

Vol 2, Num 3  
Sep-Dec, 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 April, August, and December by the Association for Counselors and Educators in Government.

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**December, 2014**

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# Journal of Military and Government Counseling

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## **Letter From the Editor**

This issue closes our second year in publication. The *Journal of Military and Government Counseling (JMGC)* is the official journal of the Association for Counselors and Educators in Government (ACEG). On July 1, 2015 ACEG's name will change to the Military and Government Counseling Association. 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.

This issue is an eclectic collection of articles in practice, theory, and research. The lead article investigated resilience in military children. The second article focuses on integrated treatment of mental health and spiritual concerns in deployment. I will not publish an issue with less than four articles – in order to publish this issue, I had to write an article and send it through the review process. With the implementation of DSM-5 rapidly approaching, the next article is an overview of those changes in the DSM that I feel are most important for those serving a military population to know. The final article is a graduate student paper with a personal view of trauma and personal growth.

I need more submissions for the JMCG – as of today, I have enough articles in the queue for another issue. So, ask around where you work – or try writing yourself. I'm advertising for submissions through ACA channels.

Benjamin V. Noah, PhD  
*JMGC Founding Editor*

## **Facilitating Resilience and Wellness in Military Connected Children Through a Collaborative Program**

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### **Abstract**

*The experiences of military families differ greatly from those of their civilian counterparts. Current issues exclusive to military connected families such as permanent change of duty station challenges, psychological and behavioral changes during the deployment cycle, grief and loss, and impairments in relational connections will be highlighted. An overview of military life and culture will orient school counselors with little knowledge about the population. A program aimed at identifying and working with military families is also presented. This program supports relational connection, resilience, and an overall wellbeing in military connected children and their families. The reader is urged to develop a program from a multicultural perspective. Best practices and limitations will be presented towards the successful implementation of this program.*

*KEYWORDS: military, children, school counseling, families, resilience*

Over the last decade scholars have devoted significant attention on topics related to the United States (U.S.) military's service members (Warner, Appenzeller, Warner, & Grieger, 2009). This focus is a direct result of the U.S. military's consistent deployment of service members to Iraq and Afghanistan since 2001 (Asbury & Martin, 2012) and extensive media coverage about the wars in Afghanistan and Iraq (Cozza & Lerner, 2013).

These frequent deployments resulted in significant changes in military culture. Service members today continue to adjust to an extended and continuous deployment cycle, the rescinding of the 1994 ban on female service members in combat roles (Pellerin, 2013), and poly-traumatic injuries (Devore et al., 2011), among others. Various trainings (Defense Equal Opportunity Management Institute, n.d.), policy guidelines, and programs (McFarland, Choppa, Betz, Pruden, & Reiber, 2010) were established to assist service members as they adjusted to the new military culture. Far less attention and resources were devoted to military families although increased attention was afforded to service members (Jordan, 2011; Warner et al., 2009).

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Military families, particularly military children, continue to adjust to a new culture and state of normalcy. Military children are faced with various challenges in this new state of normalcy. These challenges affect the educational, social, and family environments of military children and render these children with an increased risk for social, emotional, and behavioral problems (Siegel, Davis, & The Committee on the Psychological Aspects of Child and Family Health and Section on Uniform Services, 2013).

The recent increase in counselors and other mental health professionals serving military personnel and their families is directly related to this situation (Weiss, Coll, Gerbauer, Smiley, & Carillo, 2010). Many of these professionals, however, lack a basic understanding of military culture, best practices, and effective interventions. It should be noted that a helping professional who is educated about the culture, lifestyle, and common challenges experienced by military families can be instrumental towards the resilience and wellbeing of military children.

The manuscript begins with an overview of military life and culture, to provide the reader with some foundational information about the U.S. military population. This is followed by information on two major challenges, the deployment of primary care givers and frequent relocations, which are encountered by many military families. Information and resources, guided by current research are offered to assist school counselors and other mental health professionals in their collaborative work with military families who are working through these challenges. This manuscript includes a program which school counselors can utilize in their work with this population. The reader is admonished to develop a program from a multicultural perspective. This manuscript is concluded with best practices, professional limitations, and suggestions for future research.

The concept of a military family member is expanded to the term of a military connected family member to duly incorporate family members of active duty, Reserve, and National Guard personnel. Likewise the term military connected children include children whose parents, guardians, or primary caregivers are active duty, Reserve, or National Guard personnel.

## **The Military**

### **Service Branches**

There are five branches of the U.S. military. These are the Army, the Navy, the Marine Corps, the Air Force, and the Coast Guard (Petrovich, 2012). The Army is the largest branch which accounts for more than half of all military personnel (Petrovich, 2012). The Air Force is the next largest, accounting for a little over one-half million members (Petrovich, 2012). The Air Force is followed by the Navy and the Marine Corps which are comprised of about three-quarter of a million members (Petrovich, 2012). The smallest branch is the Coast Guard which is comprised of approximately five percent of military personnel (Petrovich, 2012). The Coast Guard during peacetime is part of the Department of Homeland Security (U.S. Department of Defense, n.d.). The Coast Guard becomes a part of the Navy in times of war (U.S. Department of Defense, n.d.). There are marked distinctions among the five branches. Each branch has its own history, tragedies, triumphs, rivalries, traditions, values, vocabulary, practices, and its own mission (Petrovich, 2012).

## **Personnel**

Military personnel are classified as active-duty, Reservist, or National Guard members. Active-duty members serve full time (Petrovich, 2012). Reservist and National Guard members often are referred to as citizen soldiers (Hall, 2008). Reservist and National Guard personnel serve a minimum number of days each year (Petrovich, 2012; United States Army National Guard, 2014). The number of days a person is required to serve or attend military training is depended on the Reserve component category to which the person is assigned (Knapp & Torreón, 2014).

**Reservist and guard members.** The Reserve components of the Armed Forces include: the Army National Guard of the United States, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air National Guard of the United States, the Air Force Reserve, and the Coast Guard Reserve (Knapp & Torreón, 2014). Reserve components are federal entities whereas the Guard components are both federal and state entities (Knapp & Torreón, 2014). All Reserve and National Guard members are assigned to one of three Reserve component categories (Knapp & Torreón, 2014). The three Reserve components are the Ready Reserve, the Standby Reserve, and the Retired Reserve (U.S. Department of Defense, Office of the Deputy Under Secretary of Defense, 2012). The Ready Reserves is further broken down into the Selected Reserve, the Individual Ready Reserve, and the Inactive National Guard (U.S. Department of Defense, Office of the Deputy Under Secretary of Defense, 2012).

Selected Reserve personnel train throughout the year and at least once a year with active-duty personnel (U.S. Department of Defense, Office of the Deputy Under Secretary of Defense, 2012). Selected Reserve personal specifically are usually required to perform one weekend of training each month and two weeks of training each year (Knapp & Torreón, 2014). The two weeks of training typically occurs during the summer months (Knapp & Torreón, 2014). Active Guard and Reserve (AGR) personnel, a component of the Selected Reserve, may serve up to 180 consecutive days or more (Knapp & Torreón, 2014).

Reservist can be ordered to serve on an active-duty status for a variety of reasons (Petrovich, 2012). These activations can occur under the provisions of full mobilization, partial mobilization, presidential reserve call-up, combatant command, or disaster response activation (Knapp & Torreón, 2014; see Knapp and Torreón (2014) for greater detail on these provisions). AGR personnel may be called to active duty to assist with organization, recruiting, training reserve components, or instructing (Knapp & Torreón, 2014).

Members of the National Guard serve both the state and the country (United States Army National Guard, 2014). They can be called up to duty by their respective state governor or the president of the U.S. (United States Army National Guard, 2014). More reservists and National Guard members recently were called up to active-duty status in support of the U.S. military combat operations in Iraq and Afghanistan (Petrovich, 2012; Wiles & Nelson, 2009). In the post-Cold War era Reserve components were regarded as an integral partner with the active-duty components in defending the interests of the United States (Knapp & Torreón, 2014). The post-911 period propelled this policy to the forefront with the mobilization and deployment of large numbers of Reserve personnel.

## **Culture**

**Rank.** Military culture is unique. It is a culture that maintains a strict hierarchy (Lawrence, 2006). There is a rank structure in which individuals are classified as officers, warrant officers, or enlisted personnel (Hall, 2008; U.S. Department of Defense, n.d.). Officers or commissioned officers are on the high end of the rank structure while enlisted service members are on the lower end (Hall, 2008). Warrant officers fall in between commissioned officers and enlisted personnel (Hall, 2008). Warrant officers usually are formerly enlisted personnel who become specialist or experts in certain military technologies or capabilities (Hall, 2008; U.S. Department of Defense, n.d.). The Air Force is the only military service branch that does not have warrant officers (U.S. Department of Defense, n.d.).

Officers typically have college degrees and enlisted service members have high school diplomas or equivalent when they first join the military (Clever & Segal, 2013; Hall, 2008). Officers attended Officer Training School (OTS), have a college Reserved Officer Training Corps (ROTC) commission, or attended and attained a degree from one of the three military academies (i.e., the Air Force Academy, the United States Military Academy, the United States Naval Academy), or the Virginia Military Institute (Hall, 2008).

There is a hierarchy even among the rank structure classifications. Commissioned officer ranks range from O-1 to O-10 (U.S. Department of Defense, n.d.). Officers who serve in the Army, Air Force, and Marine Corps in the ranks of O-1 to O-3 are classified as company grade officers (U.S. Department of Defense, n.d.). Officers in the Army, Air Force, and Marine Corps in the ranks of O-4 to O-6 are classified as field grade officers and officers in the ranks of O-7 to O-10 are classified as general officers (U.S. Department of Defense, n.d.). Officers serving in the Navy and Coast Guard with the equivalent ranks are classified as junior grade, mid-grade, and flag officers respectively (U.S. Department of Defense, n.d.).

Enlisted personnel similarly have distinctions within their ranks. Enlisted ranks range from E-1 to E-9 (U.S. Department of Defense, n.d.). Junior enlisted personnel wear the ranks of E-1 to E-4, mid-level enlisted personnel wear the ranks of E-5 to E-7, and senior enlisted leaders wear the ranks of E-8 to E-9 (U.S. Department of Defense, n.d.). Enlisted personnel in the ranks of E-5 and up are classified as non-commissioned officers (NCO; i.e., Army, Air Force, and Marines) or petty officers (i.e., Navy and Coast Guard; U.S. Department of Defense, n.d.). NCOs and petty officers, however, remain a part of the enlisted culture rather than the commissioned officer culture (Hall, 2008). Warrant officer ranks range from W-1 to W-5 (U.S. Department of Defense, n.d.).

**Characteristics.** The majority of service members across the five branches are enlisted personnel (U.S. Department of Defense, 2012). Among the active-duty ranks about 83.4 percent are enlisted personnel and about 16.6 percent are officers (Clever & Segal, 2013). Ready Reserve officers comprise about 14.5% of the Reserve population whereas enlisted personnel comprise about 85.5% of the Reserve population (U.S. Department of Defense, Office of the Deputy Under Secretary of Defense, 2012).

While there is a distinct rank structure, the military is characterized by a collectivistic approach that encourages interdependence, group orientation, and group cohesion (Petrovich, 2012). The military is an institution which is orderly, stoic, and one which supports a conformist approach (Petrovich, 2012). This culture is paternalistic (Lawrence, 2006) and above all military culture is mission oriented (Petrovich, 2012).

### **Initial Training**

Mission first is one of the initial principles which new military recruits learn. When an individual first joins a branch of the military, he/she undergoes a process of transformation from a civilian to a military personnel (Petrovich, 2012). This process is identified as basic training and is commonly referred to as boot camp (Petrovich, 2012). The initial training process is eight weeks long for the Navy, Coast Guard, and Air Force (Petrovich, 2012). Basic training is nine weeks for the Army and twelve weeks for the Marine Corps (Petrovich, 2012).

Whether experienced for eight, nine, or twelve weeks, this process is undertaken towards the "...conditioning, training, and indoctrination" of each recruit (Petrovich, 2012, p. 868). The new recruit is taught military protocols and procedures during basic training (Petrovich, 2012). Each recruit is assessed physically, evaluated medically, and de-individualized (Petrovich, 2012). The de-individualization process is most apparent in the issuing of anonymous uniforms (Petrovich, 2012). "The ultimate goal of the military's training regimen is for the transformation of the recruit" (Petrovich, 2012, p. 869). Recruits are transformed into "...disciplined, mission-oriented, and aggressive personnel" (Petrovich, 2012, p. 871).

### **Military Life**

Military culture, training, and protocol extend beyond the initial training experience for service members. In order to maintain their occupations and security clearances, service members are subjected to rigorous standards for personal conduct (Cohen, 2000). This is evident in random drug testing, yearly height and weight requirements, and the avoidance of questionable behavior related to their finances, sexual behavior, and drug and alcohol use (MacDermid, Wadsworth, & Southwell, 2011). Failure to adhere to these and other expectations can result in disciplinary action (MacDermid et al., 2011).

Service members are on duty 24 hours per day, 7 days during the week and are expected to report with no advanced notice (MacDermid et al., 2011). Military duties may demand a substantial amount of time, requiring members to remain at their posts until the job is complete (MacDermid et al., 2011). One researcher refers to the military as a greedy institution (Segal, 1986). The family likewise is referred to as a greedy institution (Segal, 1986).

### **Dependent Family Members**

Family is an important component of military life and culture (Weiss et al., 2010). It was not until 1942 that service members with wives or children were permitted to enlist or reenlist into the U.S. military (MacDermid et al., 2011). Families became increasingly important to the

military personnel policy following the transition from a draft to an all-volunteer force in 1973 (Clever & Segal, 2013).

More than half of all military service members have spouses, children, and other individuals to whom they provide support (MacDermid et al., 2011). Family members grouped in this category are referred to as dependents and the service member is the sponsor. Most researchers classify military families and children as the spouses and dependent children who are age 22 and younger (Cozza & Lerner, 2013). The Defense Enrollment Eligibility Reporting System (DEERS), however, regards military dependents as "...spouses and unmarried children (including stepchildren) under the age of 21 (or 23 if attending school full-time)..., of service members" (Military OneSource, n. d.).

Marriage and parenthood are common identifiers across all ranks of the U.S. military branches (Clever & Segal, 2013). There are significantly more dependent family members than military personnel (MacDermid et al., 2011). There is approximately a 1.4 to 1 ratio of military connected family members to military personnel (Clever & Segal, 2013). Over 1.2 million dependent children (62.9%) and about 709,776 spouses (36.6%) were estimated to live in active-duty families in 2012 (U.S. Department of Defense, 2012). Approximately 400,991 spouses (35.3%) and 731,632 dependent children (64.4%) lived in Guard and Reserve families in 2012 (U.S. Department of Defense, 2012). Military connected families with dependent children on average have about two children in the home (Clever & Segal, 2013). This statistic is representative of active-duty, Reserve, and National Guard families (Clever & Segal, 2013).

### **Military Codes and Policies**

The unique aspects of military culture such as codes of conduct, affect the lives of service members and also their families (MacDermid et al., 2011). This is particularly applicable if the family lives on a military installation, utilizes military support services, or the service member is in a position of leadership (Segal, 1986). Family members informally wear the rank of their service member sponsor and are held to the prescribed behavioral guidelines (Segal, 1986). There is a degree of socialization that families members are expected to follow although family members cannot be held to many military customs (Segal, 1986). Military policies enact far greater control than customs on family members. Policies result in families changing schools, changing houses, accepting the responsibility for household matters when the service member sponsor is deployed, and adopting new communities (Clever & Segal, 2013). Family members also care for their respective wounded warriors when they return from deployments with psychological and physiological impairments and other deficits (Clever & Segal, 2013).

### **Current Significant Challenges**

#### **Permanent Change of Duty Station (PCS)/ Relocation**

Job location is one area where military policy significantly affects family members (Lincoln, Swift, & Shorteno-Fraser, 2008), and consequently where a family lives around the world (MacDermid et al., 2011). A PCS move is a central component of life for military connected families (Masten, 2013). The average active-duty family moves once every two to

three years (U.S. Department of Defense, 1998). That is approximately 2.4 times more than civilian families (Clever & Segal, 2013). Moves can be over long or short distances, across state lines, outside of the continental U.S., or to foreign countries. Active-duty military connected families usually reside in local civilian communities rather than on a military installation. The PCS move pattern for National Guard and Reserve families is similar to the civilian population (Clever & Segal, 2013).

**Children.** PCS relocations can be very stressful for children. These children are challenged to acclimate to a new environment, where they have no friends, and may be disconnected from school and community activities (Clever & Segal, 2013). Military connected children may experience educational and social challenges as a result of these frequent relocations (MacDermid et al., 2011).

