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Letter from the Editors

The *Journal of Military and Government Counseling* (JMGC) is an official publication of the Military and Government Counseling Association (MGCA), a division of the American Counseling Association. The mission of the journal is to promote reflection and to encourage, develop, facilitate, and promote professional development for administrators, counselors, and educators working with all members of the Armed Services and their families, whether active duty, guard, reserve, retired, or veteran; civilian employees of the Department of Defense; first responders including EMS, law enforcement, fire, and emergency dispatch personnel; and employees of Local, State and Federal governmental agencies.

Welcome to the Journal of Military and Government Counseling

Has it only been nine months?

So much has happened since the last issue of the JMGC was published that to think of everything we've dealt with seems to go so much deeper than it should.

We're tired. More tired than we thought we could be. These past months have been tough on everyone, but especially First Responders.

But I'm also proud.

I've seen the people that support First Responders step up with support, community, services, and understanding.

I've seen the mission of this journal exemplified in the actions of professionals devoted to serving the populations of those who serve and protect our communities.

I've seen you step in to fill the gaps.

I've never known a medic (or fire, or law enforcement, or dispatch personnel) that needed to be thanked for what they did, but it has been enheartening to see the community support that recognizes the service of First Responders and what they risk to do their jobs. I hope that we will carry on that support as we start this new year.

The JMGC Editorial Team

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Decreased Substance Abuse in Suicidal Veterans After Receiving Spirituality-Based Interventions

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Retrospective chart reviews were conducted using a sample of Veterans (n=61) admitted for SI (suicide ideation) or SA (suicide attempt) to a Veterans Administration Hospital acute psychiatric unit over a six-month period. Charts were reviewed for one year before to one year after the Veterans received a novel crisis intervention, Crisis Orientation Refresh Empower (CORE). A comparable sample of Veterans who did not receive CORE was included. Researchers hypothesized a decrease in substance abuse for CORE crisis intervention recipients than those who did not. Results indicated that Veterans who completed the CORE crisis intervention were more likely to decrease substance abuse while controlling for demographic variables, homelessness, and comorbid mental health disorders. The CORE crisis intervention may be a promising crisis intervention in this population and warrants further study. Furthermore, researchers found those who were readmitted within the calendar year returned voluntarily as opposed to involuntarily. These findings suggest an increase in help seeking behaviors during a crisis.

Keywords: Veterans, substance abuse, spirituality, suicide, crisis

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The Veterans Health Administration (VHA) has been battling two major health issues among Veterans: substance use disorder (SUD) and suicidality. Veteran suicide is such a major concern that the United States Department of Veteran Affairs' Office of Mental Health and Suicide Prevention (2019) put forth a "renewed and determined call to unrelentingly address suicide in our Veteran population" (p.3). The alarming suicide rates among Veterans are far greater than rates among civilians. According to the 2019 National Veteran Suicide Prevention Annual Report (Office of Mental Health and Suicide Prevention, 2019), Veteran men die by suicide at a rate 1.3 times the rate of civilian men, and Veteran women die by suicide at a rate of 2.2 times the rate of civilian women. The suicide rate is highest among younger Veterans, ages 18 to 29, who may have served in the more recent wars (Bohnert et al., 2017). Veterans from Operation Enduring Freedom and Operation Iraqi Freedom reported that one factor affecting them post-deployment was a lack of meaning or purpose in life (Costanza et al., 2019; Denneson et al., 2015).

In 2017, Veterans who had accessed VHA services and had a mental health or SUD diagnosis had a suicide rate of 56.9 per 100,000 (Office of Mental Health and Suicide Prevention, 2019). SUD includes abuse or misuse of illegal drugs, prescription drugs, and alcohol. Just over 10% of Veterans meet criteria for a SUD (Teeters et al., 2017). Despite the availability of extensive SUD and mental health services through the VHA, the rates of SUDs in Veterans continue to rise (Teeters et al., 2017). A study of a national sample of Veterans receiving healthcare services found that the VHA was treating nearly half a million Veterans for SUD (Patterson, & Wilkins, 2018). An alarming 75,913 of these Veterans were dually diagnosed with SUD plus serious mental illness (i.e. Schizophrenia- and/or Bipolar-spectrum disorders). Another 245,675 of these Veterans were dually diagnosed with SUD plus another mental illness; such as anxiety disorders, depressive disorders, Post-Traumatic Stress Disorder (PTSD), and eating disorders (Painter et al., 2018). In 2012, 21.9% of Veterans diagnosed with PTSD were also diagnosed with a SUD (Bowe & Rosenheck, 2015; National Center for PTSD, 2019). Veterans with both

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PTSD and SUD were found to be more likely to be homeless and to require inpatient mental health treatment (Bowe & Rosenheck, 2015) due to suicidality or self-harm.

Perhaps another lesser known factor that contributes to suicidality is a lack of life significance or spiritual purpose (Kopacz & Connery, 2015). Veterans from Operation Enduring Freedom and Operation Iraqi Freedom reported that one factor affecting them post-deployment was a lack of meaning or purpose in life (Costanza et al., 2019; Denneson et al., 2015;). Spiritual distress is also associated with increased suicidal ideation and may predict suicide risk (Kopacz & Connery, 2015). Spirituality is an elusive construct with varied operational definitions dependent on discipline and context (Moberg, 2002; Park et al., 2017). However, providing a general definition of spirituality versus religion, most would agree spirituality encompasses the transcendent and meaningfulness which gives purpose to life. Spirituality is historically defined as 'a state that corresponds to a person's response to health and life processes' (Caldeira et al., 2013) such as unmet spiritual needs, questioning the meaning of life, or losing connection to self or others (Baldacchino, 2006). More recently, Burnett (2014) defined spirituality as "an openness to God, nature or the universe where one can experience harmony with truth, feelings of love, hope and compassion, inspiration or enlightenment with a sense of meaning and purpose in life" (Burnett, 2014; p. 28). By contrast, religion was defined as "the corporate expression of that connection, where one mediates their relationship to God and the community through an organized system of beliefs and practices" (Burnett, 2014, pp. 29). As such, religion is more formalized and prescriptive and usually found in well-defined organizations (Clarke & Byrne, 1993; Emblen, 1992; Koenig, 2015).

The Mental Health and Chaplaincy's Learning Collaborative (MH-C) is a joint venture between the VHA and the Department of Defense. The MH-C was established to identify new treatment approaches to address spiritual distress and activate spiritual resources to enhance Veterans' mental health. This study looks at the use of a spirituality-based crisis intervention -- Crisis Orientation Refresh Empower (CORE) -- for Veterans who were admitted to the hospital (voluntarily or involuntarily) following a suicide attempt (SA) or suicidal ideation (SI). Over five years ago, the

CORE crisis intervention was created by a licensed clinical social worker and a staff psychiatrist on the inpatient psychiatry unit as they noticed that spirituality was an important, but missing, component of treatment. The CORE crisis intervention was to incorporate spirituality in the Veteran's treatment and recovery plans.

Review of the Literature

The connection of spirituality to sobriety is not a novel idea. Grim and Grim (2019) reported that spirituality was a major concern for patients suffering from SUDs. Spirituality is already used as a component of 12-step substance abuse self-help programs, such as Alcoholics Anonymous and Narcotics Anonymous (Krentzman et al., 2010). Studies have repeatedly supported that spirituality decreases substance abuse (DeWall et al., 2014; El Ansari et al., 2014; Hatta, 2010; Hayatbakhsh et al., 2014; Kopacz & Connery, 2015; Park et al., 2017; Rasic et al., 2011; Wang et al., 2015; Worley, 2020). However, some studies use the terms *religion* and *spirituality* interchangeably. A systematic review conducted by Hai et al., (2019) found that, compared to other interventions or treatment as usual, the 12-step spirituality model demonstrated a statistically significant difference in 16 out of the 23 studies examined. DeWall et al. (2014) conducted an impressive cross-sectional, longitudinal, and experimental series of studies which provided strong evidence for the effects of spirituality. For example, DeWall et al. found that increased amount of prayer time predicted decreased alcohol use.

VHA mental health clinicians, as a group, are encouraged to not ignore and instead show respect to the patients' spiritual beliefs and needs in the treatment of substance abuse to improve patient outcomes (Nieuwsma et al., 2013). Koenig et al. (2019) argued that Veterans who employ their spirituality in their recovery may reduce negative PTSD symptomology (such as shame and guilt, nightmares) and may help improve their important interpersonal relationships over time. Many studies indicate that spirituality correlates with improved well-being for Veterans (Smith-MacDonald et al., 2017). Additionally, research suggests that including Veterans' spiritual beliefs within their mental health treatment plan may reduce suicidality, depression, and isolation (Koenig, 2015) and

increase their help-seeking behaviors and coping skills (Sinclair et al., 2016). When faced with a psychological stressor, Veterans may access their spirituality to more effectively manage stress (Raskind, et al., 2018).

According to the United States Department of Veteran Affairs (2019), VA Chaplains offer to veterans and their families who are seeking spiritual guidance or counsel as it relates to their current problem. Within their scope of duties, VHA Chaplains are extending their reach into mental health. VA chaplains have been added as an additional resource in the treatment of patients diagnosed with SUDs. They are providing both group and individual treatment to Veterans as complements to SUD treatment programs (Earl et al., 2019). Spiritual treatment provided by chaplains may reduce the severity of PTSD, substance abuse, and suicidality. For example, after an eight-week spiritually-based intervention co-facilitated by a VA Chaplain and a mental health clinician, Veterans reported significant reductions in the PTSD symptoms (Kopacz & Connery, 2015). Furthermore, the spirituality-based intervention empowered Veterans to use their spirituality to manage life stressors and to deal with past traumas (Starnino et al., 2019). Thus, integrating chaplaincy services is a promising practice in helping Veterans heal. As the rate of Veterans with SUDs receiving care at the Veterans Health Administration increases, expanding clinical care to incorporating VA chaplains may be effective for treating those Veterans with a long history of SUDs.

