained 9% of the variance in perceived quality of life, with female gender and higher levels of education being the most important predictors of high satisfaction with quality of life. The inclusion of marital status, having respite services, and caregiver burden made no additional contribution to the model. In the regression model for individuals without respite services, demographic variables explained 8% of the variance of quality of life. A higher level of education was also found to be an important predictor in this analysis. In the third model, social contacts and gender were found to explain 9% of the variance, resulting in a total explained variance of 26%.

Discussion

Quality of life is an important variable in caregiving individuals, especially with dementia patient care. If a person has a basis of an adequate or better quality of life, one can imagine that the burden of caring for an impaired but loved family member may be ameliorated by social support during difficult times. For this study, the author questioned whether the addition of respite care to those receiving community services would make a difference; that is, was the quality of life different if the caregiver's source of social support was "added to" by respite services? In the subset of caregivers with respite care, the caregivers' gender and educational level were associated with a higher quality of life, but not the presence of respite. Of note, marital status and self-rated health seemed to have no particular association with quality of life; whether or not one is married, a committed relationship may engender a similar degree of caregiver burden and impaired quality of life as one observes a family member's decline and distress. In fact, a secondary examination of those with distant or geographically close relatives disclosed that higher education was the factor seeming to enhance perceived quality of life, rather than distance from the family member.

Thus, if higher educational levels appear to influence one's perception of the quality of life or self-rated satisfaction with one's life overall, one may surmise that better educated caregivers are better able to research diagnostic and treatment indicators, connect either virtually or in social circles with other caregivers, know how to access web-based or other evidence-based medical and social care information, and perhaps better interpret, understand, and be able to implement health instructions or the teachings of health professionals encountered in the health caregiving milieu. Those better educated may also partake of health support groups and have the means to access and have transport to those services. An interesting finding is the evidence of the importance of educational level in caregiving, despite the social support being received locally or from more geographically distant relatives. The Veterans' services network may wish to evaluate outreach and programs in these areas, but this information seems important as well for community groups who frequently target Veterans for additional community services, as many organizations do. These findings emphasize the importance of screening the caregiver's social support status when medical and other clinical assessments are made. Accounts of less available social support should cue practitioners that a means of increasing social support or other alleviations of isolation may ameliorate the risks that isolation and consequent depression can bring. It would follow that alleviation of a sense of isolation and caregiver burden could

potentially decrease visits to doctors, hospitals, or emergency rooms, or could have an impact upon decisions about nursing home or assisted living placements. Thus, the costs of health care could indirectly be affected by greater social support and/or lessened caregiver burden. At least anxieties about the caregiver's ability to provide adequate supervision and services for the dementia patient might be alleviated.

A limitation of this study is the inability to assess the quality of social contacts and social activity, but rather the findings from scales measuring numbers of social contacts and social support persons in the caregiver's life. An additional limitation and subject of future study would be the relative influence of respite or non-respite service provision in the presence of varying degrees of quality of that support; that is, is a high number of supporting relatives (or friends) as important as the support of a few high quality interactions with fewer friends and relatives? Although we were able to evaluate a subsample of the study participants who did not engage in respite services, we did not ascertain the reason for declining the services. This seems an important factor to consider in future research. Additional study could focus upon ways that families and communities, as well as Veterans' organizations and governmental agencies, make social support feasible and accessible, given that social support may outweigh the impact of respite services per se. From our findings here about the influences of higher education and social support (but lesser importance of the respite situation), we might suggest that groups can address helps such as transportation to social functions, education in web-based communications, and health professionals' encouragement toward social interactions with relatives and others. Many communities offer fine examples of social support to caregivers in their homes as well as programs that can help when they have inadequate support or attention from their own family systems.

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Culturally Competent Therapy with Military Veterans: Identifying and Overcoming Issues Facing Providers

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Abstract

This article attempts to provide a framework which counselors can utilize as they attempt to navigate the inherently complex military cultural amalgam presented by Veterans in therapy. The author provides, as well as advocates, for counselors to acquire a general scope of military knowledge and insight, prior to engaging in therapy with service members. Implications for counseling practice in enriching this knowledge base through the development and use of clinician 'self-reflexivity' and resultant exploration of service-member subjectivity is discussed. Finally, the potential beneficence of counselor 'self-reflexivity' on assessment, diagnosis, and counselor education are explored.

KEYWORDS: military culture, Veterans, self-reflexivity

Introduction

Rationale

Since the beginning of the Global War on Terrorism, military mental health concerns have steadily risen (Jacobson, 2011). According to the Millennium Cohort Study (MCS), for example, approximately one in six military Veterans engage in binge drinking behaviors, often struggling with concurrent trauma-related issues (Jacobson, 2011). Perhaps surprisingly, the MCS also found that rises in acute anxiety, suicide, and substance use disorders (SUDs) appear to afflict service men and women regardless of having been deployed (Jacobson, 2011; Maurer & Watson, 2010; Walker, 2012). While mental health issues continue to grow (Smith, Ryan, Wingard, Slymen, Sallis, & Kritz-Silverstein, 2007), an increasing body of research now appears to show that some of the interventions currently used by the U.S. Veterans' Affairs Healthcare System (USVAHS) may not be adequately addressing these issues, which may result in high rates of recidivism (Gilmartin & Southwick, 2004; Jacobson, 2011; Leard-Mann et al., 2013; Smith et al., 2008).

According to Barlas (2007), there is also a significant shortage of mental health professionals working with military populations, suggesting it may be efficacious to begin

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identifying and addressing potential barriers faced by clinicians. Counselors often report interest in working with service-members, though become apprehensive due to the complexities inherent in work with this population (Bray, 2014). Bray also suggests that some clinicians without a military service background report feeling "unprepared" to empathize or "understand" Veterans' issues and that some prior military-service counselors promote this idea by suggesting that civilians require a near-emic perspective in order to be effective. One issue of particular contention, according to Bray, is that mental health providers must maintain a high degree of military cultural competency, prior to engaging in therapy with Veterans, in order to facilitate change. This paper is an attempt not only to clarify issues facing mental health providers in working with culturally diverse service members, but also, to provide knowledge and insight to empower clinicians from all backgrounds to pursue providing services to a growing and underserved Veteran-population.

Philosophical and Experiential Disclosure

In congruence with this paper's mission of identifying and overcoming potential cultural barriers in providing clinical mental health services to Veterans through explicit transparency and self-awareness, it is my intention to be explicit about my positionality relative to this paper's content. My position in relation to Veterans mental health is as an eight-year Veteran of the United States Marine Corps, as well as a mental health counselor serving military-clientele. I maintain an 'emic-perspective' relative only to my unique experiences serving in the Marine Corps, as perceived through the unique lens of my past familiarities. My insight into cultural issues related to other service branches, more broadly, is grounded in published empiricism as well as my own subjective experiences serving in the military alongside members of different branches. My cultural insights also derive from experiences as a counselor serving Veterans, and as such, I attempt not only to disclose my own assumptions, but also, to provide empirical evidence in support of my suppositions. This disclosure is intended to model the type of clinical and experiential awareness this paper advocates in favor of – a key component I promote throughout this paper in navigating many potential cultural issues in counseling practice with military populations.