**Spouses.** Spouses generally experience difficulties completing educational degrees, transferring licenses and certifications, maintaining employment, and pursuing careers (MacDermid et al., 2011). Military spouses are less likely than their civilian counterparts to work fulltime (MacDermid et al., 2011). Each PCS move is associated with a two percent decline in a military spouse's annual income (Clever & Segal, 2013). Military spouses are more likely to be unemployed and underemployed in comparison to their civilian counterparts (Clever & Segal, 2013).

## **Deployment**

Deployment is another aspect of military culture which presents significant challenges for military connected families. Military culture surrounding deployment changed significantly since the Iraqi and Afghani conflicts emerged (Lincoln et al., 2008). Deployment was an aspect of military culture which was relatively predictable (Lincoln et al., 2008). Today there are many uncertainties relating to deployment and typical deployment rotations changed significantly (Lincoln et al., 2008). This resulted in changes in service members' work and family lives (MacDermid et al., 2011). The new deployment cycle has many implications for military connected families.

**Deployment cycle.** Five stages are identified in the deployment cycle (Gambardella, 2008). The stages are (a) pre-deployment, (b) deployment (experienced during the first month away), (c) sustainment (during months 2-5), (d) re-deployment (the last month), and (e) post-deployment (3-6 months following the service member's return home; Gambardella, 2008). The sustainment and the post-deployment timeframes have changed in light of recent extended deployment timeframes. Today the sustainment period may be experienced during months 2-8, 2-11, or 2-14 rather than solely during months 2-5. The exact timeframe varies depending on the overall length of the deployment. Additionally, whereas the post-deployment stage occurred 3-6 months after redeployment, mental health professionals are increasingly working with military families facing post-deployment challenges. This work often is significantly longer than the previous 3-6 month time frame. Overall, the deployment cycle presents with unique emotional challenges for military families (Gambardella, 2008).

**Deployment Challenges.** When a service member deploys the family also deploys (Jordan, 2011). The deployment process is "...inherently stressful for military families" (Lowe, Adams, Browne, & Hinkle, 2012, p. 17). Each phase of the deployment cycle presents with specific challenges. Mansfield et al. (2010) noted that "increased stress among military family members before, during, and after deployment is a potential mechanism for the development of mental health problems" (p. 102).

During the pre-deployment stage, families may perceive that they are under extra military scrutiny so as not to disrupt the service members' performance and readiness for deployment (MacDermid et al., 2011). Families begin to deal with emotional detachment, emotional destabilization, and changes in roles and routines (Lincoln et al., 2008). Many of these issues continue in the deployment and sustainment periods where families typically experience the most challenges. Family members experience a series of ebbs and flows of emotions (Lowe et al., 2012).

*Children.* Children may communicate their feelings through behavior because they lack the required communication skills to act otherwise (Lowe et al., 2012). Children between the ages of three and five may be especially vulnerable to behavioral problems (Chandra et al., 2010). Children ages seven and older, particularly girls whose parents are deployed for extended periods of time, are likely to experience difficulty at home, school, and with their peers (Chandra et al., 2010). Behavioral problems may intensify for teenagers as the cumulative deployment increases (Clever & Segal, 2013). Cumulative length of increased parental deployment and parental distress of a non-deployed parent correlated with increased risk of depression and externalizing symptoms for children (Manos, 2010).

Relational attachment between non-deployed parents and children are negatively impacted by greater lengths of deployment times (Lowe et al., 2012). Attachment problems between non-deployed parents may stem from the daily responsibilities and stress, which compete with the child for the parent's attention (Lowe et al., 2012). Poor caregiver emotional wellbeing is associated with youth emotional, social, and academic well-being (Chandra et al., 2011). These relationships may require professional assistance in order to process feelings and work towards mutual relational growth and development.

Children may experience a spectrum of emotions when the formerly deployed parent returns home (Rossen & Carter, 2011). Some children may wonder whether their redeployed parent will remember or love them (Rossen & Carter, 2011). Older children reported experiencing more challenges with parental redeployment and reintegration (Chandra et al., 2011). Girls appeared to exhibit more difficulties than boys during this time (Chandra et al., 2011). The difficulties experienced by girls may be related to the roles, such as helping with household chores, which they assumed when the service member was deployed (Chandra et al., 2011). Girls may also experience difficulty reconnecting with their absent parent, who usually is a father (Chandra et al., 2011). Teenage girls may have the added difficulty of connecting with their father emotionally (Chandra et al., 2011).

*Spouses.* Non-deployed parents may experience changes in their emotional wellbeing. These parents often are trying to effectively function in the role of sole caregiver for children,

especially if other family members and friends are not close by to assist (Lowe et al., 2012). Incidences of one or more diagnosis for military wives whose spouses were deployed were higher than military wives whose spouses were not deployed during a study time period (Mansfield et al., 2010). Depression, anxiety, sleep disorder, acute stress reaction, and adjustment disorder were the most common diagnoses for these women (Mansfield et al., 2010). Army spouses participating in another study exhibited similar rates of psychopathology as soldiers returning from combat (Eaton et al., 2008). Likewise, Asbury and Martin (2012) conducted an empirical study which assessed the rates of depression, anxiety, isolation, and marital discord among wives of service members currently deployed, and their civilian counterparts. These researchers concluded that 80% of military spouses had frequently considered divorce compared to 17% of their civilian counterparts (Asbury & Martin, 2012).

Redeployment and reintegration can be challenging for the military connected family and the service member. Negative long term effects can be notable in the stability of the family unit if this time period is not properly undertaken (Lowe et al., 2012). Service members may struggle with substance abuse and engage in partner and familial violence (Weiss et al., 2010). Psychological distress and negative behavioral and emotional changes are likely to persist in all members in the absence of appropriate care for the family unit. These extensive changes may be related to unprocessed grief and loss.

### **Grief and Loss**

The majority of military connected families will experience the deployment of a family member or a PCS move outside of the continent U.S. (Clever & Segal, 2013). The challenges faced by military connected families as a result of PCS relocations and the deployment cycle may precipitate issues of grief and loss. The experience of grief and loss is inevitable to all humans (Duffey, 2005). The meanings ascribed to these losses are instrumental to an individual's well-being. Meaning making is an area where school counselors can appropriately assist military connected children and their families. Positive relational connections are vital (Duffey, 2005) as school counselors journey with these families working through issues of grief and loss. PCS related grief and loss may be related to the loss of friends, distance from extending family members, loss of social groups, moving and setup logistics, and adjusting to life in a new community. Military connected students may spend a significant amount of time in isolation from peers depending on the time of year the PCS move occurs (i.e., summer break).

Deployment related grief and loss may be associated with the loss of a spouse or parent in the home, parental mood changes, poor caregiver emotional wellbeing, and psychological impairments for various family members. Younger children often deal with confusion, loss, grief, and depend on the remaining parent for support (Clever & Segal). Older children may grieve the physical presence of their deployed parent in the home. If the parent is killed in action this loss usually precipitates a significant period of grief and mourning for the entire family. It is evident that many deployment related issues of grief and loss can continue into the post-deployment period.

Issues of grief and loss for National Guard and Reserve families may be related to their isolation from the larger military community. These families are especially susceptible to

experience grief and loss when their service member deploys or is away for training exercises. Children in these families may be the only military connected children in their class or their school (Clever & Segal, 2013). Teachers and administrators may be unaware of issues faced by these families and how to serve them.

### **Rationale**

The majority of military connected children attend civilian schools (Clever & Segal, 2013). Students enrolled in schools that are operated by the U.S. Department of Defense Education Activity (DoDEA) represent less than 13 percent of school-age military connected children (Clever & Segal, 2013). Children from active-duty families are more likely to attend schools in communities with a large military presence (Clever & Segal, 2013). Children from Guard and Reserve families are more likely to attend schools in communities with little military presence (Clever & Segal, 2013). Community members and school personnel where Guard and Reserve families reside are largely unaware that military connected children attend their schools (Clever & Segal, 2013). Reserve and Guard families report less community understanding of their military connected lifestyle (Chandra, Martin et al., 2010). As aforementioned, these families often struggle with isolation since they are not connected to the greater military community (Clever & Segal, 2013). Many military connected children experience discrimination from peers and teachers based on assumptions about their families and their political views (Chandra et al., 2011).

Military connected children sacrifice much due to their parent's or caregiver's military service. These children are 2.5 times more at a high risk for emotional and behavioral problems (Siegel et al., 2013). Children whose parents are away longer on repeated and extended deployments struggle more than their military counterparts (Clever & Segal, 2013).

The external stressors which military connected families experience differ greatly from those of their civilian counterparts. Military families need flexible policies which are adaptive and can support their families' dynamic and diverse needs (Clever & Segal, 2013). Preventative interventions can support health even in the presence of adversity (Cozza & Lerner, 2013). Resilience is an important component in support of the wellbeing of military connected families.

### **Building Resilience**

Easterbrooks, Ginsburg, and Lerner (2013) define resilience as "...sustained competence or positive adjustment in the face of adversity" (p. 100). The strength and resilience of military connected families and children is evident (Easterbrooks et al., 2013). Military connected families and military connected children can be strengthened in their resilience and overall wellbeing through supportive features in their family, school, and community (Easterbrooks et al., 2013). A supportive military environment can mitigate many of the stressors associated with frequent PCS moves (Clever & Segal, 2013). This can be accomplished by connecting military children to other children in their communities (Clever & Segal, 2013). Formal programs housed in military communities as well as school based programs as detailed later in this article, can be utilized to facilitate connections.

Social support is instrumental in mediating stressful life events (Heitzmann & Kaplan, 1988). Families should be encouraged to utilize their social support systems, whether informal or formal, to mediate many of the negative consequences of PCS moves and deployment. Families should be encouraged to continue connecting and building relationships amongst themselves and with others outside of their family (Hollingsworth, 2011). Furthermore, it is important to help parents understand social strains that their children may encounter (Clever & Segal, 2013). Parents should also be familiar with warning signs of behavioral problems (Clever & Segal, 2013). A balanced approach, one that measures risks and also incorporates the strengths of military families is appropriate (Cozza & Lerner, 2013).

School connectedness is a positive indicator in the degree of resilience for a military connected child. Children who feel connected to their schools are likely to exhibit positive behavior, succeed, and avoid risky behavior (Blum, n.d.). The work of school counselors and educators can be duly incorporated towards facilitating resilience in military connected children. School counselors are encouraged to incorporate interventions such as the suggested Military Family Resilience and Wellness program, which can appropriately assist military connected families in a variety of settings. Resilience ultimately is fostered through relationship in connection with others rather than isolation.

### **Military Family Resilience and Wellness Program**

A Military Family Resilience and Wellness program is an appropriate vehicle to provide military connected children and their respective families with the skills, resources, and resilience building strategies in support of their overall wellbeing. School personnel (counselors, teachers, and administrators) can be instrumented in this process for military families who do not have the support of extended family members or a military community. Information is presented about a program which school counselors can utilize in their work with military families. School counselors can utilize this model to emulate a similar program or as a framework to establish or grow their respective programs. Professionals are encouraged to do so from a multicultural perspective, incorporating culturally appropriate and inclusive interventions. School counselors are encouraged to review the Association for Multicultural Counseling and Development's document on Multicultural Counseling Competencies (Sue, Arredondo, & McDavis, 1992). The following are the individual components which are recommended for each program: (a) identify goal(s), (b) identify objective(s), (c) establish a budget, (d) recruit team members, (e) develop and implement process, and (f) conduct evaluations.

#### **Goals**

Each program should be goal oriented (Hall, 2008). Consistent with military culture, the program should have specific goals which team members can readily articulate to the target group. The target group includes military parents/guardians, caregivers, and children. School counselors should identify two to three goals for their program.

Each program should have the goal of formally identifying and establishing a relational connection with all enrolled military connected families and their children. Identification of military connected students can originate from information obtained on school enrollment forms.

Public and open-enrollment charter schools counselors in the state of Texas can readily obtain this information from school enrollment forms. Texas House Bill No. 525, which was signed into law in 2013, requires schools to collect and report information related to the number of military connected students who are enrolled in the school district annually to the Texas Education Agency (Texas Legislature Online, n.d.). School counselors serving in other states may develop and send a brief needs assessment form to parents where at least one question seeks to solicit parent's/guardians or primary caregivers military status. Relational connections can be established via email, telephone call, or face to face contact after military connected status is determined.

School counselors may find it difficult to work proactively rather than reactively with military connected families without this established goal. Consistent with military culture, many families have learned to maintain a degree of secrecy, stoicism, and a mistrust of outside sources (Hall, 2008). Some military connected families espouse mottos such as *suck it up and drive on* (Johnson, 2009), *stop your whining* and *shut up and color* (Kozlowski, 2014). These families may not solicit outsider assistance even in the midst of overwhelming stress and challenges. School counselors who cultivate a relationship with military connected families are better able to assist families in building resilience and wellness. Families, additionally, are more likely to seek assistance from school counselors who they trust and who they believe have an understanding of their family situation. School counselors may readily notice changes in a military connected child's behavior if this child was identified beforehand and relationships were fostered with the child and the family.

Another goal may be to cultivate a community which supports military families. This goal is recommended for all programs. A supportive military environment can mitigate many of the stressors military connected families encounter. The school counselor can work to build school connectedness with these children.

A third goal, which may be appropriate for a private, charter, or independent school, might be directed towards the retention of military connected families. Satisfied military connected families are likely to return to a school that is attuned to their needs and where other military families are also enrolled (See Table 1). This is consistent with components of military culture such as collectivism and group cohesion.

## **Objectives**

School counselors are encouraged to identify at least two objectives for each goal. Specific objectives will assist school counselors in identifying appropriate interventions. One objective may be to develop a welcome packet and a brief orientation (e.g., digital presentation) to the program. This objective is based on the first goal which is included in Table 1. A second objective may be to establish a personal contact with each military connected family (See Table 1).

Table 1. *Military Family Resilience and Wellness Program*

**Goal 1:** Formal identification and relational connection to all enrolled military families

- Objective:**
1. Develop welcome packet and brief orientation to program
  2. Establish personal contact with each military family (i.e. via email, telephone call, face to face meeting on campus) through means of school enrollment/ application form

**Goal 2:** Cultivate a community which supports military families

- Objective:**
1. Small group component (lunch group with students, after school group with parents)
  2. Photos of military families, service members in uniform (*no name or rank*) on program website, brochures, on walls in program office)
  3. Educational programs and Social Events (e.g. Veterans Day observation, Military Family and Military Child months celebrations)
  4. Incorporate military awareness and special events into educational curriculum
  5. Orientation to military culture workshop for school faculty & staff
  6. Yearly training for school faculty and staff towards working effectively with military families (e.g. military culture, challenges for military families, current research)
  7. Conduct periodic program evaluation
  8. Article or advertisement in local newspaper
  9. Develop Local Action Plan or Memorandum of Agreement with SLO and local military officials

**Goal 3:** Targeted retention of military families

- Objective:**
1. Determine needs of military families (Series of focus groups, round table discussions, one-to-one interviews with military connected children and parents/guardians)
  2. Maintain communication with families (i.e. via email, telephone call, program newsletter, social media outlets)
  3. Provide applicable resources (i.e. school programming, transfer records, graduations eligibility, counseling, deployment survival, self-help books, videos)

**Goal 4:** Military family outreach

- Objective:**
1. Encourage families to provide brochures and cards to friends and neighbors
  2. Video on school website
  3. Develop social media presence- (Facebook page, Twitter account, Google+ account)
  4. Program signature material (e.g. vehicle decals, pens, magnets, highlighters, notepads)

## **Budget**

It is important to establish a budget for the program. Important items to consider are staff positions, materials, and other operating costs. Some questions to consider are: Will the program coordinator be a paid or volunteer position? Will it be beneficial to have a program assistant or administrative assistant? What other staff positions will be helpful to include? Will these positions be paid or unpaid?

Other budgetary considerations may include marketing materials such as a welcome packet. All welcome packets should include contact information about program personnel (e.g., business cards). This packet could include print material (e.g., brochures) and digital information (e.g., DVD) about the program. The welcome packet may also include program promotional material such as magnets, pens, pencils, stickers, and car decals. Teams may consider developing advertisement campaigns for local newspapers, television, and social media outlets for their respective programs. Budgetary consideration may also include funding for an annual staff development workshop conducted by a subject matter expert and refreshments at program sponsored open house engagements and round table or focus group discussions.

## **Team Members**

Each program should establish a program team with various personnel. The principal person on the Military Family Resilience and Wellness program team is the program coordinator. This person is the designated school representative responsible for developing and managing the Military Family Resilience and Wellness program. The school counselor may function in this capacity. Schools that do not have a school counselor or districts with a larger budget may recruit a similarly qualified professional to function in this capacity. A local counselor educator with experience as a school counselor may be recruited. This counselor educator may also be able to recommend Master level students to support the Military Family Resilience and Wellness program. School counselor track students can volunteer to support the program in conjunction with class requirements or a service learning project.