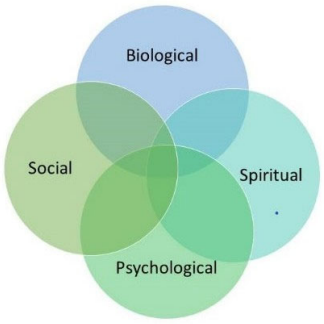
While there has been an increase in both interest and research on using spirituality in treatment plans, existing studies are primarily cross-sectional designs that look at correlations of spirituality and mental health at a set point in time. Such studies cannot provide baseline measures or temporal ordering. This pilot study contributes to the existent literature by looking at the impact of a novel spirituality-based crisis intervention over a full calendar year before and after the intervention. Further, this pilot study used an understudied sample; i.e. Veterans hospitalized for current suicide ideation and/or a recent suicide attempt.

Crisis Orientation Refresh Empower (CORE)

Background

The Crisis Orientation Refresh Empower (CORE) is a crisis intervention that evolved from the seminal biopsychosocial model of treatment (Engel, 1977). The biopsychosocial treatment model emphasizes the importance of understanding health holistically using a triad model: the biological, psychological, and social factors of health. CORE (Metcalf & Levy, 2018) expanded this biopsychosocial treatment model to a *four*-factor model of biological, psychological, social to include *spiritual* factors as the fourth factor as depicted in Figure 1. As such, CORE is one of the few crisis interventions that incorporates the patient's spirituality into his/her recovery plan. As a crisis intervention model, CORE can be provided to individuals of all religious affiliations due to its focus on recovery and wellbeing. (James & Gilliland, 2005; Roberts, 1991).

Figure 1: Four -Factor Model of Health



The primary goal of CORE is to improve health by introducing a spiritual component to the treatment plan. During the standard admission process for suicidality, nurses ask the Veteran if he or she would like to speak to a VA Chaplain. If the Veteran agrees, a consultation for chaplain services is requested. Due to the acuteness of the admission to the hospital, Veterans may decline to speak to a VA Chaplain at that time. The CORE clinician is notified of every admission. Within the first 24 hours, the newly admitted Veterans are seen by a licensed mental health provider who is trained in presenting CORE. If the patient has declined to speak to someone from chaplaincy services but has a documented belief or expresses a belief

in a higher power, the clinician offers the CORE crisis intervention. By offering the CORE crisis intervention at a later time during their hospitalization, the patient tends to be more open and willing to talk to a clinician about CORE.

Providing the CORE Intervention

CORE provides an opportunity for the counselor and patient to discuss his/her spirituality in relation to life prior to being hospitalized. The clinician promotes a safe and non-judgmental space so that a therapeutic relationship can grow. The CORE crisis intervention can be used to start the conversation about spirituality. The clinician facilitates the conversation with open-ended questions rather than dichotomous prescriptive questions often found in biopsychosocial assessments (such as "are you affiliated with any religion?"). The patient can share how his/her spirituality has helped in times of crisis and can reflect on past experiences. The clinician can help the patient draw on his/her spirituality to cope with the current crisis that led to suicidality.

The patient is provided with a CORE educational handout. The clinician and patient look over the handout together, reading out loud the information. CORE can be explained as a sequential crisis-to-recovery model. In providing the intervention, the clinician works with the patient to reflect on each sequential stage as depicted with the acronym CORE.

Crisis

The first letter, *C,* in the acronym CORE stands for 'crisis' and represents the first stage. A crisis occurs when previous methods of coping have failed. The person loses touch with his/her internal coping strategies to help them feel safe and not act on suicidal thoughts and contemplates suicide. The person may feel biologically, psychologically, spiritually, and socially disabled. At this point, the person needs help to find meaning and hope. The clinician uses active listening and content paraphrasing to communicate understanding of the crisis, build rapport, and provide support.

Orientation

The second letter, *O*, in the acronym for CORE stands for 'orientation' and represents the second stage. Orientation is the understanding of direction, position, or relationship with one's surroundings. When a person is in crisis, that person may lose orientation, sense of direction, and sense of meaning/purpose in life, and can ultimately feel lost (Costanza et al., 2019). The person may believe that death is imminent and may even welcome death. During the Orientation portion of CORE, the clinician uses unconditional positive regard, validation, reflective feeling, and emotional labeling to help the person gain a sense of control over his/her emotions. Imperatively, the clinician takes caution to meet the person where he/she is spiritually and not impose his/her own belief system. The clinician works with the individual to identify spiritual experiences. The clinician may ask about belonging to a spiritual group, connection to a Higher Power, current spiritual practices, and using spirituality to cope with trauma in the past. The clinician may explain that VA Chaplain Services can provide expertise regarding a range of spiritual needs and may be able to provide additional support, and ask the patient if he/she wants to be visited by the VA chaplain.

Refresh

The third letter, *R*, in the acronym for CORE stands for 'refresh' and represents the third stage. Refresh is the part of this process in which a person refreshes his/her spirituality. The open discussion during the Orientation stage about spirituality and past experiences may be refreshing for the patient. Spirituality goes beyond a simple belief that is complex and personal. A person's spirituality can promote resiliency, social change, unconditional positive self-regard, and social connection (Scribner et al., 2020). As a psychological allegory, *refresh* is like refreshing a webpage. The directive is for the person to 'refresh your own page' and reconnect with his/her spirituality. The clinician encourages the person to look introspectively and connect with spiritual resources (such as the VA chaplains).

Empower

The fourth letter, *E*, in the acronym for CORE stands for 'empower' and represents the fourth and final stage. As the person reconnects with his/her spirituality, he/she may experience strengthening of the ego, enlightenment, and empowerment. The crisis, which was meaningless suffering, can be converted into meaningful suffering. Meaningless suffering is suffering where nothing changes. Meaningful suffering is suffering where something changes positively. The patient may experience a spiritual renewal. The patient may feel empowered to go forward with his/her treatment plan.

After reviewing the sequential model depicted by CORE, the patient is asked which stage reflects his/her current status and why he/she is at that stage. Understandably, almost every patient says that he/she was in crisis on admission to the emergency room. Therefore, the focus is on the here and now, how the patient sees themselves today and incorporating his/her spirituality in the plan for recovery. Throughout the intervention, the clinician provides non-judgmental, supportive and encouraging therapy and thanks the patient for sharing his/her experiences. The Veteran's self-report of the stage he/she is experiencing can be collaborated by observed physiological factors (such as a relaxed body position, a smile, and eye contact). The entire CORE crisis intervention takes roughly 15 to 20 minutes.

Spiritual Intervention

The clinician does not provide any spiritual intervention or treatment as VA chaplains are considered the experts in spiritual treatment approaches. As a final component of CORE crisis intervention, the patient is asked again if he/she would like to speak with a VA chaplain. If the patient affirms, a VA chaplaincy consult is requested. A VA chaplain visits the patient and conducts a spirituality assessment. The VA chaplain provides the spiritual component of the treatment plan.

Methodology

This pilot study was a retrospective chart review using the electronic medical records of each Veteran admitted for suicidal ideation (SI) or suicide attempt (SA). These records include admissions, clinician notes, and laboratory test results. The goal was to examine the impact of CORE on the substance abuse. The study hypothesized that adding the CORE crisis intervention to standard treatment as usual will reduce substance abuse by Veterans who were admitted to the acute psychiatric unit for suicidal behavior (SB). The null hypothesis is that CORE will have no effect on substance abuse. Substance abuse was defined as having an alcohol use disorder or a SUD diagnosis. Based in the electronic medical records of the Veterans, two to three qualitative reviewers determined if each Veteran's substance use decreased, stayed the same, or increased for the full calendar year after CORE/admission compared to the year before CORE/admission. The charts document sobriety, relapse, and improvement via progress notes entered by the outpatient providers (McCormick et al., 2019). Quantitative data analysis was done using the Statistical Package for the Social Sciences Version 24 and G*Power. This social behavioral using record, chart, and dataset review using secondary data analysis. The study was approved by the University of South Florida's Institutional Review Board on 11/13/2015. Data was collected from reviewed medical records during a 12-month period before and after admission on the ARC unit between September 2014 and February 2015.

Sample

The original sample consisted of 102 Veterans who received CORE and a random sample of 60 Veterans who had not. All the Veterans had been admitted to the inpatient behavioral health unit between September 2014 and February 2015 due to Suicidal Behaviors (SB) which includes suicidal ideation and/or a suicide attempt. The inclusion criteria were (a) availability of electronic medical records for one year before and after admission; (b) age greater than 18; (c) admission was for SB; (d) documented belief in a higher power; and (e) no neurodegenerative /cognitive disorder/impairment. Of the 162 charts that were reviewed, only 61 met the inclusionary criteria. The majority (53; 87%) of the Veterans were male. As shown in Figure 2, the Veterans fell into four mutually-

exclusive comparison groups: Group A (n=17) received the CORE intervention and also saw the VA chaplain; Group B (n=9) received the CORE intervention but did not see the VA chaplain; Group C (n=15) received neither; and Group D (n=20) only saw the VA chaplain. All Veterans received standard care. As such, 26 (43%) Veterans received the CORE intervention and 35 (57%) Veterans did not. For those who experienced CORE, one Veteran experienced CORE twice. All others experienced CORE once. Thirty-nine (64%) Veterans had a service-related disability and 18 (30%) Veterans had served in combat.

Of the 61 Veterans, 45 Veterans had a diagnosis of an alcohol use disorder or a SUD. These 45 Veterans comprise the sample for analysis. Their electronic medical records were retrospectively reviewed for one calendar year before and after CORE/admission to determine if there was any change in their substance abuse.

Figure 2: Comparison Groups

Results

For the 45 Veterans diagnosed with a SUD, 53% (24) decreased their substance abuse, 37% (16) did not change their substance abuse, and 11% (5) increased their substance abuse as determined by the retrospective review of the electronic medical records. Fifteen of the 24 (33%) who decreased their substance abuse had the CORE crisis intervention and had a decrease in substance use.