Throughout this article, particularly in the latter sections referring to potential solutions, I refer to personal philosophical assumptions regarding the nature of human behavior. In correspondence with my own clinical practice with Veterans as a counselor, for example, this manuscript advocates explicitly for counselors to allow the client's phenomenological (Husserl, 1958) perspectives to drive their therapy. This perspective may not be conducive to all models of psychotherapy, including many of the manual-driven interventions employed by the Veterans Administration and community agencies, which may place constraints on therapeutic-spontaneity. In alignment with this idea, this paper also attempts to establish the client as the source of both healing, as well as cultural knowledge, advocating for collaboration as opposed to stricter client-clinician dialectics that may place more of an importance on clinician-expertise, such as approaches that rely heavily on psycho-education. This style of therapy is heavily grounded in humanism, which relies on person-driven therapy (Lemberger, 2012). Having established my own philosophical and subjective presuppositions, it is my hope that the readers will be further facilitated in acting as empowered, informed-consumers of this work's tenets.

Purpose and Learning Objectives

This paper provides a broad scope of military cultural knowledge intended to aid in orienting counselors from all backgrounds to some of the important cultural considerations, specific to work with Veterans. As previously asserted, this paper will seek to encourage counselors from all backgrounds to pursue work with military populations by explicitly challenging the notion that deep or implicit military cultural knowledge, grounded in first-hand martial service, for example, exists as a pre-requisite for effective therapy with Veterans. I advocate that even prior-service clinicians should maintain an orientation towards continued growth and awareness in this area through acknowledgment of differing subjective-experiences amongst clients that may negate the validity of any wide-reaching assumptions regarding the generalized *military experience*.

To this end, I promote an awareness of the ever-present *experiential-gap*, sometimes referred to as *existential isolation* (Frankl, 1959; Yalom, 1985), which may exist between counselors and their clients, irrespective of their perceived likeness. This experiential-gap, expanded on in later sections, can be conceptualized as an unbridgeable barrier, wherefore, counselors can never fully connect with and understand situations from the perspective of the *experiencer*, hence, limiting the applicability of any degree of counselor knowledge related to military issues. Counselor self-reflexivity regarding the existence and potential influence of this experiential-gap may provide evidence helping to invalidate the assumption that highly articulated knowledge of any culture is useful in and of itself, sans client-experience relative to the subject-matter. Rather, I contend that clinicians might be better served applying pre-existing military knowledge, such as that contained in this paper, within the context of client-elicited subjectivity. This challenge maintains a concurrent intentionality in that it may also help to inform training practices of counselor educators as they prepare their students for work with Veteran populations.

Establishing a Base of Military Cultural Knowledge

For the purpose of this paper, I define a Veteran as anyone who has served in the United States military, for any period of time, in alignment with the guidelines provided by the American War Library (Coleman, 1978). This definition of Veteran may be more inclusive than others, for example, that may require a wartime deployment or having served a pre-established amount of time on active duty, amongst others. The intentionality of widening the scope of the Veteran designation is proposed as a means of increasing perceived inter-service member connectedness through greater inclusion. According to Judith Herman (1997) in her seminal work, *Trauma and Recovery*, increasing social interaction amongst service members is an important component of their recovery from trauma, something that is increasingly common amongst Veterans (as cited in Jacobson, 2011).

Having provided a definition of Veteran as a reference point, a discussion regarding the larger Veteran culture may begin. One of the most complex, yet noticeably salient issues facing military mental health providers is, as previously noted, the cultural-complexity inherent in work with military service members. As such, much of this paper will work towards establishing a fluid base of cultural-knowledge that will adapt and expand as counselors gain experience

working with Veterans. This view of counselor cultural competency as being derived from on-going therapeutic practice and client-exploration is in harsh contrast to the notion that counselors should enter sessions with extensive pre-knowledge in order to be effective. As such, this paper is not all-inclusive, providing only a broad overview of the cultural complexity that may hinder efficacious treatment outcomes.

In 1992, Sue, Arredondo, and McDavis developed multicultural counseling competencies, which advocated for mental health clinicians to make use of their knowledge, skills, and awareness when working with culturally diverse clientele. In extrapolating these competencies, this paper challenges clinicians to maintain an ongoing awareness of potential insight-gaps that may be resolved through collaborative exploration of clients' self-defined cultural identities. One of the most prominent challenges in working with military Veterans in any capacity manifests in the form of cultural enmeshment between the individual's pre-service cultural identity, as well as his/her unique and dynamic military cultural identity.

The military cultural identity is composed of, amongst others, the client's: branch of service, rank, duty status, Military Occupational Specialty (MOS), unit designation, legal status, age and physical health, gender identity, sexual orientation, ethnicity, as enmeshed with pre-service cultural identities. The military cultural amalgam may also be influenced, in part, by widely pervasive mental health related stigmas, permeating both civilian and military systems. In an attempt to articulate how each of the aforementioned cultural identities may affect clinical counseling practice, this paper provides a brief discussion of each. This sets the stage for a discussion related to the potentially troublesome dialectic, wherein service members attempt to retain pre-service identities and values while navigating military cultural systems. Perhaps the most immediately salient military cultural identity is the service member's unique and highly specialized branch of service.

Branch, Military Organization, and Cultural Structures

There are five distinct branches of service, including the Navy, Marines (e.g., a distinct branch which falls under the Department of the Navy), Army, Air Force, and Coast Guard. Each branch maintains unique missions, histories, traditions, and policies with little overlap between them. Each service, because of their unique missions, provides differing amounts, types, and intensities of training. Recruiting efforts tend to revolve around the needs of the branch, so while the Army, Navy, Air Force, and Coast Guard often provide financially lucrative contracts, laden with monetary bonuses, the Marines provide little capital incentive, preferring recruits who join primarily to serve in combat-oriented occupational specialties (Powers, n.d.). Some people may join a particular branch of service that is in alignment with their family lineage, while others may be the first in their families to serve in the military.

This can provide important information to counselors in understanding the client's reasoning for choosing to join a particular branch, especially during a time of war. Reasons for having joined the military may be evocative of the service member's expectations and values, both of which could provide valuable information for clinicians. Though this is hardly generalizable, as many join the Army, Navy, Air Force, and Coast Guard for combat-oriented vocations, these branches make an explicit attempt to provide job-training opportunities with

easy civilian-transportability for life, sans the military. This, too, can be important information for mental health clinicians, suggesting some individuals leave the military with few directly transferrable skill-sets (Heinze, 2011).

When working with members of the armed forces, it may be helpful to consider service members as operating within multiple, strongly influential military sub-systems. These sub-systems might be conceptualized as being nested within the superordinate military cultural system, as well as within various subordinate systems, each applying unique external constraints on Veterans (as shown in Figure 1). For example, a Marine may operate within the larger military culture, as well as in accordance with the individual's branch, division, battalion and unit-specific *codes of conduct*. Each of these systems asserts differing degrees and types of pressure on Veterans; however, Veterans also may differ in terms of how they interpret and experience the effects of each, providing evidence towards the importance of approaching cultural assessment as originating in the phenomenological (Husserl, 1958).

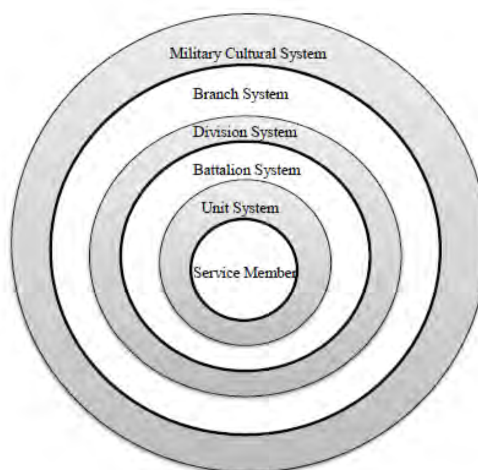

Figure 1. Service members in-context. An example of a Veteran viewed within the context of military cultural systems.