It is recommended that each team consist of one to two parents/guardians of military connected children. The number of parents recruited to serve on the team should be representative of the various grade stages of the students enrolled in the school. For example a school with elementary through high school grades should have at least three parents (i.e., one parent to represent the elementary school aged students, one parent to represent the middle school aged students, and one parent to represent the high school aged students). Each parent representative should have at least one child who is enrolled in the corresponding grade section in the school. These adults should have firsthand knowledge of military life and culture and be familiar with the specific needs of the school.

The team should also include one teacher. However, similar to the parent/guardian representative(s), it is helpful to have teachers who can represent the various grade stages. Other team members may include a school administrator, and a community member such as a military veteran. The last member that is recommended on this team is the School Liaison officer (SLO). This person is a U.S. DoDEA representative who is assigned to serve the local civilian

community close to a specific military installation (Military K-12 Partners: A Department of Defense Education Activity Partnership Program, n.d.). Information for finding a SLO across the various branches of the military can be obtained from the Military K-12 Partners website (Military K-12 Partners: A Department of Defense Education Activity Partnership Program, n.d.). Schools without access to a SLO may enlist the assistance of a parent, military veteran, or community volunteer who is willing to serve as a liaison between the local school and a nearby military installation.

### **Process**

The process of developing and implementing a program is the most important component. The time frame for development and implementation will vary by school. Much of the time differential will be related to budgetary constrictions, availability of team members, and program goals. It is advisable to solicit the services of a military life/military family consultant throughout this process. This person should be able to assist the team in pinpointing appropriate resources, educate and train team members, define and refine program goals and objectives, and identify effective interventions.

### **Evaluation**

At least one comprehensive program evaluation should be conducted on a yearly basis. It is helpful, however, to conduct evaluations on an ongoing basis. Formal feedback should be solicited from the families served by the program. Separate evaluations should be established for parents/guardians and children. Families, however, should be encouraged to offer anonymous and named feedback (simple evaluations) on an ongoing basis. Feedback can be solicited using online survey based tools on the website or social media outlets utilized by the program, or in person via traditional paper versions.

Formal evaluations should also be solicited from each individual team member every quarter or every school report card period. The program administrator can likewise utilize online survey based tools or traditional paper versions to solicit feedback from team members. Team members may also offer feedback on an ongoing basis. Ongoing feedback should be solicited by the program coordinator during weekly team meetings.

Lastly, evaluations/feedback should be solicited from teachers, parents, and community leaders who are not directly involved, but familiar with the program. This type of feedback can be solicited to provide information regarding the impressions of the school environment as supportive of military families. Other specific program goals can also be assessed by this group of individuals. Similar means utilized with the parents/guardians and program staff can be utilized to elicit feedback from this group.

## **Best Practices**

### **School Counselors**

School counselors are encouraged to utilize a strength-based approach (Hall, 2008) in their work with military connected families enrolled in the program. If counseling or psycho-education is initiated with the family, children should also be included in the process (Lambert & Morgan, 2009). As noted above, school counselors should highlight & encourage military families to recognize their resilience as a positive factor (Lincoln et al., 2008). Furthermore, through this program, school counselors can promote relational connection among family members and with others in their respective communities.

### **Educators**

School counselors can encourage and assist teachers in infusing information in curricula to bring awareness to and celebrate military families. This may include lectures, class projects, and programs about Veterans Day, Military Family month, Military Child month, and aspects of military life. In the collaborative work with educators, two resources to become familiar with are the Interstate Compact on Educational Opportunity for Military Children and Common Core State Standards (CCSS). School counselors may assist administrators and educators in understanding the implications of these two policies for their schools.

## **Limitations**

School counselors are encouraged to seek consultation services from knowledgeable subject matter experts. Implementing a Military Family Resilience and Wellness program is likely to require information from numerous sources. It should be noted that successful program development and implementation requires a significant degree of time and expertise. School counselors are encouraged to seek assistance from a military life/military family consultant. School counselors may also seek assistance of local school counselor educators who can assist with research and serve as a consultant in the development, implementation, and evaluative components of the program. School counselors may also establish a partnership with local school counselor educators to obtain assistance from school counseling student interns.

Some families enrolled in the program may require more individualized services. The school counselor may determine that the family would be better served by a community mental health counselor due to time and scheduling constraints. Moreover, school counselors are encouraged to refer families to other trained professionals if presenting concerns are outside of the school counselor's scope of practice. Referral relationships should be established with local practitioners in advance. School counselors are also encouraged to be familiar with the Department of Defense health care program TRICARE. Families may wish to pursue mental health services through TRICARE providers. Professional referrals particularly for active duty families should include TRICARE approved providers. Families regardless of service members' activation status may wish to pursue non-medical counseling through Military OneSource (Military OneSource, n. d.).

School counselors should be aware that some families may be reluctant or disinterested in further interventions. This is consistent with the culture of secrecy, stoicism, and a mistrust of outside sources (Hall, 2008). The school counselor should continue to foster a relationship with the family with the hopes of gaining the families trust. School counselors should also be aware of their responsibilities in accordance with school policies and local mental health mandates for school aged children.

### **Key Points**

Several key points are notable. School counselors embarking on installing a Military Family Resilience and Wellness program should possess some basic knowledge about military life and culture. Likewise team members should pursue ongoing education and training in matters pertinent to military connected families. This can be accomplished through workshops and presentations at local, state, and national counseling professional conferences. Teams are encouraged to invite knowledgeable professionals with specialized information specific to military communities, marriage and family, resilience, child development, and trauma, to their campuses. Team members should be familiar with common psychological, educational, and social challenges which military connected children and their families encounter. The development and ongoing maintenance of this team should be a collaborative effort between school personnel, military connected parents/guardians, and local community members. In so doing, these adults can cultivate an environment in support of the overall wellness of military connected children and their families. Above all, team members are encouraged to be present, empathic, and flexible to the needs of their population.

### **Future Research**

Additional research is needed on effective interventions which support the wellbeing of military connected children and all children (Clever & Segal, 2013). School counselors who implement a Military Family Resilience and Wellness program are encouraged to formally evaluate and publish results of their specific programs. Military connected children deserve to have programs and policies which are engineered to appropriately address their development needs (Cozza & Lerner, 2013). Future research should also be devoted to further understand the implications of the post deployment timeframe for military connected children and their families.

### **References**

- Asbury, E. T., & Martin, D. (2012). Military deployment and the spouse left behind. *The Family Journal: Counseling and Therapy for Couples and Families*, 20(1), 45-50.  
doi:10.1177/1066480711429433
- Blum, R. (n.d.). *School connectedness: Extending connections to military children*. Retrieved from [http://www.jhsph.edu/research/centers-and-institutes/military-child-initiative/resources/Exec\\_Summary\\_R3.pdf](http://www.jhsph.edu/research/centers-and-institutes/military-child-initiative/resources/Exec_Summary_R3.pdf)

- Clever, M., & Segal, D. R. (2013). The demographics of military children and families. *The Future of Children, 23*, 13-39.
- Chandra, A., Lara-Cinisomo, S., Jaycox, L. H., Tanielian, T., Bing, H., Burns, R. M., & Ruder, T. (2011). *Views from the homefront: The experiences of youth and spouses from military families*. (Report No. TR-913-NMFA). Santa Monica, CA: RAND Corporation. Retrieved from [http://www.rand.org/pubs/technical\\_reports/TR913.html](http://www.rand.org/pubs/technical_reports/TR913.html)
- Chandra, A., Lara-Cinisomo, S., Jaycox, L. H., Tanielian, T., Burns, R. M., Ruder, T., & Bing, H. (2010). Children on the homefront: The experience of children from military families. *Pediatrics, 125*, 16-25. doi:10.1542/peds.2009-1180
- Chandra, A., Martin, L. T., Hawkins, S. A., & Richardson, A. (2010). The impact of parental deployment on child social and emotional functioning: Perspectives of school staff. *Journal of Adolescent Health, 46*, 218-223.
- Cohen, S., I. (2000). *Security clearances and the protection of national security information law and procedures* (Technical Report 00-4). Retrieved from <http://www.nationalsecuritylaw.org/files/pubs/Cohen.pdf>
- Cozza, S. J., & Lerner, R. M. (2013). Military children and families: Introducing the issue. *The Future of Children, 23*, 3-11.
- Defense Equal Opportunity Management Institute. (n.d). Retrieved from <http://www.deomi.org/Education&Training/CourseInfoIndex.cfm>
- Devore, D. I., Walters, T. J., Christy, R. J., Rathbone, C. R., Hsu, J. R., Baer, D. G., & Wenke, J. C. (2011). For combat wounded: Extremities trauma therapies from the USAISR. *Military Medicine, 176*, 660-663.
- Duffey, T. (2005). When the music stops: Releasing the dream. In T. Duffey (Ed.), *Creative interventions in grief and loss therapy: When the music stops, a dream dies* (1-23). New York, NY: Haworth Press.
- Easterbrooks, M. A., Ginsburg, K., & Lerner, R. M. (2013). Resilience among military youth. *The Future of Children, 23*, 99-120.
- Eaton, K. M., Hoge, C. W., Messer, S. C., Whitt, A. A., Cabrera, O. A., McGurk, D.,... Castro, C. A. (2008). Prevalence of mental health problems, treatment need, and barriers to care among primary care-seeking spouses of military service members involved in Iraq and Afghanistan deployments. *Military Medicine 173*, 1051-1056.
- Gambardella, L. C. (2008). Role-exit theory and marital discord following extended military deployment. *Perspective in Psychiatric Care, 44*, 169- 174.
- Hall, L. K. (2008). *Counseling military families: What mental health professionals need to*

- know*. New York, NY: Routledge, Taylor and Francis.
- Heitzmann, C. A., & Kaplan, R. M. (1988). Assessment of methods for measuring social support. *Health Psychology, 7*(1), 75-109.
- Hollingsworth, W. G. (2011). Community family therapy with military families experiencing deployment. *Community Family Therapy, 33*, 215-228. doi:10.1007/s10591-011-9144-8
- Johnson, E. (2009, May, 8). Suck it up and drive on. *Metro Spirit*. Retrieved from <http://www.army.mil/article/21255/suck-it-up-and-drive-on/>
- Jordan, K. (2011). Counselors helping service veterans re-enter their couple relationship after combat and military services: A comprehensive overview. *The Family Journal, 19*, 263-273. doi:10.1177/1066480711406689
- Knapp, L., & Torreon, B. S. (2014). *Reserve component personnel issues: Questions and answers* (Report No. RL30802). Retrieved from Congressional Research Service website: <http://fas.org/sgp/crs/natsec/RL30802.pdf>
- Kozlowski, D. (2014, February, 25). Reintroducing 'shut up and color'. *Lajes Field News*. Retrieved from <http://www.lajes.af.mil/news/story.asp?id=123401376>
- Lambert, S. M., & Morgan, M. M. (2009). Supporting veterans and their families: A case study and practice review. *The Family Journal, 17*, 241-250.
- Lawrence, J. H. (2006). Poultry and patriotism: Attitudes towards the U.S. military. In T. W. Britt, A. B. Adler, & C. A. Castro (Eds.), *Military life: The psychology of serving in peace and combat* (pp. 211–228). Westport, CT: Praeger Security International.
- Lincoln, A., Swift, E., & Shorteno-Fraser, M. (2008). Psychological adjustment and treatment of children and families with parents deployed in military combat. *Journal of Clinical Psychology, 64*, 984-992.
- Lowe, K. N., Adams, K. S., Browne, B. L., & Hinkle, K. T. (2012). Impact of military deployment on family relationships. *Journal of Family Studies, 18*(1), 17-27.
- McFarland, L. V., Choppa, A. J., Betz, K., Pruden, J. D., & Reiber, G. E. (2010). Resources for wounded warriors with major traumatic limb loss. *Journal of Rehabilitation Research & Development, 47*(4), 1-14. doi:10.1682/JRRD.2009.02.0017
- MacDermid Wadsworth, S., & Southwell, K. (2011). Military families: Extreme work and extreme “work-family”. *The ANNALS of the American Academy of Political and Social Science, 638*, 163- 183.
- Manos, G. H. (2010). War and the military family. *Journal of the American Academy of Child & Adolescent Psychiatry, 49*, 297-299.

- Mansfield, A. J., Kaufman, J. S., Marshall, S. W., Gaynes, B. N., Morrissey, J. P., & Engel, C. C. (2010). Deployment and the use of mental health services among U.S. army wives. *The New England Journal of Medicine*, 362, 101-109.
- Masten, A. S. (2013). Afterword: What can we learn from military children and families. *The Future of Children*, 23, 199-209.
- Military K-12 Partners: A Department of Defense Education Activity Partnership Program. (n.d.). *School Liaison Officer*. Retrieved from <http://www.militaryk12partners.dodea.edu/resources.cfm?colld=liaison>
- Military OneSource, (n.d.). *TRICARE: The Military's Health Care Program, Eligibility and enrollment section*. Retrieved from <http://www.militaryonesource.mil/>
- Pellerin, C. (2013, January 24). Dempsey: Allowing women in combat strengthens joint force. Retrieved from <http://www.defense.gov/news/newsarticle.aspx?id=119100>
- Petrovich, J. (2012). Culturally competent social work practice with Veterans: An overview of the U.S. Military. *Journal of Human Behavior in the Social Environment*, 22, 863-874.
- Rossen, E., & Carter, C. D. (2011). Supporting students from military families. *Principal Leadership* 11, 14-18.
- Segal, M. W. (1986). The military and the family as greedy institutions. *Armed Forces and Society* 13, 9-38.
- Siegel, B. S., Davis, B. E., and The Committee on the Psychological Aspects of Child and Family Health and Section on Uniform Services. (2013). Health and mental health needs of children in US military families. *Pediatrics*, 5, e2001- e2015. doi:10.1542/peds.2013-0940.
- Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies: A call to the profession. *Journal of Counseling & Development*, 70, 477-486.
- Texas Legislature Online (n.d.). *Bill: HB525, Legislative Session: 79(R)*. Retrieved from <http://www.legis.state.tx.us/tlodocs/83R/billtext/pdf/HB00525F.pdf>
- United States Army National Guard. (2014). *Our history*. Retrieved from <http://www.nationalguard.com/legacy>
- U.S. Department of Defense. (n.d.). *The United States military rank insignia*. Retrieved from <http://www.defense.gov/about/insignias/index.aspx>
- U.S. Department of Defense, The Directorate for Information, Operations, and Reports. (1998). *Selected manpower statistics, MOI*. Washington, DC: U.S. Government Printing Office.

- U.S. Department of Defense, Office of the Deputy Under Secretary of Defense. (2012). *2012 Demographics profile of the military community*. Retrieved from [http://www.militaryonesource.mil/12038/MOS/Reports/2012\\_Demographics\\_Report.pdf](http://www.militaryonesource.mil/12038/MOS/Reports/2012_Demographics_Report.pdf)
- Warner, C. H., Appenzeller, G. N., Warner, C. M., & Grieger, T. (2009). Psychological effects of deployments on military families. *Psychiatric Annals*, *39*(2), 56- 63.
- Weiss, E., Coll, J. E., Gerbauer, J., Smiley, K., & Carillo, E. (2010). The military genogram: A solution-focused approach for resiliency building in service members and their families. *The Family Journal*, *18*, 395-406. doi:10.1177/1066480710378479
- Wiles, C. E., & Nelson, H. W. (2009). "The National Guard for the National Guard" State Defense Force Medical Support for the National Guard. *Military Medicine*, *174*, 335.

## Integrated Treatment of Mental Health and Spiritual Concerns of Deployed Military

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### Abstract

*Military service members and veterans often encounter significant challenges related to their experiences in combat. These issues often cut across several domains such as mental health and spiritual functioning. Given the interrelated aspects of these concerns, counselors may struggle with simultaneously addressing mental health and spiritual functioning when counseling military members. The concept of wellness provides a useful framework in which to address the interconnected nature of mental health and spiritual concerns. The authors provide information on the nature of common issues associated with military deployment, effective treatment approaches to address these issues, and strategies for integrating mental health and spiritual issues within counseling. A case study is offered to assist with applying an integrated approach in counseling.*

**KEYWORDS:** *military, mental health, spirituality, interventions, integrated treatment*

Serving the needs of military personnel and families presents unique challenges for counselors working in a variety of settings. Whether providing services in a mental health agency; an elementary, middle, high, or post-secondary school; or in a rehabilitation setting, there is a high likelihood of encountering military personnel and/or families in need of assistance. Military personnel and families comprise a significant segment of our population. As of 2012, 1,455,552 individuals were on active duty in the U.S. military (U.S. Department of Defense, 2012). An additional 1,267,309 service members comprise the National Guard and

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Reserve components (Military Leadership Diversity Commission, 2010). Currently, roughly 7% of the population of the United States is comprised of veterans of military service (U.S. Census Bureau, 2014).