For Model 1, we performed ordinal logistic regression to predict the odds of decreasing substance abuse using the mutually exclusive comparison groups as the predictors. Group C (standard care only) served as the reference group. The model was significant (p=.020). Model 1 explained 26.3% of the variance as indicated by a Nagelkerke R2 of .263. Within the model, only Group A (CORE and Chaplaincy with standard

care) gained statistical significance (p=.015) and had an odds-ratio of 11. The statistical power was 0.95.

For Model 2, we performed ordinal logistic regression to predict decreasing substance abuse using the comparison groups, chaplaincy, demographic factors, and comorbid disorders as predictors. The model only approached statistical significance (p=.059).

For Model 3, we performed ordinal logistic regression to predict the odds of decreasing substance abuse using CORE, chaplaincy, demographic factors, and comorbid disorders as predictors. The model was significant (p=.036). As indicated by a Nagelkerke R^2, Model 3 explained 46.7% of the variance in decreased substance abuse. CORE emerged as the only significant predictor. Veterans who had experienced CORE had a 15.08 odds ratio for decreasing substance use in the subsequent year. The statistical power was 0.95. The Ordinal Logistic Regression results for Models 1 and 3 are presented in Figure 3.

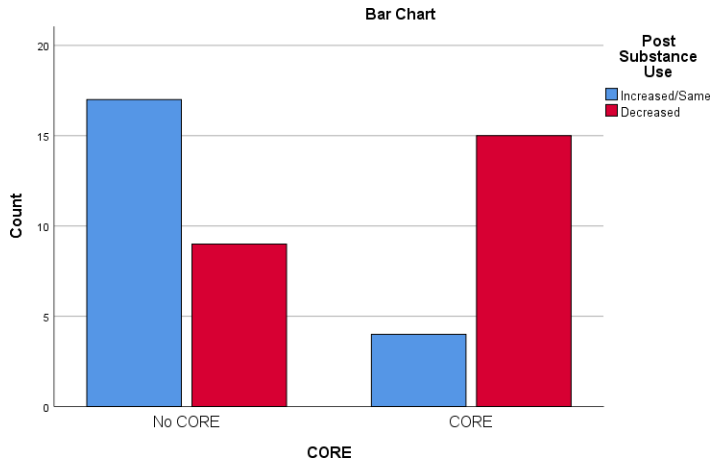


Figure 3: Bar Chart of Decreased Substance Use by CORE

Limitations of the Study

Veterans who identified themselves as having a belief in a higher power may have been more open to discuss their spirituality and so were

self-selecting into the CORE intervention. Sample bias may be possible due to the association between CORE and combat service. This pilot study utilized a small sample size which is less than optimal for performing inferential analyses with four comparison groups. Future research should utilize a larger, randomized, prospective sample. An additional limitation of this study is that the intervention itself was only performed by one clinician. For future research, CORE should be administered by other clinicians to decipher if the findings are due to CORE versus therapeutic alliance with the clinician. Another limitation is there was no follow-up with the Veterans to see if they continued to use the skills learned from the CORE intervention in times of crisis to garner spiritual strength. Studies designed to survey the Veterans' use of spiritual interventions on the outpatient basis will need to be conducted. For these reasons, the findings of this study should be considered preliminary, and additional studies are needed to confirm the findings.

Discussion

Due to the number of Veterans diagnosed with a SUD, implementing simple and effective treatment is imperative. This pilot study supports that the spirituality-based CORE crisis intervention can help patients reduce their substance abuse. Our data suggested that 53% of Veterans diagnosed with a SUD had a decrease in their substance abuse in the calendar year after receiving the CORE intervention. Further, Veterans who had experienced the CORE crisis intervention had greater odds of decreasing their substance abuse while controlling for chaplaincy, demographic characteristics, and comorbid disorders such as anxiety disorders, depressive disorders, post-traumatic stress disorder (PTSD).

The limits of this retrospective study cannot definitively reveal why CORE had a diminishing effect on the Veterans' substance abuse for a full calendar year. It is possible that the CORE is having an independent effect, or it is possible that CORE is having a moderating effect for the mental health treatment by increasing the Veterans' openness to seeking mental health or spiritual treatment. Although the data is not presented here, the chart reviews had also shown the Veterans who received the CORE intervention became more adherent to their mental health treatment and

more compliant with keeping their outpatient mental health appointments than those who did not. By contrast, it is possible that CORE promoted help-seeking behaviors. Also not presented here, the chart reviews revealed that, if admitted, Veterans who completed CORE were more likely to be admitted voluntarily rather than via a mental health commitment hold for evaluation. A third possibility is that CORE helps Veterans access their spirituality to deal with stress. Although the mechanism is unclear, this pilot study supports that CORE, a spirituality-based crisis intervention, has a diminishing effect on substance use for suicidal Veterans.

Future Research and Conclusion

This pilot study found that suicidal Veterans with SUDs had a reduction in substance abuse after receiving a novel crisis intervention while inpatient. Further, this pilot study also showed that Veterans who were readmitted within the same calendar year were more likely to be voluntarily admitted rather than involuntarily admitted. These findings support CORE's potential for decreasing substance abuse for suicidal Veterans. CORE may activate other protective factors (such as help-seeking behaviors, adherence to treatment plan, de-stigmatization, and coping skills). CORE may be an effective tool for tackling Veteran suicide rates and Veteran substance abuse rates by addressing more than one clinical factor. Despite the inherent methodological challenges, more study designs need to operationalize spirituality and examine the longitudinal effect of spirituality on substance abuse (Park et al., 2017). Since suicide and substance abuse are so closely linked, the VHA must imperatively find as many effective clinical interventions and strategies as possible to lower the suicide rate. Although more research is needed into the impact of spiritual care on substance abuse, these findings lend support for the continued integration of spirituality into the healthcare of our Veterans to achieve holistic health.

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Protect and Serve: Equipping Counselors to Support Health and Wellness Among Law Enforcement Officers

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Communities depend on law enforcement officers (LEOs) to protect and serve the needs of its citizens, and this requires them to encounter a variety of high-stress circumstances that become part of their everyday experience. While officers are given necessary tools to keep them physically safe, much less concern has been given to keeping them mentally and emotionally safe (O'Neill et al., 2018). Some LEOs may develop a number of maladaptive coping strategies, and possibly most concerning is that LEOs are 2.4 – 4.0 times more likely to die from suicide than by homicide or other felonious events in the line of duty (Heyman et al., 2018; President's Task Force on 21st Century Policing, 2015). This review of the literature revealed key factors counseling professionals can understand about LEO health and wellness, organizational culture, adaptive coping skills, family wellness, and signs and symptoms revealing struggles. These factors provided guidelines for how counseling professionals may apply useful interventions and strategies to better 'protect and serve' LEO health and wellness.

Keywords: law enforcement, wellness, holistic health, occupational stressors, counseling strategies

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Members of law enforcement experience a challenging and stressful profession, with a variety of employment demands that take tremendous physical and mental tolls (Santa Maria et al., 2018). Law enforcement officers (LEOs) witness a variety of high-stress events, including natural and manmade disasters, murder, suicide, active shootings, societal disorder, and a variety of other catastrophes that challenge them on a daily basis (Aaron, 2000; Rutkow et al., 2011). Managing governmental responses to pandemics may be one of the most recent stressful circumstances they encounter, as observed after the outbreak of the novel coronavirus (COVID-19) was declared a worldwide pandemic on March 11, 2020 by the World Health Organization (WHO, 2020). The United States Department of Justice (US-DOJ, 2020) reported that LEOs are employed by federal, county, and local agencies, and they fill a variety of sub-divisions that include the court system, natural resources, college campuses, tribal law, and correctional facilities. LEOs are required to function throughout these multiple domains of society, which demonstrates just how integrated they are on multiple layers of interaction with the civilian population. LEOs remain vital for upholding peace and order within the fabric of civilization, so ensuring their wellbeing remains highly relevant topic to address.

Given the complexities of law enforcement as a profession, many communities and departments highlight the importance of supporting our LEOs with greater care. The heightened stress that LEOs encounter leaves them at higher risk to experience multiple psychosocial problems, including substance abuse, anger, violence, and family discord (Boram & Philpot, 1993; Copenhaver & Tewksbury, 2018; James, 2008; Violanti, 2006; Wassermann et al., 2019). Pratia and Pietrantoni (2010) advocated that social supportive features be implemented to help LEOs navigate through the pressures of the occupation by emphasizing their contributions are vitally important, their service is not taken for granted as they enforce the laws, and they will receive support to be mentally sustained in their homes and on the job. Laws and policies equip our LEOs with the latest tools, equipment, and personal protective equipment (PPE) to guard LEOs against the dangerous (and sometimes paramilitary-like) operations they may

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encounter (Kraska & Cubellis, 1997). Equipping LEOs with the most appropriate forms of wellness remains an important investment to pursue further (Pratia & Pietrantoni, 2010).

Role of Mental Health Counselors

Mental health counselors and other practitioners consider the importance of guarding the mental and emotional health of LEOs as a top priority. The Military and Government Counseling Association (MGCA) demonstrated this point by appointing a task force in 2018 to develop competencies to assist mental health counselors and practitioners with the ability to serve the First Responder population with adequate forms of strategies and knowledge (MGCA, 2020). These competencies addressed the needs of LEOs, along with other First Responders, and how counselors can address the unique experiences of LEO culture, family systems, assessment of the presenting concerns, and treatment. LEOs regularly are exposed to critical incidents that can impact them negatively (Waters & Ussery, 2007), but mental health counselors who understand the unique factors influencing their reactions can support law enforcement agencies with creating environments that are conducive for greater mental and emotional support.