Subsystems within the larger military cultural system maintain unique policies and procedures, as well as strictly adhered to social norms that may aid in dictating honorable service. Some Veterans report systemic-pressure, for example, that invalidates the need for mental health care for emotional and intra-psychic issues (Wilkes-Edrington, 2013). Many Veterans are asked to become adept at adjusting to otherwise intolerable living-conditions, in congruence with the common military mantra "improvise, adapt, and overcome." Their military colleagues may misperceive the valid angst experienced by service members living in these conditions as evidence of a "weak character" (Hsu, 2010). This fallacy of "emotional distress as a character flaw" likely contributes to some of the apprehension Veterans experience when evaluating the potential ramifications of discussing their issues, particularly in the immediacy of the experience, with anyone, including mental health professionals.

Rank

Next, each service branch maintains a unique rank hierarchy, composed of Officers (e.g., members who have at least a Bachelor's Degree and have undergone officer-specific training), Warrant Officers (e.g., members who may or may not have Bachelor's Degrees, though remain distinct from 'full' Officers), and Enlisted women and men (e.g., members who are not required to have a Bachelor's Degree, and who remain at the lowest-echelon of military authority). Officers train specifically for unit planning and leadership, and are at the highest level of martial decision-making. This may be useful information for counselors because the client's rank may provide an indication of education-level and transferable vocational skills. Rank may also be an indication of time-in-grade, or time-in-service, potentially indicative of traumatic exposure (e.g., the higher the rank may suggest more time in the military, and a higher potential likelihood of war-time service), though this, too, is hardly generalizable.

Duty Status

Duty status is typically characterized as Active, Reserve, or National Guard. The Navy, Marines, and the Coast Guard are composed of Active duty personnel who serve in full-time billets (e.g., jobs), as well as Reserve personnel whom typically perform their duties one weekend per month, including longer-duration annual trainings (e.g., typically two-weeks). The Army and Air Force have Active and Reserve personnel, as well; however, they also have a National Guard component, which include the Army National Guard and Air National Guard, respectively. National Guard units engage in a diverse range of operations, both domestic and abroad, inclusive of things such as riot-control and national disaster relief and can be mobilized through state-authority; however, while the Reserve components also assist in domestic humanitarian aid, they are both commonly sent on international deployments in relief of Active duty personnel, more recently in support of the Global War on Terrorism (GWOT), in addition. Army Reserve units tend to focus on combat-support missions, whereas, the Army National Guard focuses more on direct combat-arms jobs (Military.com, n.d.).

Military Occupational Specialty and Civilian Reciprocity

Military occupational specialty (MOS) refers to the service member's job. As aforementioned, vocations tend to vary dependent on the branch of service. Each job has a branch-specific coding, often used in common-usage amongst Veterans, such as '0311' signifying Marine Corps Infantry, or 11-Bravo articulating a member of the Army infantry. Also previously discussed, are the discrepancies in civilian-portability of military vocational training. Active duty members who are trained, for example, as a heavy equipment mechanic while serving, often have a difficult time receiving civilian reciprocation due to state-specific credentialing procedures that do not acknowledge military-training as commensurate to civilian certifications. Though she or he may have received even advanced or extended education in a particular job in often-horrendous conditions (e.g., such as those experienced during war-time), the service Veteran may struggle to find work after transitioning away from military service. Some military occupations, particularly in the combat-oriented vocations, appear to have narrow civilian equivalencies, directing many of these Veterans towards jobs in the public service.

Military Unit and Identity

Each service branch is divided amongst a multitude of individual units, each with a specific mission. As such, it would be a daunting task for clinicians, much less service members, to gain an appreciation for each; accordingly, this section will serve towards increasing counselor awareness of the potential benefits of exploring this with Veterans. The Marine Corps, for example, has multiple divisions, each separated amongst battalions, which are further separated into specific units within each battalion (United States Marine Corps, 1998). Within each unit are platoons, each with specific missions in support of the unit's unique mission (United States Marine Corps, 1998). The longer the unit has existed, the more storied its history is likely to be amongst past and current military-conflicts, which typically becomes a source of pride among its members. The historical significance of each unit, or even amongst specific platoons within units, often becomes closely aligned with a Veteran's self-identity relative to other service members. Counselors may find it beneficial to explore unit-specific, Veteran-clarified identities in reference to his/her role while serving, as this may provide critical data for counselors, as well as clients, as to client values and strengths, potentially fostered in service of a highly specialized unit.

Legal Status

Legal status, as aforementioned, can affect service longevity; however, it is also an important consideration for counselors attempting to understand issues presented by Veteran clients in a multitude of other ways. The Uniform Code of Military Justice (UCMJ) (United States of America, 2014) articulates the federal laws enforced amongst service members, which can differ significantly from civilian state and federal laws. Service personnel, for example, receive payment to train; however, superficial injuries, which result in a temporary removal from training, might be assessed as malingering, a punitive offense (United States of America, 2014). If, particularly in the case of less visible, intra-psychic symptomology, the individual's issues are deemed unworthy of being removed from training, a charge of malingering may further discourage some from seeking assistance.

A service member's legal status also dictates other rights, such as access to medical and mental health services, as evidenced by the loss of benefits experienced by those who receive a Dishonorable Discharge. This type of separation from the military commonly occurs in the wake of substance-related offenses, such as consuming an illicit drug while on duty, which, according to the literature, may be an increasingly common response to trauma (Papanikolaou et al., 2013), such as that experienced while deployed. This may add a significant barrier to substance-use related, government-funded treatment. Exploring service member legal-status may provide counselors with important insight regarding client access to community resources prior-to, during, and in the wake of treatment.

Age and Physical Health Status

Exploring client age and physical health status may be of particular importance when working with service members, where both can significantly affect the life of the Veteran. Each branch of service has a different maximum age cut-off, often dictated in accordance with

recruitment issues and differing levels of physical-requirements. Some individuals join at the age of 17, with parental permission, while others may join as late in life as 42 (Powers, n.d.). Military service mandates physical fitness requirements, which may be negatively affected by the service member's age or physical health. Failure to meet the minimum physical fitness standards commonly results in either loss of job (e.g., in favor of a less physically demanding vocation), or even removal from the military under an Other than Honorable medical discharge.

Age-related as well as physical injuries sustained on or off-duty can also affect retirement benefits, job promotions, and entrance into rigidly screened training schools. Individuals who suffered physical or other injuries that lead to separation from military-service may also struggle to obtain stability in civilian life, particularly if the service member receives low or no disability benefits through the Veterans Administration (VA). Other injuries sustained by Veterans may have altered their physical appearance, such as severe burns in the wake of a blast from an improvised explosive device (IED), an increasingly common injury amongst Veterans of the Iraq and Afghanistan campaigns (Norton-Taylor, 2014). Clinicians may need to be especially sensitive to the age and physical-health related domains of their military clients' identities.

Gender Identity and Sexual Orientation

Those with the physical gender of female have only recently been permitted to fill combat-roles (Fishel, 2013); however, few training programs exist which include vocational training towards placing women in positions to serve in combat. Also, a recently emerging yet long-existing epidemic amongst service personnel concerns military sexual trauma (MST). According to Bancroft (2013), between 20 and 48 percent of females have experienced a sexual assault at least once while serving in the military, thus, further articulating gender-specific issues faced by service members that may be of importance for clinicians. According to the Associated Press, as recently as 2013, while a higher percentage of females reported being sexually assaulted, a higher total number of males reported having also been sexually assailed (Brown, 2014), shedding light on the importance of thorough assessment by clinicians, regardless of clients' physical gender.