Elements of this population have been adversely affected by their recent engagements in the conflicts in Afghanistan (Operation Enduring Freedom, OEF) and Iraq (Operation Iraqi Freedom, OIF). According to the U.S. Department of Defense (Casualty Status, 2014), there were 6,628 total fatalities (including those killed in action and in non-hostile action) and 51,899 wounded in action (WIA) related to service in OEF and OIF as of December, 2014. In addition, many service members may return with polytraumatic injuries such as traumatic brain injury, injuries to several body systems (e.g., skin/soft tissue, eye injuries, etc.) complex pain syndromes, and PTSD (Collins, & Kennedy, (2008). In relation to mental health challenges, 300,000 (20 percent) of those who have served in Iraq and Afghanistan suffer from post-traumatic stress disorder or major depression (Tanielian & Jaycox, 2008). Along with other psychological concerns such as high rates of suicide for veterans under 30 years old (Kemp, 2014), there seems a unique landscape of needs within the population of military veterans.

In addition to the physical and psychological concerns, there are concerns about the moral elements of combat. Often in war, those who engage in combat are confronted with issues of morality in prosecuting their duties. In the midst of battle, one may need to put aside previously held beliefs around morality to ensure the safety of self and others (Drescher & Foy, 2012). The risk for moral injuries associated with combat experience especially within the recent conflicts in which enemy combatants are often embedded among civilians is significant (Drescher & Foy, 2012).

Apart from encountering issues with morality in combat, there are indications that spirituality is a primary consideration amongst the general population and by extension military members. One study found that spiritual and religious practices among Americans is strong; 96% of people living in the U.S. believe in a God, 90% report to praying, 69% state they are members of a religious structure, and 43% state they have attended their religious institution in the past seven days (Princeton Religious Research Center, 2009). Given the question of morality faced in combat and the valuing of religious and spiritual beliefs, integrating these considerations when working with military service members appears warranted.

The purpose of this paper is to describe an integrated counseling wellness model that offers a framework in which to address issues common in this population, provide insight as to the connected aspects of challenges faced by military members in relation to deployment, and offer specific interventions that address the multi-faceted needs of military service members around mental health and spiritual concerns. A case study is provided as an example of the utilization of this integrated approach in addressing the needs of a client.

### **Wellness Approach**

Wellness models offer a framework for counselors to address clients mental health needs by providing a rationale for appropriate treatment. The first recognized model of wellness applied to the counseling profession was developed by Sweeney and Witmer (1991) and Witmer

and Sweeney (1992). Rooted in Adlerian Individual Psychology, the Wellness Wheel provides a cross-disciplinary approach used to identify components for quality of life and improvement in overall health. Myers, Sweeney, and Witmer (2000) built on Adler's premise that the self is indivisible and purposeful and humans are more than just their parts; therefore, treatment must be multi-dimensional. The original wellness model balanced six essential dimensions: intellectual, emotional, physical, social, occupational, and spiritual. Spirituality was purposely placed in the center of the wheel and was considered the core and most crucial component of well-being. In this version of the model, spirituality focused on a person's meaning in life and religious/spiritual beliefs, rituals, and practices.

The Wellness model increased in complexity with 12 components of self-direction, viewed as the driving force of the wheel; awareness of self-worth, awareness of self-control, realistic beliefs, emotional responsiveness and management, intellectual stimulation, problem solving and creativity, sense of humor, exercise, nutrition, self-care, stress management, gender identity, and cultural identity. Further the revised model integrated an ecological basis indicating other forces such as the government, media impact, and global experiences influence the wellness of individuals (Myers & Sweeney, 2005). The components of the wellness model can be integrated to allow an individual to regain those ideals, sense of normalcy, or develop a new normal. This is crucial when evaluating a person's perception of his/her needs and how to get the person to his/her baseline or to develop a new normal.

In addition to the attention to spirituality within wellness models, focus on spirituality seems beneficial to integrate within mental health interventions specifically when working with military service members. Spiritual and religious beliefs and practices have been viewed as impacting worldviews, behaviors, and coping at religious ceremonies and services (Biema, 2001). There are indications spiritual/religious elements positively impact mental health concerns. Spiritual practices, having a strong support system, assigning meaning to traumatic events, and overall positive thinking may be linked to decreasing posttraumatic stress (Meisenhelder, 2002). Prayer, meaning, and positive faith have been linked to lower symptoms of posttraumatic stress to those directly and indirectly exposed to the trauma. Gerber, Boals, and Schuettler (2011) found positive religious coping practices were related to posttraumatic growth and decreased symptoms associated with posttraumatic stress. In a study of current deployed military, Harris et al. (2011) found individuals who perceived their Higher Power as a source of validation and acceptance were more likely to find healthy meaning in their deployment and to recover from trauma. Accurate assessments are needed in counseling to determine spiritual and religious practices and how these practices may have been impacted. Building on this complex wellness model, with spirituality being the core, a case study of Fred will attempt to utilize the wellness model and demonstrate how counselors may integrate the various treatment options for Fred to address the 12 essential components of the wellness model.

### **The Cycle of Deployment**

In order to understand the unique experience of military members, it is useful to consider the experience of deployment related to the recent engagement in Afghanistan and Iraq providing context in the examination of their psychological and spiritual well-being. The deployment cycles in the conflicts in Iraq and Afghanistan have been unique in length and frequency

(Lincoln, Swift, & Shorteno-Fraser, 2008). The length of deployment, which was once fairly predictable, has been unpredictable given frequent deployment extensions and multiple deployments during Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). The deployment cycle is not solely a service members' time in theatre, but also her/his time away from home (Erbes, Polusny, MacDermid, & Compton, 2008). Logan (1987) first conceptualized deployment as a cycle as opposed to a singular event (Lincoln et al., 2008) and has since be refined to include five distinct phases: (a) pre-deployment (from notification to departure), (b) deployment (from departure to return), (c) sustainment, (d) redeployment, and (e) post-deployment (Pincus, House, Christensen, & Adler, 2005). Each phase can affect both service members and their families.

During pre-deployment, spouses or partners prepare to rely on alternative sources of social support (Erbes et al., 2008) and form new roles and norms for the household. Children within the family require significant logistical arrangements as the non-deployed caregiver likely will function as a single parent for an extended period of time. There also exists the potential that the serving member may not return at the designated time, requiring additional preparation and coping by the family.

During deployment, it is typical for both partners to worry about the safety and well-being of family members in addition to concern for maintaining the relational bond (Erbes et al., 2008). Current technology allows for unprecedented communication between service members and family members, but these interactions do not always prevent or minimize stress. Issues experienced by both the deployed service member and the non-deployed partner still occur without problem resolution. Awareness of various concerns may increase due to ongoing verbal and visual communication while limitations due to physical distance may inhibit both partners from fully addressing certain concerns. Children may also struggle in the absence of a caregiver. Celebrations and milestones are often missed by the deployed member, which can result in a greater sense of isolation and alienation within the family.

Post-deployment (or reintegration) presents the potential for numerous concerns including adjustment back into the family (Erbes et al., 2008), adapting to new roles and rules in the family, reinforcing one's authority in the house, and addressing internal or external blame/guilt for the absence. The reintegration period entails the service member and partner reconstructing their relationship and roles at home as both have likely changed due to the deployment. The family must also adjust to resuming of roles as partner and parent (Lincoln et al., 2008) as changes in caretaking roles, discipline, and other familial functions often have changed.

This cycle of deployment presents significant elements to consider when assisting military personnel and families. These considerations of harm to oneself as well as to loved ones in addition to unpredictable patters of separation can create stress both for the service member and his or her family. Many of these issues during the deployment process raise questions related to emotional and psychological well-being in addition to a sense of meaning and purpose for deployed service members and their families. These unique considerations in relation to aspects of life related to the cycle of deployment appear worthy of attention when counseling the individual or family members.

### **Mental Health Issues for Military Personnel in Relation to Deployment**

Apart from the experience of deployment, there have been indications of significant psychological distress for those experiencing combat. Recent conflicts have involved, for the first time in history, a greater number of psychological casualties related to combat than physical injuries or deaths (Sammons & Batten, 2008). Projections of the current rate of psychological issues resulting from active service indicate that over 30% of combatants will develop symptoms consistent with a mental health diagnosis. There are indications that 40% of OEF (Afghanistan) and OIF veterans have or are accessing services at the Department of Veterans Affairs Medical Center for mental health concerns, including posttraumatic stress disorder (PTSD), anxiety, and depression (Sammons & Batten, 2008). The depth of these issues which often deeply impact service members' worldview can have an existential/spiritual element to consider when addressing their needs.

Apart from the high prevalence of mental health issues, traumatic brain injury (TBI) is especially significant in recent military conflicts. Appropriate referrals should be made to medical professionals to ensure treatment of the whole person. Even though injuries and issues may increase over time, there is also an indication that symptoms of combat-related mild TBI or PTSD may disappear or be significantly reduced after returning from combat. Milliken, Aucheterlonie, and Hoge's (2007) study found that as many as 50% of service members experiencing PTSD did not exhibit any symptoms after three months post-deployment. Hoge et al. (2004) reported several service members who have mild TBI (sometimes referred to as a concussion) did not experience symptoms within 4 to 12 weeks post-deployment. A counselor encountering these issues would benefit from determining both the symptomatology related to PTSD and mild TBI, the timeframe associated with the injury, and the past and current treatment implemented to address these issues.

In addition, there has been a fair amount of media attention given to the growing rate of suicide of service members (Roan, 2012). Additional analysis has determined a significantly higher rate of suicide of veterans in comparison to the nonveteran population (Kaplan, McFarland, Huguet, & Newsom, 2012) although the reported underlying issues in suicides remains connected with relationships. Service members are also at risk for substance abuse issues (Jacobson et al., 2008) and short-term readjustment reactions manifesting as difficulty sleeping, irritability, and difficulty concentrating (Shea, Vujanovic, Masfield, Sevin, & Liu, 2010).

Women service members face additional stressors. A study of women veterans in the military who have sought services for PTSD found that 23% reported military sexual trauma (Skinner et al., 2000). The high rate of military sexual trauma presents a unique challenge for women who serve in the military. Thus, counselors must have an understanding of how this increased victimization may also impact one's religious and spiritual growth and connections. The indicated issues around psychological and physical trauma, high prevalence of suicide and exposure to sexual trauma on the part of women military service members can affect psychologically and spiritually functioning for clients connected to the context of the military. Given the connection between these elements of the human experience, counselors would benefit

from considering methods, which simultaneously address both mental health and spiritual considerations.

### **Integrated Framework to Address Mental Health and Spiritual Concerns**

The overwhelming majority of research on deployed military and their families have focused on stressors associated with combat deployment such as depression, violence, PTSD, and reintegration within the family and society. Counseling interventions often occur post-deployment after the military member returns home and a mental health concern is evident. There is a paucity of research related to strategies to address the religious and spiritual elements of military members concerns. Given the aforementioned integrated wellness conceptualization of attending to multiple needs of the client, interventions can be developed to address the unique experience of military service members.

### **Common Interventions for Mental Health Issues of Deployed Military**

There is little information in the literature as to ways in which to integrate interventions related to mental health and spiritual considerations. To provide a basis in which to address the mental health considerations common in this population, specific interventions are offered to provide strategies through which a counselor can intervene. This discussion of interventions will provide specific interventions to address common issues among military personnel, such as PTSD, TBI, and suicide. The approaches reviewed are by no means an exhaustive list of ways to support military personnel and families. This discussion is intended to provide tangible approaches to intervene in common situations of deployment related mental health issues in addition to connecting this to issues of spirituality.

**Resilience training for PTSD.** There has been greater emphasis within military mental health on building preventive resilience to PTSD prior to exposure to traumatic events. Working with service members to develop resilience when it is apparent they are likely to be exposed to traumatic events provides a preventive approach as opposed to addressing PTSD. This would involve education and counseling prior to a deployment to assist in decreasing crisis, in this case PTSD. Casey (2011) provides a detailed description of resilience training within the U.S Army which may assist a counselor in developing knowledge and skills related to this intervention. Working with service members prior to deployment to enhance resilience exploring all facets of resources such as mental health and religious/spiritual assets can create protective factors to distress for military service members. Assessing military service members valuing of spiritual beliefs and practices can be useful in developing strategies of enhancing resilience against such concerns as PTSD can integrated resilience training. Regular engagement in various practices such as meditation and prayer can be a focus of resilience against PTSD.

**Trauma-focused cognitive-behavioral therapy.** Trauma-focused cognitive-behavioral therapy (CBT) involves confronting the memories of the traumatic events and the feared and avoided external situations that remind clients of the events (Creamer, Fletcher, Wade, & Forbes, 2011). These maladaptive interpretations and beliefs associated with the events interfere with adaptation and recovery (Forbes et al., 2007). One intervention within trauma-focused CBT that has evidence of being effective is prolonged exposure techniques in which the service member is

exposed to the stressful or feared event *in vivo* (Foa, Rothbaum, Riggs, & Murdock, 1991; Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010). Specialized training is mandated prior to implementing this type of intervention. Focusing on the impact of the trauma both on psychological functioning and meaning-making on the part of the client can provide a deeper-level examination of the issue and properly inform the work of the counselor.

The focus on the beliefs and messages related to experiences associated with cognitive-based interventions leads to infusing spiritual elements when appropriate. Discussing the impact of traumatic events within several facets of one's experience such as his or her spiritual beliefs opens up potentially meaningful discussions beyond the mental and affective domains. Encouraging clients to access spiritual tools when reprocessing traumatic events via exposure techniques can provide additional resources needed to weather discomfort during this experience. Adapting the use of spiritual interventions based on the beliefs of the client can enhance the use of trauma-based cognitive behavioral therapy.

**Cognitive-processing therapy (CPT).** Cognitive-processing therapy (CPT) focuses on the range of emotions, in addition to anxiety, that may result from traumatization (e.g., shame, sadness, anger). One benefit of this approach with PTSD is that CPT can be generalized to comorbid mental health conditions and day-to-day problems, and also integrates issues associated with purpose and meaning or other existential issues. It is through this focus on the existential elements that discussions around the level of identification with spiritual principles can occur. Depending on the views of the client, developing spiritual-oriented strategies to address daily manifestations of mental health concerns can be utilized as a pragmatic adjunctive intervention couples with the cognitive techniques of this approach.

Cognitive-processing therapy can be implemented using a 12-session, manualized approach (Resick, 2001) focused primarily on cognitive interventions such as writing an impact statement; identifying the connection between thoughts, feelings, and events; and challenging problematic beliefs and cognitions when appropriate. Identifying and addressing affective and cognitive elements of traumatization are hallmarks of this approach.

The infusion of mental health and spiritual principles is primarily determined by the needs of clients in addition to their identification with elements of religious and spiritual principles. Developing skills and facilitating these types of clinical interactions may result in therapeutic benefit to clients. Though there may be a fine line between integrating spiritual principles into mental health interventions and imposing the values of the counselor on the client, being open to utilizing spiritual principles within mental health interventions based on the belief system of the client can create a powerful mode of support.

### **Case Study**

The following case study is designed to provide a tangible illustration of a wellness approach that focuses on integrating mental health and spiritual concerns when working with active-duty military service members and veterans in counseling. This discussion is by no means intended to offer a confining or exclusive view of religious/spiritual views either on the part of the client or counselor participating in this process. It is understood that both parties may have

varying identities and degrees of belief related to religious/spiritual matters. The population of military veterans is diverse in ethnicity, political affiliation, race, religious or nonreligious affiliation, sexual orientation, and several other characteristics. Though the case study lends to a specific approach, the benefit of providing a detailed example appears to outweigh the exclusionary elements of this discussion. It is hoped the adaptability in application will be continually considered by the reader throughout the case study.

The case of Fred is designed to offer a concrete example of ways in which a counselor can examine and intervene from a wellness perspective when working with service members struggling with mental health and other life issues and questions of meaning stemming from experiences within the military. The case is derived from the collective experiences of the authors as opposed to an actual clinical interaction. While the specific content related to psychological and spiritual considerations may differ depending on the client, the process of examining and addressing these types of concerns can be facilitated across a broad spectrum of the military population.

### **Case of Fred**

Fred is a military service member in his late twenties who joined the service post-9/11. He engaged in two deployments in Iraq and one in Afghanistan. He had recently separated from the military and was pursuing educational goals. He was not exactly clear as to his desired career, but believed he would find something that fits once he resumes his education. Fred had been in counseling, with the encouragement of his girlfriend, Angela, at a community agency to discuss his difficulty adjusting to civilian life and his emotional outbursts directed toward his girlfriend.