This is no small task because the US-DOJ (2019) reported in the 2016 Census of Federal Law Enforcement Officers (CFLEO) that there are 801,000 full-time, sworn LEOs between federal, general-purpose, state, and local agencies. Banks et al. (2016) outlined the structure of law enforcement in the United States, explaining there are about 18,000 federal, state, county, and local agencies. These numbers represent a large population worthy of due attention, especially in light of the ongoing services they provide their communities. In order for mental health counseling professionals to provide the greatest benefit to the LEO population, they must better understand the unique challenges they face and the factors that will help improve their quality of life (Heyman et al., 2018; MGCA, 2020). The American Counseling Association (ACA, 2014) expressed requirements in the *ACA Code of Ethics* for counselors to be properly equipped to support any client population with competence, training, and skill. This expectation compels mental health counselors to

approach LEOs with this same level of intentionality and rigor with developing adequate competence.

Further Rationale

Each year, far too many LEOs are killed, or assaulted in the line of duty. The US-DOJ (2019) indicated that in 2018, 55 LEOs died in the line of duty due to felonious events, as compared to 46 in 2017 (US-DOJ, 2018). Unfortunately, these statistics do not tell the full story. Among the variety of health challenges that occur within the LEO community is the problem of suicide. The US-DOJ does not currently track the number of deaths by suicide for law enforcement, but there is a general consensus that suicides outnumber the line-of-duty deaths each year (International Association of Chiefs of Police, 2019). In 2015, a national study using data of the National Occupational Mortality Surveillance found that police died from suicide 2.4 times as often as they do from homicides (President's Task Force on 21st Century Policing, 2015).

Several nonprofit organizations have taken on the task of this research and calculated the number of LEO suicides each year. In 2018, Blue HELP (2019), a nonprofit organization dedicated to supporting the mental and emotional needs of law enforcement, identified the number of confirmed suicides by LEOs in the United States at 167. Heyman et al. (2018) issued a white paper with findings indicating 140 LEOs died by suicide in calendar year 2017. These results demonstrated LEOs were about three times more likely to die by suicide than by death in the line of duty due to felonious events both in 2017 and 2018. The National Alliance on Mental Illness (NAMI, 2020) further reported that law enforcement officers were nearly four times the national average for completing suicide compared to the general public. These startling numbers have exhibited the importance of careful attention to the mental and emotional needs of our LEOs, and the ongoing need to 'protect and serve' the ones who have sworn to do the same for our homes and communities. While this motto has become popularized through the oath that LEOs have commonly sworn, their commitment to *protect and serve* becomes embodied in the work that places them at risk each day (Rudd, September 2009).

Properly Equipping

The rationale for properly equipping LEOs with the physical resources they need enables them to complete the tasks of enforcing our local, state, and federal laws. Proper equipment helps LEOs perform their duties effectively and safely, such as the use of body armor serves as protective gear to minimize the impact of a threat, and the possession of firearms to use deadly force during moments of imminent danger (O'Neill et al., 2018). The Centers for Disease Control and Prevention (CDC, 2020) even provided specific guidelines to follow for protecting LEOs against disease when needing to make contact with those suspected of infection during the COVID-19 pandemic, including what gear to wear and how to approach others. While these physical needs of protection are undoubtedly necessary, so are the various needs that support overall LEO wellness when they are not on duty.

The purpose of this article is to explore the current trends and practices for supporting LEOs throughout professional counseling literature, and to consider how counseling professionals can effectively integrate these principles to foster improved health, awareness, and protection of LEOs in the United States. Key factors revealed from the literature first provide the necessary foundation for understanding common themes impacting the overall health of the law enforcement community. This content provided helpful direction for how counseling professionals may properly apply evidence-based interventions and practical strategies useful for supporting law enforcement wellness. Application of this content from the literature is considered further to *properly equip* counselors with direct interventions to apply, and to help counselors to *properly equip* law enforcement agencies to establish environments that promote overall health and wellness.

Key Factors Affecting LEO Health and Wellness

When attempting to understand the factors involved in the overall mental health and wellness of the law enforcement community, the professional literature seemed to converge on four key factors worth recognizing by counseling professionals. These factors included:

organizational culture, adaptive coping skills, family wellness, and signs and symptoms. Understanding these factors revealed throughout the literature provided helpful guidance for how counselors might use this information to support appropriate interventions for improving overall wellness among LEOs.

Organizational Culture

Gershon et al. (2009) explained that organizational stressors, not critical incidents, are most strongly associated with perceived LEO stress. This finding suggested that while many officers are aware of the inherent dangers associated with their positions, they may be unaware and ill-equipped to manage the challenges of unfairness and inequity within the ranks of their police force. Gershon et al. (2009) described scenarios where work schedules, poor performers, favoritism, nepotism, supervisory concerns, promotions, and work assignments may perplex officers in their approach to their position leading them to question if the profession is appealing. Some personnel may experience depressive and anxiety symptoms that would be factors of adverse work conditions and poor relationships with peers and supervisors (Nelson & Smith, 2016; Young et al., 2012).

Davey et al. (2001) indicated the challenge associated with organizational stressors may be more pronounced in the law enforcement community due to the added pressures of responding first to critical incidents. Additionally, their research found lower organizational support yielded higher job stress. Hansson et al. (2017) further agued lower organizational support results in lower overall mental health among LEOs. Without adequate organizational support, personnel may struggle to perform at their best in their position, furthering an organizational culture of discontented personnel. Carlan and Nored (2008) described positive support of wellness initiatives within the organization has been observed as a supportive feature for law enforcement, and as a method to work through organizational challenges and demands of their positions. This yielded lower stress levels by officers taking advantage of counseling and organizational support where available.

Trauma Responses & Perceptions

When confronted with job related stressors and traumatic experiences Tehrani (2010) found that officers tended to group their responses in key ways. In some circumstances, officers needed time to mentally comprehend their experience. It may be appropriate to give the officer the time and space to work through their challenges of the trauma, with hopes of reflecting on the situation and employing appropriate coping skills. Tehrani (2010) also found another coping skill LEOs employed to the trauma experience was seeking the support of a counselor.

Due to the tight knit associations of law enforcement organizations, seeking support of a counselor may be challenging for some to consider. Bowler et al. (2016) found that some officers who responded to the terrorist attacks of 9/11 presented a fear of stigmatization based upon obtaining mental health support. Some wanted to avoid perceptions they are incapable of performing their duties if they decided to converse with a mental health professional regarding the trauma or other challenges experienced on the job. Some expressed fear of a non-supportive organizational culture, whether this fear was self-created or actual. Further concerns emerged for LEOs with regard to divulging the challenges of their positions because of the worry that mental health professionals could share privileged information with the officer's department or superior, further stigmatizing the officer (Balmer et al, 2013; Bowler et al., 2016).

Bishopp and Boots (2014) described the strains of the work environment experienced by LEOs and an application of general strain theory, which indicated officers may respond to their trauma experiences by focusing on suicidal ideation. LEOs may begin to question their role and impact as individuals charged to protect the public. Further, LEOs experienced feelings of worthlessness, inadequacy, or employment burnout. With these concerns, some officers responded with suicidal ideation, believing the best solution for their lives and for the lives of their family members was to no longer live (Bishopp & Boots, 2014).

Competing Social Factors

As with many professions, LEOs may spend much of their time with their colleagues as they perform daily activities or conducting other necessary work required of the position. However, Borum and Philpot (1993) explained that unstable schedules and unpredictable overtime frequently prevent LEOs from attending social gatherings such as a child's activity, dinner with family and friends, or extended vacations that allow them to leave work behind. The reality of life as a LEO can compete with other natural and healthy social connections that add quality to life remain important components of healthy social support (Violanti, 2006).

The organizational structure of law enforcement agencies often competes with marriages for time and commitments (Borum & Philpot, 1993, Violanti, 2006; Waters & Ussery, 2007). LEOs rarely work a typical work schedule identified as a nine-to-five, 40-hour week. Arrests made late in the shift, special details, and calls that require extensive paperwork commonly required the LEO to put in sizable amounts of overtime. Specialty team assignments and supervisory positions often require 24-hour on-call status, keeping an officer engaged in activities even while present with family or friends. The organizational culture typically expects officers be willing to put in extra hours and make the job a priority (Borum & Philpot, 1993).

Further complicating matters, when LEOs do have an opportunity to socialize outside the walls of their work location, some may associate only with other off-duty LEOs. Borun and Philpot (1993) found that solidarity with other LEOs created an isolation which magnified the power of the peer influence, sometimes with stronger influence than marital relationships. These bonds with associates, due to the strict external boundaries of law enforcement, may serve as their source of relational aptitude more so than an intimate partner or close friend.

Adaptive Coping Skills

The organizational culture of law enforcement agencies influences the nature of coping skills, and the crucial role they can play in the mental and emotional health of LEOs (Arble et al., 2017). Shepherd (2017) found

that maladaptive coping strategies were negatively correlated to resilience among LEOs. The literature provided a number of opportunities to recognize the maladaptive coping strategies some LEOs may exhibit in the face of heightened stress, including physical and emotional absence, anger, depression and anxiety, suicide, substance abuse, and family discord (Copenhaver & Tewksbury, 2018; Kuhns et al., 2015; Ménard & Arter, 2014, MGCA, 2020; Nelson & Smith, 2016; Wassermann et al., 2019). The following review of the counseling research focuses more on the adaptive coping skills discussed throughout the literature.

Positive Mentality

Some research emphasized the importance of developing coping skills to obtain a more positive focus or perspective (Arble et al., 2017; Shepherd et al., 2019, Wassermann et al., 2019). Arble et al.'s (2017) research identified that framing events positively along with humor can aid in the wellness of law enforcement. LEOs that utilize strategies that allow for a greater perspective of their circumstances can begin to see their challenges through varying lenses and ultimately improve their ability to cope and increase resilience. Additionally, seeking support, identifying methods to problem solve situations, and positively appraising circumstances can aid officers as they process stressful experiences (Wassermann et al., 2019). Shepherd et al. (2017) indicated acceptance and self-distraction became associated with resilience, which included fostering strategic thought development around positively-oriented thinking. Both counselors and law enforcement agencies have the opportunity to support these types of environments where LEOs can work to manage their stress in positive ways.