Prior to the rescinding of 'don't ask, don't tell' (DADT), proclaiming or asking a service member's sexual orientation was a punishable offense. Though many states now recognize same-sex marriages, it is only a recent occurrence that the military has reciprocated spousal rights to same-sex spouses of service members (Phillpot, 2013). Members of the lesbian-gay-bisexual-tran-sexual (LGBT) community, though they appear to be making progress in terms of legal equality, still face many obstacles in working towards equal opportunity. According to Storm (2013), only recently have there been reports of openly gay United States Marines, for example, serving in combat-zones. Lavers (2012) reported that the Commandant of the Marine Corps, General James Amos, suggested openly gay service members were not an issue of contention; however, Storm (2013) notes that many members of the LGBT community who serve in the armed forces still face oppression, for example, through the use of malicious slurs. Mental health clinicians might find it helpful to explore the service members' lived experiences around their sexual orientation, as equality appears to be a continued struggle, in spite of recent progress.

Typical Training Pipelines and Service Trajectories

When attempting to give a broad, yet thorough understanding of the cultural diversity inherent in military service, it may be helpful to provide an overview of typical training pipelines and service trajectories. As previously discussed, each branch's mission, amongst other things, dictates the type, duration, and intensity of its training programs. While each service branch maintains unique idiosyncrasies, such as the United States Marine Corps' emphasis on ensuring all Marines receive extensive combat training prior to MOS-specific education, there are training and service trajectories that maintain stability across branches. All service members, upon beginning their service commitment, attend some type of basic training. Some may struggle to accommodate new values and routines during this phase, which may be in harsh contrast to their prior-service worldviews. Those in training remain at the lowest end of the rank-hierarchy, and hence, also the power-continuum.

After initial training and indoctrination, all service members then engage in job-specific training. The timeline for vocational training varies widely from several weeks, to multiple years, prior to arriving at their units. Reservists and National Guard members who plan on engaging in civilian endeavors, such as personal careers or college, may be required to put these plans on hold until their initial as well as vocational training end. Once at their units, military members receive further guidance regarding things such as standard operating procedures and unit-specific codes of conduct. Some service members remain at their initial units for the entirety of their careers while others experience life at any multitude of units across their service lifespan. Service lifespan can last anywhere from four years, to 20+ years and retirement and can be determined by many factors, including personal choice, early-separation (e.g., due to injury or punitive action), and service component; however, the typical initial obligation is typically either four or six years of 'active' service (e.g., as defined by time-durations where Veterans are required to train) for Active and Reserve/National Guard personnel, followed by either four or two years of service in the Inactive Ready Reserve (e.g., an obligation of time to the military, sans formal training), respectively (Department of Defense, 2013).

Stigma

Bray (2014) notes that many Veterans feel clinicians, as well as their communities often associate being a servicemember with having post-traumatic stress disorder (PTSD). He goes on to assert that many Veterans receive diagnoses of anxiety disorders, sans in-depth exploration of actual client-symptomology (Bray, 2014). According to Wilkes-Edrington (2013), some Veterans are discouraged from seeking mental health assistance by their peers for fear of diagnosis-related stigmas. Having a diagnosis of PTSD may be incongruent with the lived experiences of Veteran survivors of combat, as well those servicemembers who have not been deployed to combat-zones, yet still struggle with symptomology consistent with trauma (Jacobson, 2011), which run the risk of being under-assessed.

As aforementioned, diagnostic assessments that lack comprehensive exploration of client-issues also may lead to Veterans being legally prosecuted for malingering. This particular legal issue may lead to the long-lasting and explicitly harmful label of malingerer amongst service members, which, for clinicians, may harm Veterans, thus, deviating from Kitchener's (1984)

principal of non-maleficence in ethical decision-making. Counselors may also need to assess section E.5.d. of the American Counseling Association's (ACA) *Code of Ethics* (2014), regarding refraining from providing a diagnosis, should Veterans request this, in light of the pervasiveness of such stigmas amongst servicemembers. It is important for clinicians to engage in competent diagnostic assessment practices not only to minimize the stigmatization of Veterans' mental health issues, but also, to ensure service members receive clinical interventions commensurate to their reported symptomology.

Service Member Ethnic and Pre-Service Cultural Identity

According to the Department of Defense (DoD; Department of Defense of the United States of America, Office of the Deputy Under Secretary of Defense, 2012), the United States military is composed of more than 3.6 million members. Among this population, less than a third identified themselves as a minority, including African Americans, Asians, American Indians, Alaskan Natives and Pacific Islanders, though they suggest the number of self-identified non-whites is growing (Department of Defense of the United States of America, Office of the Deputy Under Secretary of Defense, 2012). The DoD reported having 11.2 percent of the overall military population as having self-defined, Hispanic heritages, which they do not include in the minority category, leaving the remaining 58.6 percent of service members self-identifying as white (Department of Defense of the United States of America, Office of the Deputy Under Secretary of Defense, 2012). This paints a picture that one might expect, representing a country as diverse as the United States (U.S.). Though the Eurocentric roots of the U.S. tend to promote individualistic value-systems that prioritize personal goals (Douglass, n.d.), many sub-cultures within the country maintain collectivist ideologies that place the focus on group objectives, such as some Asian and Hispanic subcultures, similar to that espoused in the military. That said, counselors might find differing experiences amongst clients when they transitioned either into or away from the military culture, based on the perceived degree of similarity with their pre-service culture-of-origin.

Important Military Cultural Considerations

Attempting to Maintain and Balance Cultural Identities

Earlier in this manuscript, I introduced the potentially troubling dialectic of attempting to balance personal identities and values with those formed during military service. To help articulate this apparent tension, this paper will look, specifically, at the challenges faced by Reservists and National Guard members; however, it should be noted that this dynamic likely exists amongst Active personnel as well, though it may be more difficult to express for the purpose of this paper. Reservist and National Guard part-time military service may create unique mental health challenges when attempting to navigate operations in multiple, often enmeshed, yet explicitly dissimilar cultural systems composed of, amongst others, civilian communities of origin, the cultures of the Reserve or National Guard, as well as that of the military more broadly, such as when called to Active service for deployments.

To highlight these challenges, there is an emerging body of research that appears to underline the unique mental health challenges faced by Reservists and National Guard members

who struggle with, in some cases, higher rates of PTSD, chronic anxiety, substance use, and suicide, relative to their Active duty counterparts (Jacobson, 2011; Lane, Haurani, Bray, & Williams, 2012). Exploring the qualitative experiences of Reservists and National Guard members may provide insight into how cultural expectations negatively affect service member wellbeing. For example, Reservists or National Guard members develop personal identities, prior to joining the military. Then, once they begin their service, they are asked to accommodate, in some cases, previously incongruous cultural values specific to their branch or unit. They are then tasked with having to re-assimilate into civilian systems, with the cultural adjustments made during military training, in-tow. From this point forward, they must become *masters of cultural adaptation*, regulating to, at times, vastly different cultural expectations amongst civilian and military systems for the remainder of their service obligations.

As previously discussed, Active Duty members, too, are tasked with a similar mission, as they attempt to navigate military systems for a majority of their service contracts, in lieu of potentially incongruous value-expectations. It may be efficacious for clinicians to explore this apparent cultural-adaptation dynamic, in session, as it may provide insight into the etymology of presenting symptomologies. In alignment with this paper's philosophical assumptions, however, the phenomenological experiences of service members related to this dynamic should be thoroughly assessed prior to making inferences regarding the source of any presenting issues. To my knowledge, there is a significant gap in either qualitative or quantitative inquiry into the challenges presented by cultural-adaptation amongst military Veterans and its potential effects on mental health. As clinicians attempt to navigate cultural barriers towards facilitating Veteran wellness, it may be efficacious to explore this dynamic in further depth.