He reported struggling to find work and getting frustrated with his girlfriend when she continually asked him about his experiences during deployment. During the initial intake, Fred identified as a practicing Christian, but his experiences during deployment had raised some questions related to his religious beliefs and sense of meaning. Fred and his counselor began to process his emotional outbursts and examine his transition out of the military. Fred had reported some health-related concerns that surfaced during reintegration.

The multiple issues presented by Fred are not uncommon to most military individuals with similar deployed experiences. Addressing Fred's varied concerns primary and secondary concerns using a wellness approach were critical to his healing process.

### **Addressing Fred's Concerns**

Situations like Fred's occur within a broader context of experience requiring a counselor to have a basic understanding of common experiences of military members and those close to them. In Fred's situation, the counselor initiated the counseling relationship by inquiring about Fred's military experience.

*Counselor:* So Fred, I understand you have some things you are trying to address in terms of adjusting to separating from the military and your relationship with your girlfriend. It would be helpful for me to understand aspects of your military experience to the degree

you feel comfortable sharing this information at this time. Tell me about your time in the service.

This exploration into Fred's experience assisted with assessing the meaning Fred has made about his time in the military in addition to the potential existence of psychological distress related to this experience. Fred indicated he lost several members of his unit in a fire fight in Afghanistan, which has been very difficult for him. Fred stated he thinks about this situation at least once a day experiencing anger about what happened as well as not being sure why he was spared. After some additional discussions, Fred processed his experience in the military called into question his sense of purpose and by extension his Christian beliefs as he was unsure how things he witnessed could happen in a world governed by a higher being.

The counselor was sensing a few different issues in need of attention. Fred may have some trauma associated with his loss of unit members while also having his belief system shaken as a result of these experiences. To address the shame and guilt along with the problematic beliefs and cognitions, the counselor determined elements of cognitive processing therapy along with exploration of Fred's spiritual standing was an appropriate approach. With this strategy in mind the counselor began to engage with Fred around his issues.

*Counselor:* Fred, I appreciate you sharing these difficult experiences with me. I am sure it was not easy both to experience these things as well as share them with me. I am curious to the degree these experiences are affecting you now in your adjusting to being out of the military as well as with relationship with your girlfriend. It also seems like you aren't sure of how to address your questions of your belief in God, which have been impacted by what you experienced while deployed. What are your thoughts on what I just shared?

*Fred:* Yeah, things have been tough for me. I am not quite sure what to make of what happened over there. I am not sure if it is connected to my issues with Angela (girlfriend), but I guess it could be. Regarding the God thing, I have no idea how to deal with that. I really just don't get how some higher being would allow things like what I saw happen. Just not sure of my purpose in the world at this point. I wouldn't even know where to begin, but my belief is important to me though so I guess it would be good to think about it.

*Counselor:* I hear that these things can be difficult to consider and comprehend. In terms of the issues with what happened during your deployment, it might be useful for us to discuss how your thoughts and feelings related to what occurred (Trauma-focused Cognitive Behavioral Therapy). Regarding the question of your faith, we can explore what goals you would like to develop in relation to this aspect of your experience and what steps we can take to get there. We may find at times we want to consider speaking with other professionals such as a spiritual advisor related to this question, but we can cross that bridge when it seems appropriate. How does that sound?

*Fred:* That seems fine. Not sure about the spiritual advisor piece, but we'll see how things play out. Certainly seems like a good place to start.

The counselor and Fred continued with their work. There were indications of post-traumatic stress such as re-experiencing various traumatic events and intrusive thoughts, but not fitting the full criteria for PTSD due to a lack of stimuli avoidant behavior (American Psychiatric Association, 2013). Fred began to discuss the experiences he had during deployment. The loss of

his unit members had deeply affected him due to his close connection with them. Fred processed his beliefs associated with these events identifying thoughts such as “I should have done more to prevent this from happening,” and “why did I survive and they did not?” These questions of meaning and purpose along with issues resulting from the trauma warranted the counselor to address both the mental health and spiritual elements of Fred’s experience.

He explained how his anger with Angela often is expressed after watching the news or speaking with one of his unit members. The counselor and Fred began to develop strategies to process Fred's emotions related to these experiences expanding his emotional vocabulary around his feelings related to watching the news or speaking with a unit member.

Related to the issues of trauma especially with Fred’s blaming himself for unfortunate demise of his unit members, the counselor and Fred examined these beliefs determining if they were functional and replacing them with beliefs such as “I did all I could to serve my fellow unit members. For reasons unknown, I survived to honor those who have fallen.” This protracted process of identifying and replacing problematic beliefs began to reshape elements of Fred’s perspective enabling him to begin to view his life as having meaning.

After much work, Fred determined that he desired to focus on his sense of meaning and purpose and its connection with his Christian beliefs. The counselor and Fred discussed this matter, but it appeared Fred desired to examine specific questions such as where in the Bible it discusses death and suffering, which was seemingly outside the purview of the counseling relationship. After consultation, it was determined Fred might benefit from meeting with a spiritual advisor.

Fred began meeting with a local spiritual leader at a church he frequented when he was younger to discuss his beliefs associated with this process. The counselor asked Fred to sign a release allowing the counselor to speak with his pastor about their work to ensure they are coordinating their efforts. The counselor emphasizes he did not intend to influence Fred’s spiritual development in a particular direction, but was honoring this important aspect of his value system. Fred discussed how he began to pray again regularly to address his emotional upheaval using the Serenity prayer suggested by his pastor to assist him when upset. Fred indicated a desire to include this in session when he became agitated discussing his experiences. The counselor honored this request pausing the session when Fred indicated a need to pray.

The counselor emphasized using all resources including his belief in God as a mechanism of support to address his development of effective methods for addressing his experiences in combat, his anger with Angela, and his psychological and spiritual functioning. The counseling concluded with Fred indicating tangible growth in these areas and a desire to employ mutually identified methods for addressing his concerns with the potential to return to counseling at any point if desired.

Along with the mental health and spiritual concerns, the counselor worked with Fred to examine and address other life issues and concerns. Since his return from combat, Fred had found it increasingly difficult to communicate with Angela. He reported communication problems existed between them prior to deployment and have worsened following his return.

During their work together, Fred revealed that it had always been difficult to be vulnerable in intimate relationships because of his low self-concept and self-worth when attempting to get close to women. His emotional outbursts, while more prevalent since his return from combat deployment, were also a way to create distance between him and others to minimize feelings of vulnerability. Through his work in counseling, Fred was able to identify the source of these maladaptive beliefs and begin to challenge their validity. The counselor also used role-play techniques to help Fred practice communicate his feelings appropriately. In conjunction with role-playing, communication skills training was infused into their work to provide a mechanism to help Fred learn appropriate methods of expression with Angela and others. Additional conversation on Fred's renewed interest in his spiritual beliefs as it relates to his romantic relationships was also discussed when appropriate with Fred being the initiator of these discussions.

Fred's lack of clarity regarding his occupational direction appeared to be creating additional stress and frustration. Working with the counselor, Fred deconstructed the gender and cultural roles underlying the occupational struggles. Fred mentioned that he grew up in a family where men were expected to engage in traditional blue collar gender work roles. Being in the military was one of those expected roles of all males, with five generations serving in the armed services. Part of Fred's occupational confusion related to breaking from his family's expectation that he work in the local factory or go back to school to learn a "real trade" such as plumbing or carpentry rather than pursue his desire to tap into more creative and artistic aspirations such as computer animation, graphic design, and photography. Fred and the counselor explored career options and the messages associated with these cultural and gender role expectations. The counselor, using career developmental and trait-factor models supplemented with career assessment tools, helped Fred explore career options and gain occupational clarity while processing the expectations and messages he received from his family.

Another issue that has surfaced since Fred's reintegration has been his poor dietary patterns, weight gain, and development of Type II diabetes. Prior to deployment, Fred was quite active and prided himself in being in good shape. Since his deployment he has been stress eating to cope with the stress of deployment and difficulties with reintegration. Fred reported that eating had been "a way to cope with all the things that have felt overwhelming and beyond my control." The counselor and Fred examined better means of managing his stress such as returning to an exercise regimen with specific goals and activities. They also worked to identify triggers to stress eating and process the underlying causes as well as restructuring his thoughts so he can manage these triggers. The counselor also taught Fred relaxation techniques and meditative tools that could be used to increase self-efficacy and gain control over urges and cravings associated with stress eating. Psychoeducation was also used to help Fred learn about healthy eating, nutrition, and managing his Type II diabetes.

### **Conclusion**

Though the specifics of Fred's experience offer a confining view of a method to simultaneously address his concerns, the process of examining meaning and purpose concurrently with psychological distress can be applied in other clinical interactions. The work with Fred encompassed several elements of his experience aligning with the holistic approach of

the Wellness model. Though much ground was covered, integrating these different concerns in a cohesive manner was critical in this clinical engagement. In regards to religious/spiritual belief structure, the willingness to attend to these connected domains of functioning and involve religious/spiritual advisors such as imams, ministers, pastors, priests, or rabbis as collaborative helpers in the process of working with military service members can provide a deeply meaningful framework for helping.

Serving the needs of military personnel and families presents unique challenges for counselors working in a variety of settings. The likelihood of counseling a military member who has been deployed or working with family members during deployment continues to increase, even with the reduction of the fighting force abroad. Many military members will take advantage of counseling services provided in their civilian and military communities. Deployments offer a unique experience and many deployed military may encounter physical, mental health, and spiritual issues requiring collaboration and services from counselors. Families left behind during deployment also may experience mental health concerns requiring professional counseling services. Most military and families make adjustments and do not encounter individual or family crises. Others may require some additional assistance to deal with the deployment or reintegration back into the family and culture.

The counseling field has a variety of behavioral, cognitive, and integrative approaches to address family adjustments and other psychological issues related to deployment and combat related experiences. However, one element that may be missing is the integration of one's spiritual and/or personal religious/faith base that may be essential in the treatment and healing process. Counselors who are working with military members may find it beneficial to integrate spirituality and religious identity during pre-deployment, deployment, and post-deployment training as well as counseling opportunities in an effort to treat the whole person. In taking an integrative preventative approach, counselors who are working with military prior to deployment may find it helpful to the service member to treat the whole person and explore all the aspects on the wellness, including spirituality and religious practices. In being willing to simultaneously the comprehensive needs of this population, counselors can offer a holistic level of support to enhance development in all areas of functioning.

## References

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5<sup>th</sup> ed.). Arlington, VA: Author.
- Biema, D.V. (2001, October). Faith after the fall. *Time*, 158, 76.
- Casey Jr., G.W. (2011). Comprehensive soldier fitness: A vision for psychological resilience in the U.S. Army. *American Psychologist*, 66(1), 1-3.
- Collins, R. C., & Kennedy, M. C. (2008). Serving families who have served: Providing family therapy and support in interdisciplinary polytrauma rehabilitation. *Journal of Clinical Psychology: In Session* 64(8), 993-1003.

- Creamer, M., Wade, D., Fletcher, S., Forbes, D. (2011). PTSD among military personnel. *International Review of Psychiatry* 23, 160-165.
- Drescher, K.D., & Foy, D.W., (2012). When they come home: Posttraumatic stress, moral injury, and spiritual consequences for veterans. *Reflective Practice: Formation and Supervision in Ministry* 28, 86 – 102.
- Erbes, C. R., Polusny, M. A., MacDermid, S., & Compton, J. A. (2008). Couple therapy with combat veterans and their partners. *Journal of Clinical Psychology: In Session* 64, 972-983.
- Foa, E., Rothbaum, O., Riggs, D., & Murdock, T. (1991). Treatment of posttraumatic stress disorder in rape victims: A comparison between cognitive-behavioral procedures and counseling. *Journal of Consulting and Clinical Psychology* 59(5), 715-723.
- Forbes, D., Creamer, M., Phelps, A., Bryant, R., McFarlane, A., Deville, G.,...Newton, S. (2007). Australian guidelines for the treatment of adults with acute stress disorder and post-traumatic stress disorder. *Australian and New Zealand Journal of Psychiatry*, 43, 637-648.
- Gerber, M. M., Boals, A., & Schuettler, D. (2011). The unique contributions of positive and negative religious coping to post traumatic growth and PTSD. *Psychology of Religion and Spirituality*, 3, 298-307.
- Harris, J. I., Erbes, C.R., Engdahl, B. E., Thuras, P., Murray-Swank, N., Grace, D., & Le, T. V. (2011). The effectiveness of a trauma-focused spiritually integrated intervention for veterans exposed to trauma. *Journal of Clinical Psychology*, 67, 425-438.
- Hettler, W. (1984). Wellness: Encouraging a lifetime pursuit of excellence. *Health Values: Achieving High Level Wellness*, 8, 13-17.
- Hoge, C. W., Castro, C. A., Messer, S. C., McGurk, D., Cotting, D. I., & Koffman, R. L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine*, 351, 13–22.
- Jacobsen, I. G., Ryan, M. A., Hooper, T. I., Smith, T. C., Amoroso, P. J., Boyko, E. J.,... Bell, N. S. (2008). Alcohol use and alcohol-related problems before and after military combat deployment. *Journal of the American Medical Association* 300, 663-675.
- Kaplan, M., McFarland, H., Huguet, N., & Newom, J. (2012). Estimating the risk of suicide among US veterans: How should we proceed from here? *American Journal of Public Health* 102(S1), S21-23.
- Kemp, J.E. (2014). *Suicide rates in VHA patients through 2011 with comparisons with other Americans and other veterans through 2010*. Veterans Health Administration. Retrieved from: <http://www.blogs.va.gov/VAntage/11973/january-2014-va-suicide-data-update/>

- Lincoln, A., Swift, E., & Shorteno-Fraser, M. (2008). Psychological adjustment and treatment of children and families with parents deployed in military combat. *Journal of Clinical Psychology: In Session 64*, 984-992.
- Logan K.V. (1987). The emotional cycle of deployment. *U.S. Naval Institute Proceedings 113*, 43-47.
- Meisenhelder, J. B. (2002). Terrorism, posttraumatic stress and religious coping. *Issues in Mental Health Nursing*, 23, 771-782.
- Myers, J. E., & Sweeney, T. J. (2004). The Indivisible Self: An Evidence-Based Model of Wellness. *Journal of Individual Psychology*, 60(3), 234-245.
- Myers, J. E., Sweeney, T. J., & Witmer, J. M. (2000). The Wheel of Wellness counseling for wellness: A holistic model for treatment planning. *Journal of Counseling and Development*, 78(3), 251-266.
- Milliken, C. S., Auchterlonie, J. L., & Hoge, C. W. (2007) Longitudinal assessment of mental health problems among active and reserve component soldiers returning from the Iraq War. *Journal of the American Medical Association*, 298, 2141 – 2148.
- Military Leadership Diversity Commission (2010). *National Guard and Reserve Manpower*. Retrieved from: [http://mldc.whs.mil/download/documents/Issue%20Papers/53\\_Manpower.pdf](http://mldc.whs.mil/download/documents/Issue%20Papers/53_Manpower.pdf)
- Pincus, S. H., House, R., Christensen, J., & Adler, L. E. (2005). *The emotional cycle of deployment: A military family perspective*. Retrieved from: <http://www.hooah4health.com/deployment/familymatters/emotionalcycle.htm>
- Powers, M., Halpern, J., Ferenschack, M., Gillihan, S., Foa, E. (2010). A meta-analytic review of prolonged exposure for posttraumatic stress disorder. *Clinical Psychology Review 30*(6), 635-641.
- Princeton Religious Research Center, 2000). Americans remain very religious but not necessarily in conventional ways. *Emerging Trends*, 22, 2-3.
- Resick, P. A. (2001). *Cognitive processing therapy: Generic version*. St. Louis, MO: University of Missouri—St. Louis.
- Roan, S. (2012, March 8). Suicides among army personnel up 80% in 4 years. *The Los Angeles Times*. Retrieved from <http://www.latimes.com/health/boostershots/la-heb-army-suicide-20120308,0,7002109.story>
- Sammons, M. T., & Batten, S. V. (2008). Psychological service for returning veterans and their families: Evolving conceptualization of the sequelae of war-zone experiences. *Journal of Clinical Psychology: In Session 64*, 921-927.