Prevention

Law enforcement agencies can support the needs of the LEOs by implementing thoughtful prevention efforts that target their needs adequately. Rutkow et al. (2011) explained how First Responders could benefit from mental health screenings before, during, and after traumatic events and other emergencies in order to identify a healthy baseline to

work. This kind of early prevention could lead to establishing healthy coping with occupational stressors. Screenings also support opportunities to cope with the challenges of the job with greater understanding of what wellness truly means and the theoretical principles behind psychological methods of improvement.

When working to increase appropriate coping mechanisms, various wellness programs incorporate holistic wellness approaches to provide a wider range of preventative supports (Church & Robertson, 1999; Williams et al., 2010). Working to influence holistic health have provided opportunities to address physical fitness, nutrition, substance use education and treatment, tobacco cessation, and the incorporation of mindfulness (Copenhaver & Tewksbury, 2018, Kuhns et al., 2015; Ménard & Arter, 2014,). These specifics offer an inclusive, holistic view to ensure adequate health and awareness.

Strong partnerships between law enforcement leadership, LEOs, and clinical mental health practitioners has successfully supported effective prevention efforts and treatment outcomes (Papazoglou, & Tuttle, 2018). Santa Maria et al. (2018) expressed that the development of coping skills highlighted the need for top-down encouragement from leadership. LEOs were not only encouraged to utilize the resources available in this type of environment, but also to take the time necessary to do so. This leadership strategy included training on mental wellness, stress management, necessities of social support, which emerged as protective factors supporting LEO wellness (Santa Maria et al., 2018).

Family Wellness

Waters and Ussery (2007) described that a significant challenge encountered by LEOs is the impact the occupational role has on immediate family members. Some families have lived with daily fear regarding the developments of officers while they are away at work. The uncertainty of the daily challenges and potential exposure to violence presented potential concerns family may experience (Waters & Ussery, 2007). Example questions raised by LEO family members in light of these challenges may include: “Will my loved one return at the end of their shift?”, “Why is my mother angry tonight?”, “Why does my father spend more time on the job

than with me?", "Who is going to help my father if he is injured?", or "Will my husband have enough time for me after work?"'

Tuttle et al. (2018) and Miller (2007) also articulated experiences where LEOs may raise questions about their role in their families. Further example questions may include; "Does my family understand what I go through daily?", "If I ask my supervisor, would I be allowed to leave work early to attend my son's play?", "Should I be spending more time with my colleagues than my children?", "Will my colleagues help me get home every night?", or "Will I be too tired to help my sister with her homework when I get home after shift?" Because the LEO does not know what will occur during the day, neither does the family. These types of questions lead to challenges in coping with the realities of the job, family, marriage, and commitments to oneself (Tuttle et al., 2018).

Describing the challenges of family dynamics and wellness, Miller (2007) articulated that some officers may place unrealistic demands on spouses by requesting them to administer home and family affairs or maintain the upkeep of the home without the support of the LEO. Loyalties may seem in conflict with the family environment when the job gets in the way of meaningful family experiences, including holidays, vacations, special events, and other occasions. Law enforcement agencies that strive to minimize the work-family conflict yielded LEOs with greater resiliency and lower stress and burnout (Griffin & Sun, 2018). In order to support the greater wellness of families within the LEO community, Miller (2007) proposed that counseling professionals can target family relationships by setting treatment goals to enhance communication skills, healthy structure and boundaries, mutual support, anger management, and relationship skills among family members.

Signs and Symptoms

Counseling professionals have the opportunity to collaborate with family, friends, and organizations to identify signs and symptoms that LEOs are experiencing difficulty managing their stress. Larned (2010) believed counselors can help draw attention to signs and symptoms among LEOs struggling to maintain an acceptable level of mental wellness. Counseling professionals also can help identify maladaptive strategies and

harmful coping mechanisms that have the potential to impact LEOs and their families. Many of the signs and symptoms of heightened stress or trauma reactions reflected very clear similarities to the maladaptive coping responses described previously, and in some cases they have overlapped.

Physiological and Psychosocial Problems

LEOs have displayed the potential for a variety of uniquely problematic reactions as a result of their stressful work environment and exposure to traumatic events (James, 2008). Symptoms of stress some LEOs reported included digestive disorders, cardiovascular disease, alcoholism, substance abuse, domestic violence, Posttraumatic Stress Disorder, depression, anger, suicide, violence, and arguments with loved ones (Violanti, 2006; Waters & Ussery, 2007). Boram and Philpot (1993) explained that trauma experienced on the job has the potential to emerge with the family or the spouse directly as bursts of anger unless the officer effectively employs adaptive coping mechanisms like the ones described previously. Violanti (2006) explained how these factors may develop and increase in frequency and intensity if left unchecked, because of the compounding exposure to traumatic experiences.

PTSD Symptoms

The high-risk activities required by LEOs underscore how they remain at a higher risk for Posttraumatic Stress Disorder (PTSD). The American Psychiatric Association (APA, 2013) described the prevalence for PTSD in the *Diagnostic and Statistical Manual, 5th edition* (*DSM-5)*: "Rates of PTSD are higher among veterans and others whose vocation increases the risk of traumatic exposure (e.g., police, firefighters, emergency medical personnel)" (APA, 2013, p. 276).

The criteria for a PTSD diagnosis in the *DSM-5* reflected common experiences LEOs may likely encounter (APA, 2013). Exposure to traumatic or life-threatening events (Criterion A), would be nearly immediate and regular among LEOs due to the nature of their daily work experience. The subsequent criteria would develop for any LEOs that begin having PTSD reactions, including recurrences and responses (Criterion B),

stimulus avoidance (Criterion C), and negative thoughts, emotions and behaviors associated with the event (Criteria D and E) (APA, 2013).

In addition to understanding the criteria for PTSD (APA, 2013), the literature identified a number of factors that increase the risk for LEOs to develop PTSD. A study by Carlier et al. (1997) revealed that 7% of their total sample of LEOs obtained a PTSD diagnosis, compared with 3.5% from the general population (APA, 2020). A variety of other risk factors identified by the study showed evidence for PTSD symptomatology after three months, including introversion, the ability to self-express, emotional exhaustion at the time of the trauma, insufficient time to deal with the trauma, dissatisfaction with the organizational supports, and insecure job features. At the end of 12 months, the absence of hobbies, additional traumatic events, dissatisfaction with the job, brooding over work, and the lack of social interaction suggested stronger risk for chronic PTSD.

Marchand et al. (2015) also described a range of risk factors for PTSD among LEOs, including the cumulative exposure to traumatic events, which can be a regular occurrence for LEOs. Occupational factors, as alluded to among LEOs above, were also found to increase risk. LEOs may have times when they are involved with multiple high risk or traumatic events within the same year, which will increase their risk for PTSD symptoms. Marchand et al. (2015) described how limited work experience also can increase risk for new officers in the field because of the inability to adequately frame their novel experiences against what they may experience on the job. Additional risk factors included LEOs with personal trauma (related to work or not), family psychiatric history, those with difficulty expressing their emotions, fear of anxiety symptoms, and hypersensitivity to threats they may encounter (Marchand et al., 2015).

Suicide Risk

The general concerns related to LEO suicide were previously described in greater detail. Counseling professionals have continued to advocate for the need to maintain conversation about suicide, and reduce stigma around approaching the topic within the LEO community (Kuhns et al., 2015). A variety of risk factors associated with suicide among LEOs throughout the literature included career status (compared with volunteer status) and the

history of responding to a suicide attempt or death (Jones, 2017). Bishopp and Boots (2014) identified depression and burnout as risk factors for suicidal ideation among LEOs as well. Thompson (2019, May) highlighted that warning signs to consider for suicidal risk among LEOs included the presence of suicidal statements, alcohol abuse, expressing feeling like a burden, relationship issues, and feelings of hopelessness. These factors, coupled with the natural access to lethal weapons, increase the risk for suicide substantially among LEOs.

Applying Interventions

The preceding key factors described a variety of ways that the health and wellness of LEOs are affected by their chosen occupation. The following content explores ways counselors work to *protect and serve* our LEOs with greater accuracy by integrating the information strategically. Variations of the following points can be applied both with LEOs, their families, and with law enforcement agencies looking to make a difference among their officers.

Facilitating Heathy Coping Skills

Counselors can facilitate development of adaptive coping skills that lead to greater health and resiliency as discussed earlier. Practical ways to support this development can be for LEOs to become educated about coping styles, resilience training, and rational coping strategies (Balmer et al, 2014). Larned (2010) suggested LEOs may develop greater resiliency through increased self-awareness, which can be enhanced through emotional intelligence training and developing personal introspective opportunities. Increasing self-awareness also can assist LEOs with recognizing one's emotions, strengths, and limitations. This will open the door for more specific coping skills as detailed previously.

Leadership in law enforcement agencies can focus energy on training programs to mentally prepare for the stress of the job and enhance responses in the field (Arnetz et al., 2009), much like the physical training that is routinely required to prepare LEOs for the field. This focus on developing coping skills and why they are important can help law

enforcement develop a healthier appreciation for wellness training (Arnetz et al., 2009; Can & Hendy, 2014; Santa Maria et al., 2018). Counseling professionals may use these training environments to provide police-specific imagery to prepare LEOs to deal with similar scenarios in the actual line of duty. LEOs then can reflect on the nature of various incidents (i.e. required use of force), the necessity to counteract the circumstances with appropriate coping skills (i.e. anger management, social support, etc.), and employ skills to help reduce psychological stress (i.e. de-escalation techniques, mindfulness, etc.).