Implications for Clinical Practice: Navigating Military Cultural Ambiguity

Thus far, a broad base of military cultural knowledge has been established, inclusive of the service member's branch of service, rank, duty status, Military Occupational Specialty (MOS), unit designation, legal status, age and physical health, gender identity, sexual orientation, ethnicity, and pre-service cultural identity. A discussion of important military cultural considerations then ensued, noting the unique challenges Veterans face in adjusting to the cultural expectations of multiple, often over-lapping systems of operation, relative to both civilian, as well as military cultural sub-systems. How, then, can counselors assess, navigate, and honor the presentation of multiple, ever-changing cultural strata, in the context of therapy? One potentially effectual course of action includes thorough exploration of the phenomenological, in conjunction with continuous counselor-reflexivity and self-reflection.

Importance of Counselor Reflexivity in Responding to the Experiential Gap

Attempting to navigate a perpetually changing, nested cultural amalgam, such as that presented by service-members, may require a high degree of counselor reflexivity. Counselor reflexivity, for the purpose of this paper, will be defined as a constant state of clinician self-reflection, resultant in adjusted-action from increased awareness of what clients present and how clinicians conceptualize and respond to it. For example, a counselor who once served in the Marines may perceive a high degree of empathy when providing mental health services to, for example, other Marines. It is important, however, for the counselor in this scenario to remain

self-reflexive, ensuring that, though the therapist may perceive the client's past experiences as exceptionally similar to those of the counselor's own, an unbridgeable experiential gap ultimately limits the ability to fully comprehend the subjective experiences of the client (Frankl, 1959; Yalom, 1985). Having remained self-reflexive regarding the limits of therapists' perceived understanding; they can then adjust their responses, in some cases, towards deeper exploration of their client's own phenomenological experiences (Frankl, 1959; Lemberger, 2012; Yalom, 1985).

The existence of an experiential gap does not, ultimately, negate the importance of what Carl Rogers (1995) referred to as accurate empathic understanding; wherefore, counselors attempt to understand client-issues as if they, too, experienced them. That being said, attempts to bracket out their own past experiences may be both inadvisable (Sue, Arredondo, & McDavis, 1992), as well as unrealistic. Rather, providers should remain reflexive, framing any perceived cultural or experiential similarities within the constraints of the ever-present experiential gulf, therein, remaining open to potentially efficacious, deeper exploration. If the philosophical construct of experiential gaps is accurate, this may partially invalidate the notion that counselors who work with Veterans should enter sessions with extensive pre-knowledge of client issues (Bray, 2014), as even wide-ranging knowledge or insight may be misleading, in light of subjective differences. Further, inaccurate assessments may result from an unawareness of the influences of therapist preconceptions regarding client experiences. Counselor self-reflexivity may also help to diminish the likelihood of misdiagnoses or exceedingly inaccurate empathic understanding from experiential or cultural over-generalization (Sue et al., 1992).

Assessing the Phenomenology of Cultural Identity and Presenting Issues

Counselors with limited insight or understanding of the experiences of service members, such as those without a military-background, might find it equally as beneficent to allow self-reflexivity to widen the scope of their pre-existing knowledge base. As mentioned earlier in this paper, developing a broad understanding of military culture may contribute to culturally competent therapy; however, it is also important to remain aware of potential deficiencies, later enriched in collaboration with the client (Sue et al., 1992). As previously discussed, wide-reaching insight into the lives of clients may not be a pre-requisite for culturally sensitive counseling; further, allowing clients to educate clinicians on their identities and experiences (e.g., their phenomenology) may significantly enhance the therapeutic alliance through explicit collaboration. Counselor self-reflexivity and thorough exploration of the phenomenological may decrease the likelihood of misinterpretation, including inaccurate diagnoses, resultant from experiential or cultural over-generalization. Decreasing misdiagnoses through collaborative phenomenological exploration in light of self-reflexivity, while ensuring appropriate treatment, may also help to ameliorate Veteran-related stigmas related to mental health (Bray, 2014).

Implications for Counselor Education: Setting Realistic Expectations for Psychoeducation of Counselors and Trainees

While counselor self-reflexivity and exploration of the phenomenological may greatly enhance culturally competent therapy with Veterans, how can counselor educators transfer these skills to future generations of military mental health professionals? It might be prudent to begin

by actively challenging the notion that extensive military knowledge or experience, alone, facilitates effective treatment with Veterans, as asserted by Bray (2014). According to Sue et al. (1992), the knowledge component of their multicultural counseling competencies revolves not necessarily around objective facts relative to the client's culture, but rather, clinician self-knowledge as to preconceived perceptions that could bias a therapist's work. While his paper does explicitly advocate for clinicians to engage in therapy with service members having first developed a novice base of military cultural knowledge, the position of this paper is congruent with prioritizing awareness of preconceived notions and their potential impact on treatment. Thus, counselors-in-training should also be encouraged to develop realistic expectations as far as how much objective cultural knowledge they should possess prior to working with Veterans, as well as how this information might be enriched through the use of communication skills that elicit the client's own subjectivity.

Teaching skills, such as self-reflection in conjunction with open-ended questions, intended to penetrate client phenomenology, may also help ameliorate some of the valid apprehension potential military mental health providers experience in response to the task of working with such a complex and underserved, yet rewarding population. If it were possible to provide clinicians with extensive pre-knowledge, such as that advocated for by Bray (2014), making use of this knowledge would be difficult without also being framed within the context of the client's subjective experience. Trainees who build awareness, also, of the experiential gap (Frankl, 1959; Yalom, 1985), may then begin to couple broad, pre-existing military knowledge with client subjective data towards more accurate diagnoses, thus, also helping to challenge military-related stigmas associated with mental health resultant from under-assessed misdiagnoses.

That being said, some important information for potential clinicians to possess prior to engaging in therapy with Veterans might include a broad understanding of the differences between military branches, military organizational structure, issues related to civilian vocational reciprocity of service-training, an awareness of some of the more salient current and past military conflicts, and common presenting issues. It may also be important to have an understanding of the some of the differences between service components (e.g., Active, Reserve, and National Guard), as well as some awareness of military rank structure. Counselors may benefit from acquiring a general understanding of what cultural subsystems, such as those contained in this manuscript, compose the larger superordinate military system. Finally, trainees may find it efficacious to garner an awareness of the challenges Veterans face in balancing pre-service values throughout, as well as in the aftermath, of military service, to be enriched through client dialogue upon beginning therapy.

Implications for Research

As Veteran related mental health issues continue to grow (Jacobson, 2011) outnumbering the number of mental health professionals who specialize in Veterans therapy (Wood, 2013), it is imperative that clinicians critically examine both barriers discouraging clinicians from working in this area (Bray, 2014), as well as how counselors are trained to meet their needs. Research that explores the current attitudinal climate regarding mental health work with Veterans amongst both counselors-in-training, as well as licensed therapists may be helpful in highlighting, validating,

and challenging beliefs that may detract from interest in Veterans work. Further, exploratory research in how counselors are trained to work with military populations may also be important towards articulating minimal standards of competency, or even adjusting any preexisting standards, prior to engaging in therapy with Veterans. Finally, outcome research that studies military counseling interventions that are grounded in humanistic philosophy, prioritizing phenomenological exploration in conjunction with relevant empiricism (Lemberger, 2012), may help to both develop new treatments, as well as alleviate some of the concerns regarding prerequisite training, such as those espoused by Bray (2014).