- Shea, M.T., Vujanovic, A.A., Mansfield, A. K., Sevin, E., & Liu, F. (2010). Posttraumatic stress disorder symptoms and functional impairment Among OEF and OIF National Guard and reserve veterans. *Journal of Traumatic Stress* 23, 100-107.
- Skinner, K., Kressin, N., Frayne, S., Tripp, T., Hankin, C., Miller, D., & Sullivan, L. (2000). The prevalence of military sexual assault among female veterans' administration outpatients. *Journal of Interpersonal Violence* 15, 291-310.
- Sweeney, T. J., & Witmer, J. M. (1991). Beyond social interest: Striving toward optimum health and wellness. *Individual Psychology*, 47, 527-540.
- Tanielian, T. & Jaycox, L.H. (Eds) (2008). *Invisible wounds of war: Psychological and cognitive injuries, their consequences, and services to assist recovery*. Santa Monica, CA: RAND Corporation.
- U.S. Census Bureau (2014). *A snapshot of our nation's veterans*. Retrieved from: <http://www.census.gov/library/infographics/veterans.html>
- U.S. Department of Defense (2012). *Report of the size of the fighting force*. Retrieved from: <http://siadapp.dmdc.osd.mil/personnel/MILITARY/ms0.pdf>
- U.S. Department of Defense. (2014). *Casualty status*. Retrieved from <http://www.defense.gov/News/casualty.pdf>

## The DSM-5 and Military Mental Health

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### Abstract

*From the start of the revision process in 1999, through its publication in 2013, the DSM-5 has been criticized and the subject of speculation within the helping professions. Now that it is in use, what are its implications for those who work with military and Veteran populations? There are a number of significant changes in philosophy, diagnostic criteria, and assessment of mental disorders. What is presented here is not an in-depth discussion of the changes – merely a highlight of those changes that will impact diagnosis with military members, Veterans, and to a lesser extent their families.*

**KEYWORDS:** *military, Veteran, DSM-5*

The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association [APA], 2013) was in development from 1999 to its publication in May, 2013. During this period, there was near continual controversy, skepticism, anxiety, and anticipation within the helping professions. Now, there is a rush to become familiar with the many changes before the original HIPAA imposed deadline for use on October 1, 2014. This rush is turning into uncertainty due to recent congressional action which pushes the deadline to October 1, 2015 (Pittman, 2014). Any attempted workshops, presentations, or articles on the range of changes are akin to trying to force 10,000 gallons of water into a five gallon bucket – it only makes one wet. Therefore, this article is merely an attempt to highlight those changes pertinent to the military population (serving members, Veterans, and their families).

### Background

The *DSM-5* Task Force was guided by four principles: (a) “revisions must be feasible for routine clinical practice,” (b) revisions be research based, (c) “continuity with previous *DSM* editions be maintained (if possible),” and (d) no restrictions were placed on the degree of changes made (APA, 2013, p. 7). These guidelines allowed significant expansion of the scope of considerations in diagnosis such as lifespan and developmental, cultural, and gender issues. These considerations are included in the definition of a mental disorder:

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A mental disorder is a syndrome characterized by clinically significant disturbances in an individual's *cognition, emotion regulation, or behavior* that reflects a dysfunction in the *psychological, biological, or developmental* processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or *culturally approved response* to a common stressor or loss such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are *primarily* between the individual and society are not mental disorders *unless* the deviance or conflict results from a dysfunction in the individual, as described above [emphasis added] (APA, 2013, p. 20).

The *DSM-5* is clear that a diagnosis does not equal a need for treatment. Rather, the need for treatment is a clinical consideration based on a number of assumptions. These assumptions guide the clinical case formulation (see APA, 2013, p.19).

### **Clinical Assessment**

One of the more noticeable changes is the deletion of the multi-axial assessment and a move toward a non-axial assessment (APA, 2013, p. 16). King (2013, Aug) uses the term "dimensional" assessment as a replacement for non-axial assessment. The *DSM-IV-TR* stated "the multi-axial distinction among Axis I, Axis II, and Axis III disorders does not imply that there are fundamental differences in their conceptualization, that mental disorders are unrelated to physical or biological factors or processes" (as cited in APA, 2013, p. 16). However, this distinction was made by many third-party payers and clinicians. The non-axial assessment removes the Axis distinction and allows practitioners to list the most pressing problem first and others in decreasing order of importance for treatment.

A second significant change is the concept of dimensional and cross-cutting assessments for diagnosis (Jones, 2012; King, 2013, Aug). "Earlier editions of [the] *DSM* focused on excluding false-positive results from diagnoses; thus, its categories were overly narrow, as is apparent from the widespread need to use NOS diagnoses" (APA, 2013, p. 12). Research indicated a clustering of disorders by internalizing factors (disorders characterized with prominent anxiety, somatic, and depressive symptoms) and externalizing factors (these include prominent symptoms of disruptive conduct, impulsive, or substance use). This leads to dimensional measures of severity in diagnosis based on disorders' criteria. Another dimensional aspect is found is the dropping of the Global Assessment of Functioning (GAF) scores and replacing it with the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0), which provides assessment of six domains – cognition (understanding and communication), mobility (getting around), self-care (general hygiene and daily living activities), getting along (interaction with others), life activities (domestic, work, and school responsibilities), and participation (join community activities; APA, 2013; WHO, 2014).

A simple scan of the manual for the WHODAS 2.0 (Üstün, Kostanjsek, Chatterji, & Rehm, 2010) quickly highlights a number of strengths and weaknesses. The WHODAS 2.0 was carefully normed in 19 countries producing a culturally sensitive instrument (Üstün et al., 2010). The psychometrics are fairly strong – allowing for consistent pre-treatment/post-treatment assessment of efficacy of the therapy protocol (Üstün et al., 2010). The major weakness (and source of possible confusion) is in the scoring of the schedule. The manual presents two scoring options (simple and complex) with two different ranges of scores (Üstün et al., 2010). The *DSM-*

5 (APA, 2013) presents a third option for scoring. Thus, the practitioner needs to know which scoring option was used for the client's assessment in order to understand the level of disability.

### **Case Formulation**

“The case formulation for any given patient must involve a careful clinical history and concise summary of the social, psychological, and biological factors that may have contributed to developing a given mental disorder” (APA, 2013, p. 19). This formulation goes beyond the diagnostic and associated features of a disorder and prevalence – though these are important and part of the assessment. Other diagnostic content includes the development and course, risk and prognostic factors (genetic and physiological, environment, temperament, and course modifiers), culture- and gender-related issues, suicide risk, and functional consequences. Address any comorbidity or subtypes that may be present. Finally, the *DSM-5* includes specifiers for course, description, and severity (in full/partial remission, mild/moderate/severe/extreme/profound, single/recurrent/episodic/persistent, acute/subacute, generalized/situational, and lifelong/acquired (APA, 2013).

### **Trauma- and Stressor-Related Disorders**

Posttraumatic stress disorder (PTSD) and acute stress disorder (ASD) were moved from the anxiety disorder category (APA, 2000) into a new category – trauma- and stressor-related disorders (APA, 2013). “Trauma- and stressor-related disorders include disorders in which exposure to a traumatic or stressful event is listed explicitly as a diagnostic criterion” (APA, 2013, p. 265). Individual psychological reaction to trauma or stress may present as anxiety or fear, but can include anhedonia, dysphoria, aggression, anger, or disassociation. Significant changes from the *DSM-IV-TR* diagnoses for posttraumatic stress disorder (PTSD) and acute stress disorder (ASD) are of particular importance for the military-oriented population.

#### **309.81 (F43.10) Posttraumatic Stress Disorder (PTSD)**

“*DSM-5* criteria for PTSD differ significantly from the *DSM-IV* criteria” (APA, 2013, p. 812). There are now four symptom clusters (vs. three in *DSM-IV-TR*, 2000): re-experiencing, avoidance, persistent negative alterations in mood and cognition, and arousal. Thresholds have been lowered and criteria modified for children age 6 and younger. Both acute stress disorder (ASD) and PTSD are more explicit in how the event was experienced (direct witness or indirectly).

Criterion A presents exposure to real or threatened death, injury, or sexual violence. The exposure can be through direct experience, witnessing in person, learning of an event of violent death of relative or close friend, and experiencing repeated or extreme exposure to details of trauma. More than 25 possible traumatic events are listed in the *DSM-5* (see APA, 2013, p. 274). Specifically excluded is “exposure through electronic media, television, movies, or pictures, unless the exposure is work related” (APA, 2013, p. 271).

Several items in Criterion B (intrusion symptoms) are rewritten to add or augment certain distinctions now considered important. These include recurrent, involuntary, and intrusive

distressing memories; recurrent distressing dreams related to event(s); dissociative reactions (e.g., flashbacks), which may occur on a continuum; intense or prolonged psychological distress at exposure to cues; and marked physiological reactions to cues (APA, 2013).

Criterion C (avoidance and numbing; APA, 2000) has been split into C and D (APA, 2013). Criterion C (APA, 2013) now focuses solely on avoidance of behaviors or physical or temporal reminders of the traumatic experience(s). Avoidance is demonstrated by one or both of the following: avoidance or efforts to avoid distressing memories, thoughts, or feelings about or associated with the event; and/or avoidance or efforts to avoid external reminders (people, places, etc.) that arouses distressing memories, thoughts, or feelings about or associated with the event (APA, 2013).

The new Criterion D focuses on negative alterations in cognition and mood associated with the traumatic event(s) and contains two new symptoms, one expanded symptom, and four largely unchanged symptoms specified in the previous criteria. These include the inability to remember important aspects of the event, persistent and exaggerated negative beliefs, persistent distorted cognitions, a persistent negative emotional state, a marked diminished interest in significant activities, feelings of detachment or estrangement, and a persistent inability to experience positive emotions (APA, 2013).

Criterion E (formerly D), which focuses on increased arousal and reactivity, contains one modestly revised, one entirely new, and four unchanged symptoms. Arousal and reactivity is demonstrated by irritable behavior and angry outbursts (verbal or physical), reckless or self-destructive behavior, hypervigilance, an exaggerated startle response, problems with concentration, and sleep disturbance (APA, 2013).

Criterion F (formerly E) still requires duration of symptoms to have been at least one month. Criterion G (formerly F) stipulates symptom impact ("disturbance") in the same way as before. Criterion H stipulated the disturbance is not due to the effects of a substance or another medical condition. Two specifiers may also be applied to the diagnosis: with dissociative symptoms (depersonalization or derealization) and with delayed expression (full criteria not expressed until at least six months after traumatic event).

### **308.3 (F43.0) Acute Stress Disorder (ASD)**

“Frequently, an individual’s reaction to trauma initially meets criteria for acute stress disorder in the immediate aftermath of the trauma” (APA, 2013, p. 277). This being the case, it should surprise no one that the diagnostic criteria for ASD and PTSD have significant overlap. Criterion A is identical for both ASD and PTSD. Criterion B presents 14 symptoms in five categories (intrusion, negative mood, dissociation, avoidance, and arousal). The presence of nine of the 14 symptoms is necessary for a diagnosis of ASD. Criterion C requires a duration of three days to one month. Criterion D is met when the disturbance causes clinically significant distress or impairment. Criterion E requires the disturbance is not attributable to the physiological effects of a substance, a medical condition, or better explained as a brief psychotic disorder (APA, 2013). The similarities in diagnostic criteria between PTSD and ASD allow for a seamless transition from ASD to PTSD.

### Substance-Related and Addictive Disorders

Significant changes have been made in how substance and addictive disorders are assessed and reported. The *DSM-IV-TR* (APA, 2000) diagnoses of substance abuse and substance dependence have been eliminated because the research showed little difference, thus these are combined into a single substance use disorder. “The essential feature of a substance use disorder is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems” (APA, 2013, p. 483).

Nearly all substances are diagnoses based on the same overarching criteria. The recurrent legal problems criterion has been removed and replaced by craving (APA, 2013). This may prove problematic for many unit commanders and non-commissioned officers, as the legal problems in conjunction with deficient duty performance have been the traditional “signs” that a unit member may have a substance use issue. Craving will certainly be more difficult to determine in the normal course of duty.

Craving (Criterion 4) is manifested by an intense desire or urge for drug that may occur at any time but is more likely when in an environment where the drug previously was obtained or used...shown to involve classical conditioning and is associated with reward structures in the brain...is queried by asking if there had ever been a time when they had such strong urges for drug could not think of anything else...may be a signal of relapse. (APA, 2013, p. 483)

Ten of the 11 criteria in the *DSM-IV-TR* (APA, 2000) have been carried into the *DSM-5*. The threshold for diagnosis is based on two of 11 symptoms (APA, 2013) and noted as *impaired control* (criteria 1-4), *social impairment* (criteria 5-7), *risky use* (criteria 8-9), or *pharmacological criteria* (criteria 10-11). The same criteria are used for most substances (APA, 2013), an abbreviated look at the criteria are:

- ▶ Criterion A – impaired control
  1. Taking increasing amounts over a longer period than intended
  2. Persistent desire or unsuccessful efforts to control or cut down use
  3. Great deal of time spent in activities to obtain, use, or recover from its effects
  4. Craving or a strong desire or strong urge to use
- ▶ Criterion B – social impairment
  5. Recurrent use resulting in failure to fulfill major role obligations at work, school, or home
  6. Continued use despite having persistent or recurrent social or interpersonal problems caused by use
  7. Important social, occupational, or recreational activities given up or reduced to use
- ▶ Criterion C – risky use
  8. Recurrent use in physically hazardous situations
  9. Use continued despite knowledge of having persistent or recurrent physical or psychological problem likely caused or exacerbated by use
- ▶ Criterion D – pharmacological criteria
  10. Tolerance defined by – markedly increased amounts to achieve intoxication or desired effect or marked diminished effect with continued use of same amount of substance

11. Withdrawal as manifested by – characteristic withdrawal symptoms or substance or closely related substance is taken to relieve or avoid withdrawal.

Criteria are delineated for intoxication, withdrawal, substance/medication-induced disorders, and unspecified substance-induced disorders. Specific ICD-9 (ICD-10) codes may or may not differentiate severity of the disorder. A number of the *DSM-IV-TR* (APA, 2000) disorders have been deleted or combined; this simplifies the diagnostic process.

There is no longer a distinction of partial or full remission. This has been replaced by *early remission* (at least 3, but less than 12 months without substance use disorder criteria, except craving) or *sustained remission* (at least 12 months without criteria, except craving). The final piece of a diagnosis is a severity rating where two to three criteria indicate a *mild* disorder, four to five criteria indicate a *moderate* disorder, and six or more criteria describe a *severe* disorder (APA, 2013).

### V-Codes (Z-Codes)

V-codes (Z-codes) are used to identify conditions, other than a diagnostic condition, that may have a significance impact on care. Traditionally, V-codes were not used for a primary diagnosis, but might be important for medical billing or managed care operations and could influence covered treatments. The *DSM-5* expands the number of V-codes (Z-codes) available for case consideration. The *DSM-5* Task Force recommended a select set of V-codes from the ICD-9-CM and Z-codes from the ICD-10-CM be used, rather than develop its own list for psychosocial and environmental problems (APA, 2013). Four of these new codes have direct bearing on the military/veteran population.

**V62.21 (Z56.82) Problem related to current military deployment status.** This code is listed under *Occupational Problems* and “...should be used when an occupational problem directly related to an individual’s military deployment status is the focus of clinical attention or has an impact on the individual’s diagnosis, treatment, or prognosis” (APA, 2013, p. 723). The *DSM-5* notes that psychological reactions to the deployment should be coded with the appropriate mental or anxiety disorder. The language in the *DSM-5* clearly intends for this code to be used with the military or Veteran. However, those who work with this population know that military deployments also affect the entire family of the military member. The spouse and children are affected as much as, or more than, the military member. One could easily speculate on how much time will elapse before this code finds its way into the medical charts of military dependents or Veterans’ families.

**V60.0 (Z59.0) Homelessness.** This *Housing Problem* is for use “...when lack of a regular dwelling or living quarters has an impact on an individual’s treatment or progress” (APA, 2013, p. 723). While the number of homeless Veterans declined from a reported 62,000 in 2012 (Zoroya, 2012) to an estimated 57,849 in 2013 (National Alliance to End Homelessness, 2014), homeless Veterans continues as an issue of significant concern. This code will be useful as a course descriptor with this population.

**Others.** Two additional codes may prove useful in working with the military and Veteran populations – V62.89 (Z65.4) Victim of terrorism or torture, and V62.22 (Z65.5) Exposure to disaster, war, or other hostilities (APA, 2013, p. 725). These codes are listed as *Problems Related to Other Psychosocial, Personal, and Environmental Circumstances*. As no descriptions are provided, clinical judgment will be the determining factor in their use.

### **Something for the Military Child**

#### **296.99 (F34.8) Disruptive Mood Dysregulation Disorder**

A parent's deployment can have a devastating impact on a child. Changes in eating patterns, social withdrawal, sleep problems, nightmares, fear, acting out, and school problems are among the many ways a child may react (Harrison & Vannest, 2008; Pavlicin, 2003). Severe mood swings between anger and depression are typical behaviors; these behaviors, singularly or together, could result in a diagnosis of bipolar. The dramatic increase in the number of children being diagnosed with bipolar disorder and the concern with the increased use of psychotropic medications for this population became a focus group developing the criteria for bipolar disorder. The result is a new diagnosis – disruptive mood dysregulation disorder (DMDD; King, 2013, Nov).