Supporting Positive Replacement

Information on coping skills also detailed the benefits of maintaining a positive focus for LEOs (Arble et al., 2017; Shepherd et al. (2017). Seligman and Csikszentmihalyi (2000) described an approach to address distorted thoughts, which may develop in response to feeling overwhelmed with trauma exposure. In this model, principles of positive psychology provided a theoretical approach to combat negative thoughts about themselves and their circumstances. This intervention involved identifying personal, negative reactions to events and replacing them with positive perspectives or outlooks on events. Seligman and Csikszentmihalyi stated this approach may employ the notions of subjective well-being and optimism to gain a greater evaluation on events and reframe thoughts. Recognizing and using positive reframing techniques can help combat negative emotions that may occur (Arble et al., 2017). Various negative reactions have the potential to emerge as a result of the heightened stress LEOs may face. Four types of negative reactions are highlighted here in order to demonstrate ways that positive replacement strategies may be exercised within a counseling context as shown in Table 1.

Negative Self-talk

An officer experiencing a negative self-talk reaction to a circumstance may state, for example, “I am worthless,” or “I can’t do anything right,” because of their frustration with a variety of circumstances. To make use of positive replacement, counselors can apply the concepts presented by Seligman et

al. (2005) to help LEOs identify positive perspectives on life and articulate a more optimistic focus. These may include: "I know I have value, and I try my best", or "I am good at what I do because I can identify my accomplishments." In these examples, counselors can engage conversations that draw out personal beliefs and enhance awareness through rational processing that combats negative self-talk.

Negative Outlook

Positive psychology and counseling strategies according to Seligman and Csikszentmihalyi (2000) can be useful when replacing a negative outlook such as: "Life has no purpose," or "Nobody cares about whether I do my job well or not." This can be replaced with honest reflections of more positive perspectives, such as what inspired them to enter the field of law enforcement in the beginning and the desire to help others. The application of positive replacement may help reframe thinking to include a focus on the way one is improving the world (Seligman & Csikszentmihalyi, 2000). Counselors can support replacement with a more positive outlook such as: "There is purpose in trying to make a difference through my work," or "I make the world better one step at a time."

Secondary Emotions

Secondary emotions such as anger or depression may emerge from the intense feelings of stress among LEOs as described throughout this article (Boram & Philpot, 1993). Recognizing these secondary emotions along with their root causes can provide opportunities for counselors to help LEOs replace them with strategies that elicit more positive emotions. Understanding which emotions are truly primary will provide greater clarity with the types of interventions that will provide the greatest emotional management options. Counselors may support positive replacements for these negative emotions by helping LEOs elicit positive emotions through the coping strategies described, such as engaging in humor (i.e. watching a comedy) or utilizing social supports available (i.e. communicating more with loved ones).

Unproductive Behaviors

Unproductive behaviors can be identified with some of the risk factors and unhealthy coping methods previously described. Counselors can explore these maladaptive tendencies that may be occurring, such as substance abuse or violent reactions (Larned, 2010). Healthy actions for replacing them can be developed with the LEOs themselves, such as developing a workout routine (i.e. joining a gym) or engaging in healthy social activities (i.e. joining a basketball league, bike club, etc.).

Table 1

Positive Replacement Strategies

Negative Reactions	Positive Replacements
Negative self-talk: "I am worthless." "I can't do anything right."	**Positive self-talk:** "I know I have value, and I try my best." "I am good at what I do because I can identify my accomplishments."
Negative outlook: "Life has no purpose." "Nobody cares about whether I do my job well or not."	**Positive outlook:** "There is purpose in trying to make a difference through my work." "I make the world better one step at a time."
Secondary emotions: Anger Depression	**Positive emotions:** Elicit happiness by engaging humor Elicit satisfaction by utilizing social supports
Unproductive behaviors: Substance abuse Violent reactions	**Positive activities:** Develop a workout routine Healthy social activities

Promoting Holistic Wellness

The literature provided helpful perspectives on multiple ways that holistic growth may be fostered, including fitness and nutrition (physical), self-awareness development (emotional), the incorporation of mindfulness (mental), family wellness (social), and exercising religious beliefs and practices (spiritual) (Acquadro Maran et al., 2015; Chopko & Schwartz, 2009; Copenhaver & Tewksbury, 2018, Kuhns et al., 2015; Larned, 2010; Ménard & Arter, 2014; Waters & Ussery, 2007). Counselors can take time

to explore holistic needs with LEOs regarding physical, emotional, mental, social, and spiritual factors, such as displayed with the example in Table 2.

Table 2

Holistic Health Needs

	Physical	**Emotional**	**Mental**	**Social**	**Spiritual**
EXAMPLE questions to explore	What helps me feel physically healthy?	What helps me feel OK about myself? What helps me deal with my emotions?	What helps me concentrate, be motivated, be inspired?	How much time do I need around others/ by myself? With whom do I need to invest my time most?	What inspires my sense of meaning and purpose? What helps me feel more connected to God?
EXAMPLE responses	▪ workout 3x weekly ▪ 7+ hours of sleep	▪ journaling my reactions ▪ going to counseling weekly	▪ reducing clutter around me ▪ making to-do lists	▪ 3 social activities weekly ▪ 60 minutes daily focused conversation with my kids	▪ daily prayer or meditation ▪ attending church weekly

Myers et al. (2000) described a foundational view of wellness as the total development of an individual so there may be harmony and integration amongst one's mind, body, and spirit. With this approach to wellness, LEOs can be prompted to consider the aspects that help keep them healthy in every avenue of their lives. As counselors foster inventory of these holistic areas, they promote growth by generating a greater understanding of themselves in relation to what helps them function in a healthier manner. The goal with remaining holistically balanced, is that when LEOs encounter difficulty they may already be engaged in these preventative efforts to maintain a balanced approach to their life circumstances (Tanigoshi et al., 2008).

Enhancing Communication and Awareness

Because much of the challenges presented in the literature demonstrated difficulties with the overall LEO organizational culture and difficulties in family dynamics, it stands to reason that enhancing communication offers a helpful intervention. Communicating emotionally about the incidents that occur can become difficult due to fear of stigma LEOs may face (Balmer et al., 2013; Bowler et al., 2016). There are many ways in which counselors still can support communication that is healing among the law enforcement community.

Processing Critical Incidents

Critical incident stress management (CISM), incorporated by many policing organizations, has shown to be a source of wellness that supports LEO communication (Mitchell, 2009). This intervention focuses on alleviating the potential traumatic reactions acquired through a crisis event and supporting First Responders through the reactions they may have. With these outlets, LEOs have an ability to articulate their responses and emotions involving an event, while hearing encouragement to apply healthy coping skills.

Rutkow et al. (2011) argued that receiving debriefings (or screening, etc.) would allow counselors and leaders an exploration of pre-existing conditions that may be exacerbated through exposure to emergency scenarios, and how to effectively identify triggers that may compromise wellness. Having supportive, dependable people through such debriefings can provide tremendous social support. LEOs may sometimes face isolation from others outside of the profession, but engaging other LEOs as an outlet or refuge through shared experiences has been found important during stressful circumstances (Borum & Philpot, 1993).

Addressing Difficult Topics

Counselors can employ multiple approaches for opening discussion about physiological or psychosocial concerns, PTSD symptoms, or suicide risk as described previously. The more the LEO community knows about increased risk, the more people may be open to sharing what they feel before greater problems arise. Family therapy, group therapy, and reflective techniques are known to be helpful methods for addressing signs and symptoms that create concern among LEOs (James, 2008). The APA (2020) described some of the most current treatment approaches as Cognitive processing therapy, prolonged exposure therapy, group therapy, medication, and other possible modalities. Other important topics to address may include psychotropic medications, and a focus on anxiety reduction to increase awareness of symptoms and impact on one's life (Larned, 2010). At the heart of any of these interventions is the need to communicate clearly and directly about options available for LEOs.

Counseling professionals may be in unique positions to facilitate conversations among LEOs that highlight both risk factors and protective factors that will keep them informed. Introducing these factors can range from individual interventions to larger prevention program trainings. Either venue may provide the appropriate space to channel anger-related feelings pertaining to their job, family, or social environment. In doing so, LEOs can release the stress and anger in appropriate methods rather than maladaptive formats that are exacerbated with high levels of stress (Can & Hendy, 2014). Mental health counselors and LEOs can be trained to articulate their thoughts on a variety of important issues sometimes avoided within law enforcement culture, including suicide, persistent acute stress exposure, PTSD, and alcohol and drug abuse (Waters & Ussery, 2007).

A key element in addressing difficult topics is the need for proper listening and observing. Ramchand et al. (2018) provided a helpful example, where the Israeli Defense Force noticed a significant number of suicides over the weekends among young soldiers. Officials began requiring them to leave their firearms on base when they returned home on weekends, and they soon witnessed a 40% reduction in the suicide rate among young Israeli men. While this example is very different from the average LEO circumstance, understanding the problem of each unique

setting will permit agencies to develop to multi-pronged strategies with programs to prevent suicide or harm by: 1) raising awareness and promoting self-care, 2) identifying those at high risk, 3) facilitating access to quality care, 4) providing quality care, and 5) restricting access to lethal means when they are unnecessary (Ramchand et al., 2018, p. 8). Counselors are in a good position to foster these discussions.

Helping LEOs Help LEOs

Possibly one of the most important intervention strategies that counseling professionals can utilize would be the opportunity to train LEOs how to use the key concepts affecting their fellow colleagues and apply intervention strategies that can assist each other in meaningful ways. LEOs can be trained in some of the basic concepts of psychosocial support already described, along with a variety of other interpersonal response strategies (Ruzek et al., 2007). This presents an opportunity for law enforcement to identify key areas with one another and address the importance of their health and wellness. While assisting a LEO to decompress following an event, opportunities to engage and process the event in a non-intrusive manner has shown great benefit (Ruzek et al., 2007).