Limitations and Conclusions

As with any approach to counseling, there are limitations that should be acknowledged. I take a clear stance in favor of therapists allowing phenomenological exploration to drive mental health work with Veterans; however, over-relying on a client's subjective experiences may result in making little use of relevant empirical data, such as that from psychometric instruments intended to assess symptomology. In alignment with Lemberger (2012), therapists may benefit from coupling client experiential data with existing objective information towards a holistic assessment of client needs. Also, some especially low functioning clients, in my experience as a therapist, may struggle to accurately articulate their own experiences due to conditions such as traumatic brain injury (TBI) or substance-related delirium tremens. This, once again, highlights the potential beneficence of making use of a diverse set of data sources (Lemberger, 2012), when providing counseling to Veterans.

Thus far, this manuscript has established a need for reassessing barriers detracting from military mental health, as evidenced by the rising number of Veterans struggling with intrapsychic issues (Jacobson, 2011). I then refocused this assessment towards the immense and ever changing cultural amalgam clinicians are tasked with navigating in providing treatment to servicemembers, in part, through the development of a broad base of knowledge used as a primer, preceding therapeutic work with Veterans. Issues related to the fluidity of Veterans' value systems as they attempt to accommodate both military, as well as civilian standards and expectations was explored, particularly in reference to cultural enmeshment.

This paper assessed implications for counseling practice, highlighting the importance of continual counselor self-reflection and resultant exploration of client subjectivity (e.g., self-reflexivity), in understanding Veterans' presenting issues, as well as in enriching counselor knowledge related to military issues. Implications for counseling practice were extrapolated to the training of counselors seeking to provide services with military populations, noting the importance of trainee self-reflexivity as being the primary vehicle towards which clinicians acquire, as well as clarify military cultural insight. Implications for research in the areas of both counselor education, as well as interventional studies were identified, and some potential limitations of this paper's tenets were explored. As Veterans' mental health concerns continue to rise (Jacobson, 2011), counselors might benefit from continued assessment of cultural, as well as other barriers that may detract from competent, ethical, and ultimately effective therapeutic services. This paper was intended, in part, to empower counselors from all backgrounds to successfully navigate, as well as find meaning in contributing to an underemployed, vastly

interdisciplinary community of military mental health professionals that attempt to reciprocate service to those who serve.

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© 2014 ISSN: 2165-7726

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Volume 2, Number 2 2014

Is There More to the Experience of War Trauma than PTSD? The Development of Moral Injury and its Impact on Soldiers

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Abstract

The focus of war trauma has historically been on exposure to fear-based, life-threatening events that are linked to the development of post-traumatic stress disorder (PTSD). Recent research has explored the impact of moral trauma that can also lead to long-term psychological scars. A review of literature suggests that conceptualizations of PTSD do not adequately capture the nature and manifestation of human-generated traumas. Likewise, clinical practice purports that current PTSD interventions may not address the moral dilemmas that impact how military personnel are affected by their experiences. The purpose of this paper is to advance a conceptual and theoretical framework through a critical review of the extant literature on moral injuries of war.

KEYWORDS: PTSD, moral trauma, military, combat Veterans

The notion that war can produce emotionally damaging consequences, like posttraumatic stress disorder (PTSD), in service members is not a new concept. A common assumption among clinicians and researchers is that trauma associated with war primarily involves fear-based reactions to life-threatening situations. Much emphasis has been placed on research and treatment of PTSD in relation to military combat exposure, but what about the warzone exposures that produce profound repercussions on an individuals' psyche? Researchers are just beginning to explore the internal experience of human-generated acts of war that produce deeply disturbing emotional reactions to events involving action or inaction (e.g., killing, engaging in acts of atrocity) that transgress the Soldier's deeply held moral beliefs and can also lead to long-term psychological impairment (Litz et al., 2009).

While it is necessary to place high importance on the prevalence of PTSD and other post-deployment adjustment difficulties, current PTSD models generally explain long-term experiences of individuals harmed by others, but do not consider other multifaceted layers of trauma including the phenomenology of perpetration and moral transgressions in traumatic contexts (Litz et al., 2009). What has been found is that individuals are diagnosed with PTSD, but exhibit more complicated emotional symptoms of moral injury (Litz et al., 2009). Combat-

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related violence, including the act of engaging in behavior or witnessing others behave in a way that is not accepted at an individual level can lead to symptoms such as shame or guilt. As such, there is a lack of understanding as to how moral injury is conceptualized both within and beyond the realm of traditional understandings of PTSD, and therefore is not being addressed in a way that promotes alleviation of specific shame and guilt symptomology.

Conceptualization of Moral Injury

Although not formally recognized by the current version of the DSM, moral injury is identified as "perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations" (Litz et al., 2009). This is thought to result in concurrent negative emotional responses and dysfunctional behaviors that result in long-lasting psychological impairment (Drescher et al., 2011) by way of either indirect exposure (i.e., witnessing) or directly participating in the conflicting event. Moral injury is different from traditionally-recognized post-deployment mental health issues since it is a dimensional problem as opposed to being defined as a mental disorder that elicits a formal diagnosis (like PTSD) (Maguen & Litz, 2012). For example, a diagnosis of PTSD requires that an individual meets a certain number of criteria and symptoms (American Psychiatric Association, 2013). There is no threshold for establishing the presence of moral injury; rather, at a given point in time, symptoms of moral injury may be experienced on a continuum. Although moral injury is thought to co-occur and sometimes function as an antecedent to PTSD, especially in the context of military combat environments, there are unique issues when considering the manifestation of outcomes with each (Mann, 2013).

Often times, Soldiers suffering from higher order dimensions of emotional distress are misdiagnosed with having PTSD symptoms; however, the emotional consequences of moral injury are not well explained by the PTSD framework (Dombo, Gray, & Early, 2013). Soldiers who face unprecedented moral choices and demands in the military, including prescribed acts of killing or violence, failing to prevent harm to others, and witnessing cruel and inhuman acts (Maguen & Litz, 2012) may present with symptoms that may be misinterpreted as PSTD. However, this disorder does not account for the complex moral responses to trauma, and subsequently practitioners may not target moral injuries in treatment effectively.

Emotional outcomes of moral injury are related to personal core beliefs and the formation of schemas influenced by childhood experiences within social, familial, cultural, and societal contexts (Beck, 1976). Individuals form assumptions about the self and the world through early life events, resulting in beliefs that are embedded in a personally-created theory. These underlying core beliefs and worldly assumptions may become triggered and shift in the aftermath of a traumatic event. Other critical facets to moral injury include the inability to contextualize or justify personal actions or the actions of others, in addition to the inability to accommodate potentially morally challenging experiences into pre-existing moral schemas. Thus, moral injury is essentially an incongruence between the internal and external worlds of an individual, resulting in psychological distress (Lee, Scragg, & Turner, 2001).

Individuals interpret traumatizing events as a dangerous threat to physical wellbeing. With moral injury, however, a traumatic act or behavior that is in conflict with beliefs and values

is evaluated as a threat to the integrity of one's own moral schemas. The experience of acting in ways that counter one's ethical and moral code then can be perceived as traumatizing. While some indicators of moral injury overlap those of PTSD, unique self-handicapping cognitions and behaviors that surface as a result of moral injury are described below.