The essential feature of DMDD is severe temper outbursts with underlying persistent angry or irritable mood. The diagnostic criteria are temper outburst that occur three or more times a week; the temper outbursts and the persistently irritable mood between outbursts lasts at least 12 months; the temper outbursts are present in two settings and severe in at least one; the mood between anger outbursts is persistent irritability or anger most of the day, nearly every day, and observed by others; and symptoms must exist 12 or more months (and had no more than three or more consecutive months without symptoms). The onset of DMDD should be before the age of 10, but should not be diagnosed before the age of six. DMDD cannot be diagnosed for the first time after the age of 18. The common rule-outs are bipolar disorder (based on longitudinal course of core symptoms), intermittent explosive disorder, depressive disorder, ADHD, autism spectrum disorder, separation anxiety disorder, substance use, and medication or medical conditions. If oppositional defiant disorder is present, do not also diagnose DMDD (APA, 2013).

#### **309.81 (F43.10) Posttraumatic Stress Disorder for Children 6 Years and Younger**

Modified criteria for PTSD have been developed for children six years old and younger. Expose to trauma (Criterion A: actual or threatened death, serious injury, or sexual violence) may involve direct exposure to a traumatic event, personally witnessing an event as it occurs to others (especially a primary caregiver), and/or learning that an event occurred to a parent or caregiver. (Witnessing an event does not include electronic media or pictures.) Intrusion symptoms (Criterion B) occurring after the event are similar to the adult expressions; however, they may not appear distressing and may be expressed in play reenactment (APA, 2013). The other criteria and specifiers are similar to the adult presentation. Given the high number of current military personal and Veterans with families and young children, encountering PTSD in young children is very much a possibility.

### **Putting It All Together**

As set forth in the first paragraph, this review can in no way be comprehensive, as the *DSM-5* has significant changes from the previous *DSM*. In order to provide proper diagnoses, counselors have an ethical obligation to be fully conversant in the use of the *DSM-5* before full implementation occurs on October 1, 2015 (see American Counseling Association [ACA], 2014, E.5.a.). Since the *DSM-5* has been developed to be culturally sensitive (see ACA, 2014, E.5.b.) and recognizes historical prejudices (see ACA, 2014, E.5.c.), it should be viewed as the ethical choice for proper assessment of clients. However, counselors also need to remember the *DSM-5* is just one aid among many used for proper diagnosis. “The *DSM-5* does not make diagnoses; counselors, systematically and objectively using standardized and nonstandardized, specialized clinical assessment techniques and case conceptualization procedures, make diagnoses that are developmentally and culturally sensitive. Let me repeat: Counselors make diagnoses, not the *DSM-5*” (King, 2013, July, p. 21)!

### **References**

- American Counseling Association. (2014). *2014 ACA code of ethics*. Alexandria, VA: Author.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.
- Harrison, J., & Vannest, K.J. (2008). Educators supporting families in times of crisis: Military reserve deployments. *Preventing School Failure, 52*(4): 17-23. Retrieved from ProQuest Education Journals database.
- Jones, K.D. (2012). Dimensional and cross-cutting assessment in the *DSM-5*. *Journal of Counseling & Development, 90*(4), 481-487. doi: 10.1002/j.1556-6676.2012.00059.x
- King, J.H. (2013, July). The *DSM-5* does not make diagnoses. *Counseling Today, 56*(1), 18-21.
- King, J.H. (2013, August). Understanding and using the *DSM-5*. *Counseling Today, 56*(2), 18-20.
- King, J.H. (2013, November). Assessment and diagnosis of disruptive mood dysregulation disorder. *Counseling Today, 56*(5), 18-20.
- National Alliance to End Homelessness. (2014). *Veterans*. Retrieved from <http://www.endhomelessness.org/pages/veterans>
- Pavlici, K.M. (2003). *Surviving deployment: A guide for military families*. Saint Paul, MN: Elva Resa.

Pittman, D. (2014, April 2). Date of ICD-10 switch still uncertain. *Medpage Today*. Retrieved from <http://www.medpagetoday.com/PracticeManagement/InformationTechnology/45087>

Üstün, T.B., Kostanjsek, N., Chatterji, S., & Rehm, J. (Eds.). (2010). *Measuring health and disability: Manual for WHO Disability Assessment Schedule (WHODAS 2.0)*. Geneva, Switzerland: WHO Press.

World Health Organization (WHO). (2014). *WHO Disability Assessment Schedule 2.0 WHODAS 2.0*. Retrieved from <http://www.who.int/classifications/icf/whodasii/en/>

Zoroya, G. (2012, December 27). Homeless, at-risk veterans double. *USA Today*. Retrieved from <http://www.usatoday.com/story/news/nation/2012/12/26/homeless-at-risk-veterans-double/1792557/>

## **Positive Trauma Growth from Life Altering Events**

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### **Abstract**

*Some people react to trauma and tragedy by becoming stuck in complicated grief that impacts every facet of their lives to include relationships, work, and even health. Other people respond to trauma and tragedy with resiliency and seem to bounce higher, achieve more, and make meaning from the unthinkable events. A sense of a strong spiritual foundation often is the factor shared by people displaying a life of purpose. This sense of purpose and resiliency leads to increased and strengthened coping skills among people recovering from illness, death, injury, or witnessing of such events.*

**KEYWORDS:** *resilience, positive trauma growth, meaning making, complicated grief, coping*

### **The Personal Story That Started the Journey**

I met Phil just before my 27<sup>th</sup> birthday. He was a 21-year-old airman who came strutting into my pool one day. I wasn't interested in a young enlisted military man, but we became friends. Phil had come to the United States from Venezuela at the age of 12. He spoke French and Spanish. He joined the Air Force at the age of 18 to get his American citizenship. He spoke ten languages fluently and could speak English as well as any other person born in America. Phil spent 16 years enlisted, 10 as an officer.

On the 20<sup>th</sup> time he asked me out, I consented. We eloped four months later. During the early years of our marriage, he deployed often. I worried about his safety when he deployed to South America for the drug wars more than I worried about him when he decided to volunteer to go over to Afghanistan as a trainer and an advisor five days after completing his PhD. After being married 23 years and Phil being in the military 26 years, I considered his yearlong deployment an interruption of our life. I never once thought that he was unsafe.

On April 27<sup>th</sup>, 2011, I was feeling a little peeved because I had not heard from my husband for three days. He was deployed to Afghanistan helping the Afghan's set up their

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hospital. It was Phil's general practice to withdraw while deployed because the separations were too hard for him. It never occurred to me to be nervous, thus when the MSN ticker tape flashed across the screen announcing seven confirmed American deaths in Kabul, I was confident enough to go next door to the music teacher to express relief that Phil was not there and that our daughter had just returned home safe from that area. Little did I realize that five and a half hours later I would be that girl and that one of those nine (it was nine, but initially seven got reported) was my Phil.

When my principal came to get me from my gym, I was in the middle of teaching over thirty first graders. I thought I was losing my job. My school had essentially declared bankruptcy and teachers were being let go that day. I had volunteered to be the one to be let go knowing that when Phil came home, we would be moving again. As I approached the front of the school, I saw media trucks everywhere. I thought I was going to have to give an interview about losing my job. Never in a million years did I think that the media would be there for any other reason.

When I got to the office, the phones were ringing, the naughty children were leaving the office, and everyone was staring at me. I thought everyone knew I was being fired except for me. How I wish that had been the case. As I rounded the corner, the sea of blue uniforms stepped up to begin reading those horrible unforgettable words, "On behalf of a grateful nation, we regret to inform you that..." I immediately dropped to my knees keening. As I dropped, one cognizant thought crossed my mind. How could I claim to have faith if in my darkest hour, I turned from that faith? I chose to fall into my faith and it has made all of the difference.

This faith framework gave me "social networks, different ways to perceive and process my loss, and it gave me a stronger adaptation to the event" (Peres, Moreira, & Nasello, 2007, p. 245). People never really know how strong they are or what they are capable of withstanding until body slams come. It is not a matter of if trauma and tragedy will happen to us, but when (Dees, 2011; Drescher & Foy, 2010, p. 148). Even the Bible addresses that "in this world all (sic) will have tribulation" (John 16:33, NKJV), but I know that I thought that my life was going to follow a certain trajectory and that I had plenty of time before I had to deal with the loss of a spouse or illness. On 27 April 2011, every skill and every coping mechanism I had became very real.

While welcoming Phil's body back to his adopted American country, the casualty officer challenged me to go running because it would help me with the decisions I had to make. I had been a runner for 38 years and she had done her research. Through that 2 hour run, I was able center myself enough to make decisions about Phil's burial and about my approach to the media, people, and even my own reactions. I made the decisions to not waste time and energy in being angry with the assassin because it wouldn't bring Phil back and I made the decision that the assassin wasn't getting me too. I decided that if I stopped living that the assassin essentially got two of us and that he wasn't going to get me too.

That run also fostered something else in me. I was never comfortable talking about my feelings, but I needed to write down my thoughts. I wrote which helped me to "heal, grow, and fulfill my creative potential" (Forgeard, 2013, p. 257). I shared my blogs on Facebook so that my family and friends, who were all over the world, knew where my heart was. The writing

became my way of expressing my feelings, my grief, and it became a technique to connect with people because in military death the surviving family members loses their identity as a military family, their place of living, and their culture (Holmes, Rauch, & Cozza, 2013; Siegl, 2008). I never expected that those blogs would become a book, a regular series, or lead to the opportunities of speaking on military loss. I was just doing what felt right for me to manage the pain I carried. I never realized that in doing what felt right, that I was making something positive come from the worst moment of my life or that a better version of myself would emerge. I am a living example of how trauma can cause a person to grow, adapt, and to develop increased personal strength.

### **Positive Trauma Growth from Life Altering Events**

Trauma is an event “that places a person at threat to life or serious injury” to self. As a witness, or vicariously to someone we hold dear (Drescher & Foy, 2010, p. 148). Most people are uncomfortable with trauma, tragedy, and grieving, but it is not a matter of “if, it is a matter of when” (Dees, 2011) for people if they live long enough. “Only people who avoid love, can avoid grief” because “to love is to be vulnerable” (Corr & Corr, 2013, p. 236). Being young does not mean that a person is immune to trauma or tragedy. Corr and Corr (2013) found that teens have been exposed to death and mourning at a higher rate than assumed. People react to trauma and tragedy in a variety of manners. These reactions stem from personality, cultural context and social roles, relationships, and value belief system (Corr & Corr, 2013). All of a person’s coping skills and surviving traits for resiliency, or the ability to bounce back, unbroken, at full potential, and at times, better than before (Dees, 2011; Siebert, 2010).

Not everyone responds in the same manner to trauma or tragedy. Some people respond by becoming better versions of what they once were, while others get stuck in a negative downward spiral (Dees, 2011). Some people are even able to turn disaster into a gift or find a way to thrive in spite of personal circumstances (Siebert, 2010). This paradigm includes adapting, living productively, doing new things, responding to life’s challenges, taking new roles and identities, finding meaning, and personal growth (Corr & Corr, 2013). This growth can come from any type of adversity to include health traumas, natural or environmental disasters, war, and any other adverse life event (Sheikh, 2008). Posttraumatic growth (PTG) is a “positive psychological response to trauma, manifesting as improvements in critical life areas such as relationships, personality, self-efficacy, and spirituality” (Moran, Burkner, Schmidt, 2012, p. 12). Not every person responds the same nor do all people grieve equally (Dees, 2011; DeSpelder & Strickland, 2011) which is why this concept is hard to predict in surviving people. People displaying the highest levels of PTG, however, share basic character traits.

### **PTG Predictors**

A person with a strong sense of self and high sense of purpose reports less psychological distress (Corr & Corr, 2013; DeSpelder & Strickland, 2011). Coping involves both the “cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (Park, Mills-Baxter, & Fenster, 2005, p. 298). Further, there are five specific factors that positive survivors share:

(a) interpersonal characteristics such as humor, kindness, and leadership; (b) fortitude, such as honesty, bravery, and judgment; (c) cognition, such as creativity and curiosity; (d) transcendence, such as gratitude, hope, and zest; and (e) temperance, such as forgiveness, modesty, and fairness. (Moran, Burker, & Schmidt, 2012, p. 12).

Extraverts and people who are open to new life experiences show a greater level of resiliency (Werdel, Dy-Liacco, Ciarrocchi, Wicks, & Bresford, 2014) because they are connected (Corr & Corr, 2013).

Additionally, a strong sense of intrinsic faith may predict PTG (DeSpelder & Strickland, 2011; Linley & Joseph, 2004; Moran, Burker, & Schmidt, 2012). People with strong faith often report higher levels of resiliency and the belief that experiences will lead to learning and growth (Zolli, 2012). Within these shared traits are the traits of optimism and a sense of humor which are factors of hope (Kashdan & Kane, 2011; Moran, Burker, & Schmidt, 2012). Humor and hope are often displayed in highly resilient people and these traits are part of the spiritual component of coping (O'Rourke, Tallman, & Altmaier, 2008). People who were traumatized often reported that faith and a reliance on prayer led to positive coping strategies such as meaning making (Meisnhelder & Marcum, 2009). Patients with cancer have reported higher levels of satisfaction and optimism with spiritual coping strategies (Denney, Aten, & Leavell, 2011), thus this factor is a commonality in highly resilient people.

One surprising facet of optimism is fostered through humor (Bonanno, 2004; Neenan, 2009). "Humor helps individuals cope with adversity and it is a vital component of the resilient mindset" (Brooks & Goldstein, 2004, p. 123). Humor essentially helps the griever to put things into perspective and to "pave the way to acceptance" of the event (Reivich & Shatte, 2002, p. 238). Laughter predicts "better adjustment and better social relationships over time" (Neenan, 2009, p. 80).

Supportive social connections are crucial for the hurting person. A person who has someone who receives "emotional support, informational feedback about the trauma, and tangible assistance" often responds with increased self-confidence and views others more positively (Werdel, Dy-Liacco, Ciarrocchi, Wicks, & Bresford, 2014, p. 58). Social supports provide an outlet for storytelling and disclosure, shared experiences, reassurance about feelings, and security to talk about the event or situation (Moran, Burker, & Schmidt, 2012; Schmidt, Blank, Bellizzi, & Park, 2011). People with strong attachments to other people display higher positive coping strategies (Schmidt et al., 2011).

Finally, the highly resilient person has outlets which increase self-concept and positive coping strategies (Corr & Corr, 2013). This resiliency comes from finding one's self through seeking and the constructed self (Siebert, 2010). In the midst of trauma and tragedy, some people are able to find meaning and value in their lives, and a commitment to surviving the trauma and tragedy is integral (Park & Ai, 2006). Meaning making fits in a faith paradigm because it gives recovering individuals a way to make sense of what is happening (God's will) and it gives them a way to focus on the positive outcomes of the loss (Dresher & Foy, 2010). A sick person would take control of his/her illness, show optimism, and look for a way to make meaning or be bigger than the threat (De Spelder & Strickland, 2011). This is a purposeful process to deal with the situation and it can involve conscious and unconscious actions to help with the cognitive

processing which allows people the opportunity to “reframe” and refocus in order to cope with the trauma (Park & Ai, 2006). This meaning making often takes place in avenues involving writing, advocacy, speaking, fund raising, memorials, or career changes (Tedeschi & Calhoun, 1996). People are able to see some good and they keep their focus on creating life and meaning beyond the tragedy.

“A person who has the why to live can bear with any how to live” (Lichtenthal & Breitbart, 2012, p. 161) which means that each individual makes meaning for living for themselves. Viktor Frankl, Holocaust survivor broke meaning making into three pathways to include “creating a work or doing a deed, experiencing something or encountering someone, or the attitude taken toward unavoidable suffering” (as cited in Lichtenthal & Breitbart, 2012, p. 161). In other words, meaning making is a choice by the individual. It is in this meaning making and purpose hope is born. People with hope have a better outcome because “they retain hope for the future and believe that there is a high probability that things will work out as well as can be expected” (Watson, 2008, p. 76). Despair keeps a “person stuck whereas hope motivates an individual to move toward a better future” (Drescher et al., 2009, p. 456).

It is important to note that PTG is not avoidance of the pain. People displaying the highest levels of PTG met trauma related cues with “awareness, openness, and the continuation of behaviors directed toward the pursuit of valued life aims versus the regulation of emotions” (Kashdan & Kane, 2011, p. 86). While hardiness and resiliency is a trait that people are born with, this trait can be a counselor needs to be intentional to “reorganize and restructure” the individual’s strengths (Zolli, 2012).