The National Alliance on Mental Illness (NAMI, 2016) listed ways in which LEOs are encouraged to maintain support to fellow officers. NAMI (2016) recommended that all LEOs be willing to approach each other by ensuring safety, providing practical help, offering to talk, listening attentively, reassuring, and leaving a number to call. Counselors can encourage these practical steps that can be learned and implemented with relative ease by any LEO, and counselors can provide training environments that support the organizational culture with promoting such concepts.

LEOs will have the best opportunities to impact one another positively when they hear validation of their mental health needs (Santa Maria et al., 2018). The hierarchical structure of law enforcement suggests that leadership encouraging safe spaces and dialogue will foster greater openness and wellness (Papazoglou, & Tuttle, 2018). LEOs may help colleagues connect with social services if necessary and provide the kind of

safe environment that is found to be critical when stress is heightened or after a traumatic event. Linking officers with applicable services to aid in managing signs or symptoms of distress can possibly be one of the most important ingredients that can foster health and safety within an agency (Ruzek et al., 2007).

Providing Competent Professional Counseling

Counseling professionals have an ethical obligation to develop greater competencies with LEOs they support by working to understand law enforcement culture, roles, and responsibilities (ACA, 2014). The MGCA (2020) provided a helpful foundation for counselors to understand how to support First Responders, with specific insights for understanding how LEOs experience challenges with the law enforcement culture, family systems, assessment of the presenting concerns, and treatment. Raganella and White (2004) identified reasons and motivations for becoming a LEO that are important for counseling professionals to consider. LEOs are members of our community who have taken the role of First Responders who have committed to helping people, protecting them, and enforcing our laws. LEOs are noted for running towards challenging situations rather than away from them (Raganella & White, 2004). Knowledge of these realities can aid counseling professionals further to understand the scope and mentality LEOs have for entering the profession, and helping inform plans of action to support them with the various interventions and strategies presented here.

There are aspects of the LEO position discussed previously that may be challenging for counselors to understand fully, and some LEOs will remain suspicious of counseling because it may not be perceived as part of the police subculture (Rose & Unnithan, 2015). Counseling professionals and practitioners can develop greater competency by remaining open-minded towards the experiences of LEOs. Working to understand the unique culture and dynamics in law enforcement will improve the ability to support LEOs through the stressful encounters they experience in the line of duty (Komarovskaya et al., 2011).

Competent counseling will require strategies for implementing interventions and approaches outlined throughout the content described

here, including facilitating healthy coping skills, supporting positive replacements, enhancing communication and awareness of trauma or burnout, and training LEOs with basic mental health skills to help LEOs. Future research will support greater competence among counselors by exploring growing concerns with the impact of marginalized populations within LEO culture (ethnicity, gender, sexuality, religion, etc.), the influence of societal stigma on LEOs in various communities, and the impact of exposure to police brutality (either perpetuated by others or oneself).

Conclusion

LEOs swear an oath to protect and serve the communities in which they live (Rudd, 2009). Consequently, this commitment places LEOs in the line of danger, not only physically, but also mentally and emotionally. Startling statistics revealed that LEOs face the risk of death by suicide roughly 2.4-4.0 times higher than the rate they risk death in the line of duty (Heyman et al., 2018; NAMI, 2020; President's Task Force on 21st Century Policing, 2015; US-DOJ, 2019). The literature revealed that LEOs face multiple stressors that exacerbate the stress of their demanding jobs, and managing the problem requires understanding the organizational culture of law enforcement, coping skills that are adaptive for the profession, addressing problems in family dynamics, and addressing concerning signs and symptoms (Arble et al., 2017; Gershon et al., 2009; Waters & Ussery, 2007).

Interventions for appropriately applying these key factors supported in the literature offered a holistic perspective with how to support LEOs. Strategies and interventions counselors can apply, based on the presented research, included facilitating heathy coping skills, supporting positive replacement strategies, promoting holistic wellness, enhancing overall communication and awareness, helping LEOs help LEOs with adequate training and support, and providing professional counseling with the necessary competency for LEO culture.

Counseling professionals have unique opportunities to protect and serve LEOs in ways that target their cultural needs. This general content does not deny that challenges occur for each individual LEO, their families,

and even their local agencies. This content rather highlights a growing effort to develop greater counselor competency with themes identified in the literature that can enhance the ability for counselors to support LEOs effectively. Many resources go into properly equipping LEOs and keeping them safe physically. The startling statistics on suicide risk, physiological problems, and psychosocial issues show these efforts are not enough to keep LEOs safe with only armor, weapons, and other tools (O'Neill et al., 2018). Physical protection remains important, and counselors also can sound the alarm for addressing the importance of holistic needs that encompass physical, emotional, mental, social, and spiritual health (Chopko & Schwartz, 2009; Church & Robertson, 1999; Williams et al., 2010). This contribution positions counseling professionals and practitioners with significant opportunities to influence the LEO population in positive ways.

Ongoing focus and attention will help shorten the gap of services received by law enforcement personnel. Further research is recommended to expand on this content to further understand effective treatments for suicide prevention, factors that increase engagement with supports and reduce stigma, trauma recovery and resiliency, depression and anxiety, supporting healthy family relationships, and establishing healthy environments that support these goals. The more information that can be acquired, the more counselors can enhance competency and treatment to better *protect and serve* the LEO population with strategies for improved health and wellness.

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A Qualitative Exploration of Combat Veterans' Lived Experiences with Treatment for Trauma: Competencies Influence Outcomes

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More than 16 veterans end their lives by suicide per day, another 20% suffer with symptoms of Posttraumatic Stress Disorder (PTSD) and 10%-25% experience moral injury and other impacts of trauma. In an effort to better understand the unique needs of members of this population, researchers completed semi-structured interviews with combat veterans to gain insight into their lived experiences receiving treatment for combat trauma. A primary theme that emerged from an Interpretative Phenomenological Analysis (IPA) of the data revealed the influence of clinician competencies on treatment outcomes, specifically regarding how they may hinder or encourage veterans' participation in treatment. Further, the findings provided insight for combat veterans regarding how they play a role in their own treatment outcomes. Implications for stakeholders and suggestions for future research are provided.

Keywords: veterans, Veterans Affairs, treatment, combat, trauma, competencies

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While current research provides a number of insights regarding how mental health professionals may most effectively serve veterans in crisis, a high number of veterans continue to lose their lives to suicide. The Veteran Suicide Prevention Annual Report (2019) indicates an average of 16.8 veteran suicide deaths per day. Additionally, up to 20% of the veteran population suffers from PTSD, and 10%-25% of this population experience moral injury (Jeromin et al., 2020). Given the high prevalence of those suffering, the Veterans Administration (VA) developed several initiatives aimed to specifically engage veterans in mental health services, including the specialized training of over 12,000 VA mental health clinicians. Clinicians were trained in evidence-based interventions, including Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT). Despite these efforts, many veterans opt out of services due to past experiences, expected outcomes, stigma, and other factors as depicted in results of a recent study from which this manuscript was derived (Hurst, 2020).

An absence of the provision and engagement of high-caliber mental health treatment may perpetuate unnecessary continued suffering as well as put veteran lives at risk. It is important to examine veterans' lived experiences traversing mental health treatment in order to better understand their unique concerns and needs. Such efforts may inform future care and aid in the development of a more holistic treatment model serving military personnel. Several major themes emerged from the study, including the influence of perceived clinician competencies on clinical outcomes (Hurst, 2020). This manuscript describes barriers related to provider and complementary stakeholder competencies. Recommendations to mitigate such barriers are also provided.

Purpose

A qualitative approach was used to analyze the lived experiences of veterans who sought counseling treatment for trauma. Specifically, it explored veterans' perceptions of treatment aimed at mitigating specific elements of PTSD, moral injury (encompassing spirituality, forgiveness, and meaning making), and physical dysfunction. Interpretative

phenomenological analysis (IPA) prompted an analysis of data to developed implications for professionals and other stakeholders (Finlay, 2014). The research questions were: 1) How do veterans describe treatment sought or provided for impacts of combat trauma including PTSD, suicidality, moral injury, and associated physical symptoms? and 2) What are combat veterans' recommendations for future treatment? The study addressed a myriad of gaps in literature not limited to: (a) the uniqueness of working with veterans entrenched in a military culture, (b) clinicians' lack of familiarity with military culture, (c) how to increase veteran empowerment in the counseling process, (d) insistence on full-spectrum treatment options, (e) the adaptation of treatment for the veteran population, and (f) emphasis on the need for leadership support following traumatic events.

Method

To explore how participants made sense of their lived experiences with treatment for trauma, a humanistic perspective was utilized, thus allowing veterans to serve as the experts. The interpretative process in IPA is described as double hermeneutic. This means data is analyzed for understanding and perceptions on behalf of the participants and by the researcher (Smith, 2004; Smith & Osborne, 2003). Semi-structured interviews were utilized in data collection and analyzed for thematic phenomenon to answer the research questions.

Participants

Purposive sampling was used to answer the research questions with experts on the studied subject (Etikan et al., 2016). Therefore, participants were sought based on the following selection criteria: a) veteran of a foreign war (Enlisted ranks only), b) experience with current or former treatment for impacts of trauma (e.g., Posttraumatic stress, moral injury, physical symptoms, or suicidal behaviors), c) experienced trauma during a war-time conflict, and d) served at least 6 months in theater of war. The study was restricted to enlisted ranks due to the distinct differences between the experiences of officers and enlisted members of the military. The

inclusion of only enlisted personnel normalized like experiences based on occupations which are unique to the enlisted ranks. Snowball sampling techniques were utilized as advertisement recipients passed on the information to others via the internet, e-mail, and direct messaging. To protect confidentiality, all interested participants were asked to make direct contact with the primary researcher versus being referred.