Indicators of Moral Injury

Individuals that engage in atrocities or highly violent environments are likely to experience intense feelings of shame and guilt (Robinaugh & McNally, 2010), which are considered to be the major constructs associated with moral injury (Litz et al., 2009). Shame and guilt can be very disabling, in that they can affect one's perception of the self, social behavior, and impede emotional processing of a traumatic event. Both are negative responses that tend to result from a perceived breach or violation of social norms or standards for social behavior (Lee et al., 2001) and are associated with negative self-appraisal (Tangney, 1996). However, they are distinguishable emotions, both having distinct impacts on the development and maintenance of posttraumatic outcomes (Ferguson, Stegge, Miller, & Olsen, 1999).

Guilt. Guilt is referred to as a self-conscious affect that relates to a sense of responsibility of the cause of harm to others (Lee et al., 2001). Individuals experience feelings of guilt when they believe they have done something contrary to their personal code of conduct or when there is an awareness of causing harm to others. Guilt derives from the thoughts, feelings, actions, or failures of actions that violate internal moral standards. With moral injury, feelings of guilt are connected through the sense that behavior is an extension of the self. Therefore, if the behavior is bad then "I" am bad.

Guilt-laden memories of a traumatic event can focus on a desire to confess wrongdoings in attempt to make amends. The possibility of reparation provides some hope of relief from the guilt (Fletcher, 2011). With regard to combat-related guilt, this is often not possible since the trauma that precipitated the guilt might include the death of others. In cases where restitution is blocked, memories of the trauma are overwhelmingly painful, often resulting in avoidance of associated thoughts and feelings (Lee et al., 2001).

Feeling responsible for traumatic experiences can increase a sense of helplessness and social inadequacy (Fletcher, 2011). Survivor guilt is commonly referenced with combat trauma, causing feelings of irrational guilt about surviving when fellow comrades have not. Survivors feel guilty not only for having survived an event that has claimed the lives of others, but also for their personal actions or absence of action during the traumatic event. Faulty thinking, known as hindsight bias, occurs when an individual ruminates about a negative experience, reflecting about what happened and how it might have turned out differently. Although individuals may feel powerless in affecting the outcome of traumatic events, there is still a sense of self-condemnation for participation, or lack thereof, associated with the event. Overall, the negative meaning attached to behaviors can affect an individual's sense of character and self-identity.

PTSD-related guilt has been conceptualized as the recognition of wrongdoing and subsequent self-blame related to actions or inactions involving a threat to an individual's survival or the protection of another's (Marx et al., 2010). According to the serial conditioning model of

psychopathology proposed by learning theory, the guilt emotion is cued before fear-related cuing that is commonly associated with PTSD (Marx et al., 2010). Thus, guilt is prompted by re-experiencing traumatic memories, and is reduced when avoidance tactics are used. Although avoidance and re-experiencing are symptoms typically treated by current PTSD interventions, the guilt reaction persists. Despite its importance in the development of PTSD, trauma-related guilt has received little examination (Kubany, Abueg, Kilauano, Manke, & Kaplan, 1997), adding to the lack of knowledge of the full scope of guilt and ramifications thereof.

Shame. Shame is defined by Tangney and Dearing (2002) as a painful, negative evaluation of the self with associated feelings of worthlessness and powerlessness. It is viewed as an organized process that exists to maintain others' acceptance and preserve self-esteem. According to cognitive-attributional theorists, shame is an affective state that is precipitated by internal, stable, and global acknowledgement about negative events (Lewis, 2003), and serves an individual's goal in terms of survival and emotion regulation (Barrett & Campos, 1987). Similarly, affect theory holds that shame is considered to be a natural social emotion (Tangney, 1996), and is part of both individual experience and collective ethos (Budden, 2009).

In the face of traumatic events, feelings of shame are activated as the primary register of perceived violation of social norms or personal standards. The shame-regulation response then influences the stress response system (Mills, 2005), which can be experienced as dissonance between the ideal and ‘‘real’’ self. As a consequence, the self is dominated by internalized ideals, which may develop into prolonged self-contempt (Wilson, Drozdek, & Turkovic, 2006) and is then ultimately expressed by diminished personal value, esteem, self-worth, and moral integrity as well as feelings of powerlessness, inadequacy, and failure. When a state of shame occurs over a long period of time, this type of perception becomes a general cognitive style. This may lead to alienation, rupturing of social ties including self-annihilation, and, in more severe cases, suicidality in fantasy or action, desire for escape and isolation, and acute social withdrawal (Budden, 2009).

Following experiences of shame, an individual has a sense of being a bad, immoral person. Unlike guilt which focuses on specific thoughts, feelings, or behaviors, shameful experiences represent failures that reflect on the core or ideal self in a negative way (Fletcher, 2011). For example, survivor guilt is the troubling feeling that one survived when others did not, whereas shame is an individual doubting the right to exist (Leskela, Dieperink, & Thuras, 2002). Shame is viewed as more of a "private" emotion than guilt, and focuses inward on the self as opposed to the behavior. As such, it is associated with a sense of personal deficiency and is more closely linked to a feeling of moral violation. Because it is often concealed from view, the central role of shame as it relates to psychological problems is often overlooked and difficult to recognize (Mills, 2005). As Wilson et al. (2006) states, ‘‘shame damages the soul of the person, his or her most cherished and inner sense of identity and humanity’’ (p. 139). This can be felt by way of either external shame, internal shame, or both.

External shame is associated with a belief that others perceive the self as inferior, inadequate, or weak in some way, while internal shame relates to a devalued self-perception that is damaging to self-identity (Gilbert, 1997). External and internal shame can be felt concurrently, or can be mutually exclusive. Individuals can harbor high levels of internal shame even though

others do not realistically view them in this perceived way. Alternatively, an individual may believe others negatively judge their attributes or actions involved with a trauma while not holding any damaging beliefs about the self.

Justification and Accommodation

From early social and cognitive development, individuals acquire an increased number and complexity of standards and rules by which to abide. Significance attached to these standards and rules is based on the evaluation of the self (Mills, 2005). Consistent with cognitive models of PTSD that emphasize the role of individuals' appraisals or interpretations of their traumatic experiences, perceived negative appraisals and interpretations about one's responses evoke prolonged and intense emotional reactions that can interfere with daily functioning (Ehlers & Clark, 2000). These emotional responses are caused by distorted or dysfunctional interpretations of the traumatic event, which can perpetuate over time.

An inability to contextualize, justify, and accommodate human-generated atrocities has also been found to likely lead to long-lasting psychological impairment and contribute to feelings of shame and guilt (Litz et al., 2009). In a recent study by Burnell, Boyce, and Hunt (2011), Soldiers' perceptions and evaluations of traumatic events determined if they found their actions during combat justifiable or unjustifiable. Soldiers identified patriotic duty to defend their homeland as justification for armed intervention, while others recognized personal validation in that armed conflict fulfilled a crucial function as a Soldier. Those Soldiers who felt that their actions were unwarranted in some way struggled with conflicting and contradictory views about the purpose of their deployment. This internal conflict is a significant contributing factor to the development of shame or guilt responses.

Treatment of Shame and Guilt

Treatments and interventions that focus on mental health effects of war trauma, like PTSD, may not be adequate in treating the emotional responses and dysfunctional behaviors resulting from moral injury. Because current evidence-based treatment strategies do not provide sufficient guidance in how to tend to moral injury, clinicians are not addressing feelings of shame and guilt in counseling (Ferguson, 2005). There tends to be more focus on events that pose life-threatening traumas than events that cause moral/ethical psychological impairments (Ferguson, 2005). For this reason, the shame and guilt repercussions of moral injury are not being targeted sufficiently. If feelings of shame and guilt remain unacknowledged over time, a characterological sense of self-blame can develop, resulting in individuals feeling that their traumatic experiences are due in large part to flaws in their character. These intensified feelings increase a sense of helplessness and hopelessness, which can in turn result in further isolation, avoidance of negative emotions, and possible suicidal ideation and attempts (Ferguson, 2005).