### **Considerations and Discussion for Helping the Traumatized Individual Move Toward Post-Traumatic Growth: Implications for the Counselor or Minister**

Appropriate intervention and aid in all facets of a person is tantamount to helping the healthy grief process. While nothing negates the loss, there are five intervention principles shown to be effective: “(1) promoting a sense of safety, (2) promoting calming, (3) promoting a sense of self-and community-efficacy, and (5) instilling hope” (Hobfoll et al., 2007, p. 283). This intervention starts from minute one of the crisis response team and continues through the bereavement process (Watson, 2008). A counselor’s sensitivity to recognizing that the traumatized person’s anger, shunning of faith, and the need to talk about the event over and over again is a normal component of the event reaction (Petersen, 2007). The counselor’s primary role is to let the bereaved person sort out what he/she believes while listening to what the griever is comfortable sharing (Petersen, 2007, p. 161-162).

A counselor needs to help the survivor “to actualize the loss” (Corr & Corr, 2012, p. 302). Even though it is difficult, attending to and exploring negative experiences can also promote broadened perspectives, new coping skills, and the development of personal and social resources (Kashdan & Kane, 2011). This involves utilizing words such as died, killed, and death versus platitudes such as lost, and it involves viewing, the funeral service, and knowledge (Corr & Corr, 2012; Kashdan & Kane, 2011). A bereaved person (and this can include losses such as divorce or health) needs to be able to ask questions, hear the details repeatedly, help in identifying and experiencing feelings, help with day to day tasks, and help making meaning

(Corr & Corr, 2012). This meaning can be done through journaling, which offers the bereaved person a place to reflect, write things they could never voice, and a place to process the feelings they are experiencing (Lichtenthal & Neimeyer, 2012). Additionally, meaning making can take place in the arts (Near, 2012) with activities like photography (Gershman, 2012), music (Berger, 2012), sand play (Bardot, 2012), dramatic role play (Neimeir, 2012), memory boxes, and letter writing (Neimeyer, 2012).

A counselor can be a critical component to helping a grieving individual to examine defenses and coping styles which may lead to more strategies in dealing with the bereavement process (Corr & Corr, 2012). It implies a joint effort and knowing one's resources (Dees, 2011). This gentle empathetic guiding and listening can help the griever to interpret normal behaviors, provides a safe place to grieve, and it provides the safety net of being able to identify and refer people who need further help with complicated grief (Corr & Corr, 2012). There are no universal truths or processes in grieving (Corr & Corr, 2012; DeSpelder & Strickland, 2011), but PTG "can be a powerful influence on individuals' lives even many years after the occurrence of the traumatic event" (Park, Mills-Baxter, & Fenster, 2005, p. 303).

The counselor can help the individual reengage and interact effectively with other people (Drescher et al., 2009). Reengaging helps the transition back into the social network and it helps emotional well-being and recovery (Watson, 2008). Connecting gives people another way to cope and to reengage in day to day life (Drescher & Foy, 2010).

The counselor can provide a framework for self-efficacy. After trauma, individuals are often consumed with self-doubt in "one's abilities to face the overwhelming challenges ahead" (Drescher et al., 2009, p. 456). This occurs through "self-regulation of thought, emotions, and behavior" (Benight et al., 2000). People with high levels of self-efficacy have good problem-solving skills and solve problems as they arise (Reivich & Shatte, 2002).

It is important to note, however, that while there are many different counseling methods that prove beneficial to the griever, counseling techniques are not a blanket guarantee to guiding individuals through the grief process and at times are "ineffective and even harmful" (Bonanno, 2004, p. 20). This uncertainty and lack of uniformity may be due to each individual's coping and resiliency strategies (Bonanno & Kaltman, 2001).

### **Implications**

Further research in the field of positive trauma growth needs to be conducted to identify what strategies and personality types are able to develop personal strengths and skills from terrible life events. Little research has been done with people accomplishing extraordinary feats after trauma. I posit that research might bear out the following:

1. Individuals acknowledge that they are unable to change the event or loss.
2. Individuals do what feels natural and right to them.
3. Individuals decide to honor, remember, or stand for a cause or person.
4. Individuals decide to act.
5. Individuals are motivated by achieving or doing by the trauma.

### **Personal Reflections**

PTG does not mean that people will not suffer (Dees, 2011). Even Jesus suffered. John 11:35 tells us “Jesus wept” (NIV). Story after story tells us of people like us dealing with loss or infirmity. No other story in the Bible presents a man who lost more than Job. Job lost his livelihood, his children, his animals, and his home. These types of traumatic loss would have broken most everyone; indeed, Job did break for a while. He cried out to God in Job 19:1, “how long will you continue to torment me and crush me....” (NIV). Job even felt that God had left him (in Job 23) as he talked about searching for God and yet not finding him, yet God did indeed bless Job again. While people cannot be replaced, Job was able to find a new purpose, renewed joy, and strengthened faith again. Job, the epitome of PTG, says, “My ears had heard of you but now my eyes have seen you” (Job 42: 5, NIV). Sometimes it is that simple—deciding to make decisions to do what a person feels he/she is unable or ill-prepared to do (Dees, 2011). It is in hoping against hope (Romans 4:18; Holzman Christian Bible) or as Romans 4:18 states, “hoping in spite of hopeless circumstances” (ISV), that I am able to look forward with confidence and faith that all things are working together for the good (Romans 8:28).

I have changed since the death of my Phil. Initially, I was just trying to breathe and get through each day minute by minute. I recognized that people were taking their cues from me. What started as “drawing from my well of courage” (Dees, 2011) to face the media, family, military members, my students, and the Air Force Academy cadets who were dealing with the death of a popular instructor, coach, and military man. None of them had seen this or experienced it before my Phil. The General he worked for wept and accidentally let enough clues out that the media was able to figure out which professor had been killed (he was the only deployed faculty member). I intuitively responded to people looking to me for cues on how to deal with the unthinkable and to find my footing.

None of this journey has been easy. In the military world, traumatic loss is different. From the start, the media has been a part of my journey. The media knew before I knew and bore testimony to the horrors of the first minutes. One day I was an esteemed military spouse; the next, I no longer fit into the group I had been a part of for more than 25 years. People who I considered friends withdrew because I was either a visible reminder of what could happen to their spouses, they did not know what to say, or they thought I might go after their spouse. I was told that I had one year to figure out where I wanted to live. I lost Phil, my community, and my sense of belonging in one event.

I initially responded by just doing what was asked of me. My family was the family that the media glommed onto because the media captured me standing with my five children—four of whom stood in military uniforms. Phil represented every soldier because he had chosen our country and had started at the very bottom to move up to a respected officer rank. I spoke because it helped me to control what going on. I could control the extent of the questions and I could keep the media away from some of my children who needed privacy. When I spoke, people listened. I never considered myself to be the subject matter expert, but through writing about my journey, making videos for the military, and training military members on coping strategies, I have grown in very unexpected ways.

I did not, nor do I consider myself as having those skills now. I am humbled when I consider the woman I have become in the past three years. This is not me. It is the me that has grown from the worst day of my life. Positive trauma growth is an apt description of something positive emerging from the worst event a person could face. I could have stared down a medical crisis of myself easier than I could consider a life without my Phil, yet somehow in spite of myself, I sense that I am a better version of the person I once was. I equate my need for teaching resiliency and talking military issues to the fire that began to blaze within my heart. I needed something good to come from Phil's death. In doing so, I have bounced back and have bounced higher (Dees, 2011) than where I was prior to my loss. Grieving is not about forgetting (Dees, 2011), but it is about bouncing back and finding a way to honor, remember, and create something positive in the pain.

### References

- Bilić, L. L. (2005). Posttraumatic growth following major trauma. (Order No. U201816, University of Sheffield (United Kingdom). PQDT - UK & Ireland, Retrieved from <http://search.proquest.com/docview/301657205?accountid=12085>. (301657205).
- Berger, J. (2012). Playing with playlists. In R. Neimeyer (Ed.), *Techniques of grief therapy* (pp. 211-219). New York, NY: Routledge.
- Bonanno, G. A. (2004). Loss, trauma, and human resilience. *American Psychologist*, 59(1), 20-26. doi:10.10370003-066X.59.1.20
- Brooks, R., & Goldstein, S. (2004). *The power of resilience*. New York, NY: McGraw Hill.
- Castella, R., & Simmonds, J. (2013). "There's a deeper level of meaning as to what suffering's all about": Experiences of religious and spiritual growth following trauma. *Mental Health, Religion & Culture*, 16(5), 536-556. doi: 10.1080/13674776.2012.702738
- Corr, C. A., & Corr, D. M. (2013). *Death and dying: Life and living* (7<sup>th</sup> ed.). Belmont, CA: Wadsworth Cengage Learning.
- Dees, R. F. (2011). *Resilient warriors*. San Diego, CA: Creative Team Publishing.
- Denney, R. M., Aten, J. D., & Leavell, K. (2011). Posttraumatic spiritual growth: a phenomenological study of cancer survivors. *Mental Health, Religion and Culture*, 14(4), 371-391. doi:10.1080/13674671003758667
- Harms, L., & Talbot, M. (2007). The aftermath of road trauma: Survivors' perceptions of trauma and growth. *Health and Social Work*, 32(2), 129-37. Retrieved from <http://search.proquest.com/docview/210555263?accountid=12085>

- DeSpelder, L. A., & Strickland, A. L. (2011). *The last dance* (9<sup>th</sup> ed.). New York, NY: McGraw-Hill.
- Dreshcher, K., & Foy, D. W. (2010). When horror and loss intersect: Traumatic experiences and traumatic bereavement. *Pastoral Psychology, 59*(1), 147-158. doi:10.1007/s11089-009-0262-2
- Dresher, K. D., Burgoyne, M., Casas, E., Lovato, L., Curran, E., Pivar, I., & Foy, D. W. (2009). Issues of grief, loss, honor, and remembrance: spirituality and work with military personnel and their families. In M. Blumenfield & R. Ursano (Eds.), *Intervention and reilience after mass trauma* (pp. 439-465). New York, NY: Routhledge.
- Feldman, D.B., K.L. Rand, and K. Kahle-Wroblewski. (2009). Hope and goal attainment: Testing a basic prediction of hope theory." *Journal of Social and Clinical Psychology 28*, 479-497.
- Forgeard, M.J. (2013). Perceiving benefits after adversity: The relationship between self-reported posttraumatic growth and creativity. *Psychology of Aesthetics, Creativity, and the Arts, 7*(3), 245-264. doi:10.1037/a0031223
- Gershman, N. (2012). Perspective photomontage. In R. Neimeyer (Ed.), *Techniques of grief therapy* (pp. 205-210). New York, NY: Routledge.
- Gibbons, S., Shafer, M., Aramanda, L., Hickling, E., & Benedek, D. (2014). Combat health care providers and resiliency: Adaptive coping mechanisms during and after deployment. *Psychological Services, 11*(2), 192-199. doi:10.1037/a0033165
- Hobfoll, S. E., Watson, P., Bell, C. C., Bryant, R. A., Brymer, M. J., Friedman, M. J., . . . Ursano, R. J. (2007). Five essential elements of immediate and mid-term mass trauma intervention: Empirical evidence. *Psychiatry, 70*(4), 283-315; discussion 316-69. Retrieved from <http://search.proquest.com/docview/220670681?accountid=12085>
- Holgerson, K., Boe, H., & Holen, A. (2010). Long-term perspectives on posttraumatic growth in disaster survivors. *Journal of Traumatic Stress, 23*(3), 413-416. doi:10.1002/jts.20530
- Kashdan, T. B., & Kane, T. Q. (2010). Post-traumatic distress and the presence of post-traumatic growth and meaning in life: experiential avoidance as a moderator. *Traumatology, 50*, 84-89. doi: 10.1177/153476560501100408
- Linley, P. A., & Joseph, S. (2004). Positive change following trauma and adversity: a review. *Journal of Traumatic Stress, 17*(1), 11-21. doi: 0894/9867/040200-0011/1
- Holmes, A., Rauch, P., & Cozza, S. (2013). When a parent is injured or killed in combat. *Future of Children, 23*(2), 143-162. Retrieved from SocINDEX database.

- Jackson, C. A. (2007). Posttraumatic growth: Is there evidence for changing our practice? *Australasian Journal of Disaster and Trauma Studies*, 2007-1. Retrieved from <http://www.massey.ac.nz/~trauma/issues/2007-1/jackson.htm>
- Kaltmann, S., & Bonnano, G. A. (2003). Trauma and bereavement: Examining the impact of sudden and violent deaths. *Journal of Anxiety Disorders*, 17(2), 131-147. doi:10.1016/S0887-6185(02)00184-6
- Kaplow, J., Layne, C., Saltzman, W., Cozza, S., & Pynoos, R. (2013). Using multidimensional grief theory to explore the effects of deployment, reintegration, and death on military youth and families. *Clinical Child and Family Psychology Review*, 16, 322-340. doi:10.1007/s10567-013-0143-1
- Lichtenthal, W. G., & Breitbart, W. E. (2012). Finding meaning through the attitude one takes. In R. Neimeyer (Ed.), *Techniques of grief therapy* (pp. 161-171). New York, NY: Routledge.
- Meisenhelder, J. H., & Marcum, J. P. (2009). Terrorism, post-traumatic stress, coping strategies, and spiritual outcomes. *Journal of Religious Health*, 48(1), 46-57. doi:10.1007/s10943-008-9192-z
- Moran, S., Burkner, E., & Schmidt, J. (2012). Posttraumatic growth: Helping clients overcome trauma. *Journal of Applied Rehabilitation Counseling*, 43(4), 12-20. Retrieved from <http://search.proquest.com/docview/1269470659?accountid=12085>
- Near, R. (2012). Intermodal expressive arts. In R. Neimeyer (Ed.), *Techniques of grief therapy* (pp. 161-171). New York, NY: Routledge.
- Neenan, M. (2009). *Developing resilience*. New York, NY: Routledge.
- Neimeyer, R. A. (2012). Correspondence with the deceased. In R. Neimeyer (Ed.), *Techniques of grief therapy* (pp. 259-261). New York, NY: Routledge.
- O'Rourke, J. F., Tallman, B. A., & Altmaier, E. M. (2008). Measuring post-traumatic changes in spirituality/religiosity. *Mental Health, Religion and Culture*, 11(7), 719-728. doi:10.1080/136470801993336
- Park, C., & Ai, A. (2006). Meaning making and growth: New directions for research on survivors of trauma. *Journal of Loss and Trauma*, 11(5), 389-407. doi:10.1080/15325020600685295
- Park, C. L., Mills-Baxter, M. A., & Fenster, J. R. (2005). Post-traumatic growth from life's most traumatic event: influences on elder's current coping and adjustment. *Traumatology*, 11(4), 297-306. doi:10.1177/153476560501100408
- Petersen, J. C. (2007). *Why don't we listen better?* Portland, OR: Petersen Publications.

- Reivich, K., & Shatte, A. (2002). *The resilience factor*. New York, NY: Three Rivers Press.
- Rolls, L., & Chowns, G. (2014). What makes military bereavement different? *Therapy Today*, 25 (4), 24-17.
- Schmidt, S. D., Blank, T. O., Bellizzi, K. M., & Park, C. L. (2011). The relationship of coping strategies, social support, and attachment style with posttraumatic growth in cancer survivors. *Journal of Health Psychology*, 17(7), 1031-1041. doi:10.1177/1359105311429203
- Sheikh, A. (2008). Posttraumatic growth in trauma survivors: implications for practice. *Counselling Psychology Quarterly*, 21(1), 85-97. doi:10.1080/09515070801936651
- Siebert, A. Y. (2010). *The survivor personality*. New York, NY: Penguin Group.
- Stewart, J., Zediker, K. E., & Witteborn, S. (2012). Inhaling: Perceiving and listening. In J. Stewart (Ed.), *Bridges Not Walls* (11 ed., pp. 163-206). New York, NY: McGraw-Hill.
- Tedeschi, R. G., & Calhoun, L. G. (1996). The posttraumatic growth inventory: measuring the positive legacy of trauma. *Journal of Traumatic Stress*, 9(3), 455-471.
- Ungar, M. (2013). Resilience, trauma, context, and culture. *Trauma, Violence, & Abuse*, 14(3), 255-266. Retrieved from SAGE Premier database.
- Watson, P. J. (2008). Psychological first aid. In M. Blumenfield & R. Ursano (Eds.), *Intervention and resilience after mass trauma* (pp. 69-82). New York, NY: Cambridge Press.
- Werdel, M. B., Dy-Liacco, G. S., Ciarrocchi, J. W., Wicks, R. J., & Breslford, G. M. (2014). The unique role of spirituality in the process of growth following stress and trauma. *Pastoral Psychology*, 63(2014), 57-71. doi:10.1007/s11089-013-0538-4
- Zebrack, B., Stuber, M., Meeske, K., Phipps, S., Krull, K., Liu, Q., & ... Zeltzer, L. (2012). Perceived positive impact of cancer among long-term survivors of childhood cancer: a report from the childhood cancer survivor study. *Psycho-Oncology*, 21(6), 630-639. doi:10.1002/pon.1959
- Zolli, A. Y. (2012). *Resilience*. New York, NY: Free Press.