From a clinical perspective, it is important to differentiate shame- from guilt-based moral wounds, as they warrant different therapeutic techniques to alleviate symptoms and challenge beliefs (Lee et al., 2001). The argument exists that individuals dealing with shame require a different kind of relational encounter than those with guilt-based issues. Shame requires more supportive or relationally-oriented counseling, while guilt-based traumatic reactions respond

better to more traditional insight or behavioral change approaches. An individual struggling with shame needs to experience affirmation and acceptance in a therapeutic dyad, while a more cognitive verification or acknowledgement of the other's forgiveness facilitates treatment of guilt (Tangney & Dearing, 2002).

In treating shame and guilt, there is often a tendency to conceal, hide, and avoid painful traumatic memories in an attempt to protect the self. Care and sensitivity on the part of the clinician is required in order to encourage engagement in the therapeutic process. When shame is the dominant emotion, the goal is strengthening the self by learning to distinguish the self from behaviors (Parker & Thomas, 2009). An individual experiencing acute feeling of shame may experience strong feelings of vulnerability and self-consciousness (Lee et al., 2001). The assessment procedure alone can re-shame an individual, so attention must be paid to behavioral indicators (e.g., loss of eye contact, reddening of the face, inability to communicate) and maladaptive core beliefs associated with shameful appraisals of the trauma. The establishment of a strong connection between the counselor and client is essential, especially when working with feelings of guilt. In this case, relationship-building is essential, and therapy strongly focuses on facilitation of forgiveness (Tangney & Dearing, 2002). A therapeutic alliance that promotes a trusting and caring relationship can yield positive expectations and active client participation (Litz et al., 2009).

Although exposure therapy has typically been found to be effective with fear-based symptoms of PTSD, research suggests that it does not take into account existing shame or guilt that may actually worsen the post-traumatic experiences (Lee et al., 2001). Revisiting a traumatic event exclusively through exposure may put an individual at risk for returning to any shame or guilt towards his/her behavior during the event, or even feel shame of any emotion he/she emit in therapy. Additionally, these emotions may not dissipate in a similar way as fear when exposure-based therapies are implemented. PTSD outcome studies have suggested that Veterans may maintain guilty cognitions over the course of therapy, despite reductions in PTSD symptoms (Owens, Steger, Whitesell, & Herrera, 2009). The residual and unattended feelings of shame or guilt associated with a trauma may then impede the emotional processing of fear, risking future avoidance and dropout from therapy (Riggs, Dancu, Gershuny, Greenberg, & Foa, 1992).

The resolution of meaning-making is a primary form of restructuring traumatic events, and is central to the therapeutic recovery process with individuals experiencing moral wounds (Janoff-Bulman, 1992). By focusing on the meaning an individual assigns to a traumatic event, alternative constructs and perspectives can be created and positive attitudes about new meanings can develop. This will entail the development of alternative constructs and perspectives so that the individual can accommodate opposing perspectives of the world (Owens et al., 2009). Ultimately, an individual can then better understand and ascribe new meaning to a traumatic event. Assisting individuals in the process of integrating their previous and current beliefs is a crucial challenge to a positive post-trauma adaptation.

Adaptive Disclosure

A recent intervention was investigated for its validity in treating moral injuries of military personnel and Veterans. This treatment, known as adaptive disclosure (AD), takes into account

unique aspects of the phenomenology of military service in war and specifically addresses difficulties such as moral injury and traumatic loss that may not receive adequate and explicit attention by conventional PTSD treatments (Gray et al., 2012). This intervention is a manualized therapy developed specifically for military service members, and consists of six 90-minute weekly sessions. The purpose of AD is to uncover beliefs and meanings in an emotionally evocative context by encouraging service members to increase their awareness and insight, and modify problematic beliefs about combat and operational traumas, losses, and moral injuries (Gray et al., 2012). Ultimately, the goal for AD is to promote accommodation of the meaning and implication of combat experiences by facilitating emotional and experiential processing.

Adaptive disclosure employs imagined exposure therapy and cognitive-therapy-based techniques used in cognitive processing therapy (CPT) designed to target loss and moral injury (Litz et al., 2009). In cases where traumatic loss or moral injury are present, individuals engage in experiential exercises that involve an imagined conversation with the deceased or a compassionate and forgiving moral authority figure about events that occurred and how these events impact the individual now. It is thought to also assist individuals who feel unredeemable about something they did (or failed to do) and related emotional impacts. This approach facilitates perspective-taking shifting of beliefs from blameworthiness to forgiveness (Gray et al., 2012). In an open trial, of 44 active-duty Marines and Navy personnel, AD resulted in reductions in PTSD symptoms, depression symptoms, negative posttraumatic appraisals, and increased posttraumatic growth (Gray, et al., 2012).

Conclusion and Future Directions

Warzone combat stressors represent a distinct trauma condition, as Soldiers who experience these atrocities may be both victims and perpetrators. Being associated with a traumatic loss, witnessing violence, and directly engaging in or observing acts that violate moral or ethical standards can generate distressing emotional responses that emanate from severe shame and failure to forgive oneself. These feelings can lead to negative psychological and emotional responses, which are considered a maladaptive reaction to trauma (Fletcher, 2011) but are not always fully expressed by individuals exposed to trauma. If feelings of shame or guilt remain unacknowledged over time, a characterological sense of self-blame can develop, increasing a sense that traumatic experiences are due to flaws within the self. These intensified feelings discourage the sharing of feelings even more, which then results in a vicious cycle (Ferguson, 2005).

Currently, there is limited research that examines the multifaceted nature involved in how servicemembers cope with feelings of shame and guilt associated with traumatic events in combat. Given the lack of understanding about the complexity of emotional responses outside the realm of PTSD symptoms, future studies focusing on the link between traumatic events and morally injurious outcomes are warranted. Specifically, further development of intervention studies that branch off from the traditional fear-based models of war-zone exposure and focus on guilt- or shame-based injuries that directly target moral injury are required. Having a better understanding of how moral injury functions within the context of Soldiers' mental health may contribute to an increase in treatment options that will support our returning Veterans.

Avoided feelings of shame and guilt are inaccessible to many traditional therapies; thus, investigation of which aspects of shame and guilt are the most significant to the development and maintenance of trauma-related psychopathology is necessary (Marx et al., 2010). This includes exploring the lasting impacts of moral and ethical trauma that occurs as a result of peritraumatic and developmental influences. Because cognitions of shame and guilt are thought to stem from personal schemas that are influenced by early social and cultural experiences, it would also be beneficial to examine the extent to which early social and cultural milieus affect the experience of post-deployment adjustment and manifestation of mental health problems (Burnell, Boyce, & Hunt, 2011).

Military service members are trained to protect their country at the cost of their physical as well as emotional well-being. A willing society prepares military members to overcome a resistance to killing; therefore, that same society is obligated to treat Veterans with the psychological trauma of moral injuries (Mann, 2013). The ways in which clinicians can effectively treat morally compromising inner conflicts are still in question. Topics of morals and values and their association with shame and guilt are not readily brought up in individual and group therapy, which exemplifies an overall lack of awareness of moral injury as an important aspect of trauma-informed care. By focusing on shame and guilt in the aftermath of war trauma, treatment can expanded to give clients the space they need to explore meanings and conflicts regarding the morality of their behavior.

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