Seven participants met selection criteria, and reported active combat service in the following branches: the active duty Army (1), a Marine reservist who served on active duty (1), Army National Guard, Active Guard Reservists (AGR) (3), a traditional Army National Guardsman who served on active duty (1), and an active duty Marine who is now retired (1). There were six males (86%) and one female (14%). Participants' average age was 39 (34-39) and the average number of months in combat was 21 (7-36). Primarily, the traumatic experiences of each participant were a result of first deployments. There were no significant commonalities in occupations. Participant ranks and grades included an E4/Lance Corporal, Marine (1), E5/Sergeant, Army (1), E6/Gunny Sergeant, Marine (1), E7/Sergeant First Class (3), and E8/First Sergeant, Army (1).

Procedure

Once the Institutional Review Board (IRB) approved the study, an automated flyer was distributed to find potential participants via the internet. Participants conducted a self-screening based on criteria mentioned on the flyer. Once they contacted the primary researcher, an additional screening was conducted to rule out suicidal behaviors within the last 12 months, and an interview was scheduled. Upon meeting face-to-face in a private office setting, the primary researcher obtained informed consent from potential candidates, emphasizing mandated reporting requirements throughout that process. Participants were instructed on how any potential issues related to talking about their trauma, would be addressed in informed consent. Further, the focus of conversations remained on treatment versus specific trauma narratives. This increased safety for participants knowing the interview was not intended to be therapy.

The primary researcher is a combat veteran and licensed clinician, which helped establish rapport with participants and enrich the overall analysis. The primary researcher used bracketing to look for personal assumptions, noting them in a daily log, and setting them aside to allow for the research to remain unbiased. A semi-structured interview format allowed for in-depth communication and additional clarifying questions to be asked, as needed (Mack et al., 2005). The primary researcher used prolonged engagement and observation of body language during the interviews to enhance meaning of interactions and to watch for participant cues (Mack et al., 2005; Pietkiewicz & Smith, 2014). In line with established interviewing practices, breaks were taken, as needed (Mack et al., 2005). The primary researcher spent a few minutes debriefing with participants and allowed them time to ask questions (Amankwaa, 2016; Lincoln & Guba, 1985).

Interviews were recorded and transcribed. In an effort to ensure accuracy and facilitate dependability, transcripts were provided to the participants for review to allow for modifications as a form of member-checking (Lincoln & Guba, 1985). If no response was received within five days, transcripts were added to the record and assumed to be correct (Mack et al., 2005). Transcripts were labeled with a de-identified marking to ensure confidentiality and to create an audit trail (Amankwaa, 2016; Lincoln & Guba, 1985; Mack et al., 2005). The primary researcher checked in with participants two weeks after the interview to inquire about additional thoughts. The researcher kept notes on each step of the research process in an effort toward confirmability (Amankwaa, 2016; Lincoln & Guba, 1985).

Data Analysis

Coding began with a review of each transcript for key phrases, words, and quotes the researcher designated as valuable or emphasized by participants as important. All codes were entered on a spreadsheet. Once complete, codes were reviewed across participants to identify sub-themes. Each theme was assigned a color and a new column was created for each. There were 17 initial sub-themes. The researcher continually reflected on the process and recorded any significant reactions in research notes.

Findings for each sub-theme were divided under the appropriate category. Data was evaluated again for selective themes. Selective themes are listed in Table 1. Selective themes were noted as significant, being that all participants added to the development of each one, or the theme emerged as novel as compared to the review of current literature.

Table 1

Table 1 ***Selective Themes to Provide Phenomenon for Experiences with Treatment and Recommendations for Future Treatment***
Theme 1: Influence of Stigma and Culture
Theme 2: The Importance of Self-Advocacy
Theme 3: Competencies Influence Outcomes
Theme 4: Psychotropics and Substance Use (Alcohol) are Mostly Viewed as Negative
Theme 5: Retraining the Mind, Body, and Soul Post-Trauma
Theme 6: The Importance of Support
Theme 7: The Importance of Conditioning the Warrior (Prevention)

Due to the richness of the data gained and the potential impact it may have on best practices of mental health when serving military personnel, it is impossible to properly explain all of these findings in one succinct manuscript. Consequently, the purpose of the current article is to present Theme 3, *Competencies Influence Outcomes,* on an in-depth basis. Theme 3 was selected as a priority manuscript due its insight into how counselors can make an impact immediately. Other themes are explored in separate manuscripts.

Results

The data revealed clinicians' perceived competencies working with military personnel impacted veterans' willingness to pursue and continually engage in mental health treatment, as well as influenced subsequent clinical outcomes. These competencies included: (a) insight into components of mental health stigma within military environments, (b) the need for clients to be treated as unique individuals who are deeply entrenched in military culture, (c) rapport building, and (d) familiarity with military terms and operations. Collectively, evidence of these competencies facilitated participants' trust in their counselors' knowledge and ability to assist them toward a path of wellness.

Mental Health Stigma

In addition to feeling some trepidation about entering the counseling process itself, veteran participants reported fear of others' reactions commonly serves as another barrier to pursuing mental health treatment. Given the knowledge that one may compromise his or her status, rank, and placement in their career because of admitting to mental health symptoms, many military personnel are leery of seeking counseling services. Having empathetic command staff and peers lessened this fear, making counseling a more palatable option. Participant 7 summarized this well when he emphasized empathy from leaders and providers as being key:

> If I hadn't had, in all honesty, a commander who cared enough to just see me move on with my life, I could have been that person out to pasture still going down that downward spiral.

Participants began assessing perceived competencies the day they returned to the United States after deployment (redeployment). One participant highlighted the fact that military leaders often tell veterans they will not return home if they display mental health symptoms to the professionals screening them upon redeployment. Participants further suggested that clinicians' approach to addressing mental health issues affected their willingness to admit their concerns, suggesting that clinical staff must be aware of - and carefully traverse - stigma and real-life

concerns veterans may have when endorsing trauma and related symptoms. Participant 6 shared the typical hesitancy associated with admitting one's symptoms, "If you say you have any problems, you're not going home". Participants indicated they were more likely to engage in honest dialogues regarding their experiences when they perceived that a clinician was in-tune with military practice and demonstrated competence regarding military culture. Particularly, they desired indication that a clinician has insight into the profound potential impact that such an admission might have on the veteran's personal life and professional status.

Clinician Competencies

Participants' lived experiences provide insight into combat veterans' therapeutic needs. All participants reinforced the idea that each veteran is unique based on their whole person. Participant 3 reminded us, "One treatment maybe that works for one is not going to work necessarily for everybody else." He shared his perception of the standard nature of the VA system:

> "It can't be this one-size-fits-all approach. Every person is unique. Every individual needs specialized treatment. And they need a clinician who can understand that and is willing to try anything and everything and they can get their hands on to treat that…."

Similarly, at the demobilization stations, veterans are advised of their benefits, including those related to mental health treatment. Participant 7 felt a disconnect between the information presented in benefit summaries provided and the reality of services actually available. For instance, military members were made to believe that job opportunities were abundant for combat veterans. In reality, the earning potential on the few opportunities provided did not suffice current standards of living for particular members.

Participant 7 perceived that the people presenting the information were not competent in veterans' perspectives. This information combined to make Participant 3 feel dismissed as "just another number" within the VA system rather than an individual appreciated for his service to the country. Participant 3 described a similar experience:

> The VA's idea of treatment at that time was, 'We will bring them in, and we'll sit them down with a graduate student…and we will

> ask this standard series of questions and then we'll throw some medication their way'.

Participant 6 also felt her treatment to be overly standardized rather than specifically tailored for her. She explained that she was asked to choose one of three therapy interventions. She reported wanting to talk about what was on her mind versus being forced to spend 15 weeks focusing on only one of her many losses. The requirement to choose was detrimental to her willingness to commit to treatment. She felt like she was just following a protocol rather than being heard. She shared:

> 'I want to just kind of sit and bullshit with you and talk to you… Could we not do that'? (Therapist stated,) 'No, we can't. We have to do…we have to focus on your problem fix your problem and then move on from there'.

The therapeutic choices provided to this veteran did not meet the intent of providing latitude in decision-making. The veteran desired to talk to the therapist and get to know that person prior to engaging in an in-depth discussion regarding her trauma. She wanted to feel like what she had to share mattered, but instead she felt dismissed when limited to one of three options, which only compounded her grief.

Not all participants' experiences ended negatively. Participant 1's experience underscores the importance of feeling valued as well. After trial and error, he found a treatment team that worked for him, but not before he already attempted suicide and accumulated well over 300 pages of treatment notes from providers. Prior to engaging with his most recent treatment team, Participant 1 had been bounced around between providers with no clear and concise treatment plan. Coupled with the lack of support by a former command, Participant 1 was unable to find success in treatment previously. Most recently, in reference to the inclusive treatment team, he stated, "They (VA)… made me feel like they cared. I'm not just a number…." He expanded, "…one of the biggest things that's helped me is my team…psychologist and my psychiatrist and my primary care doctor. They wanted to know [about him in depth]…". Together, these perspectives highlight that, like their civilian counterparts, military veterans seek service that is personalized to their individual experiences, rather than manualized treatment based on perceptions and standardization.

Given the mission of the VA health administration is to serve veterans, study participants expected that their unique circumstances would be recognized, understood, and attended to in this environment. Yet, a few participants suggested that the VA mental health services they received were unhelpful as many clinicians working within the system failed to fully understand military culture. One participant even asserted "…some of the treatment at the VA is bad". Participant 4 indicated he perceived his assigned clinician to be incompetent. He explained, "…got treatment through the VA for a while…I was more qualified to run the session than the person who was doing my counseling". He stated, "The counseling that I got from the VA was just kind of useless". He explained that the VA therapist working with him did not fully understand his experience as a member of the military. He noted, "…we were always off topic and he could not relate as a civilian". Participant 4 indicated that the ability to fully engage with his counselor was dependent on the professional's ability to empathize with his circumstances. In the absence of such understanding, the participant was unable to fully participate in the therapeutic relationship. He stated, "One of the barriers that I remember being a real issue…is you have no idea what we're going through as a (civilian) clinician."

Identifying her own need to be recognized as a distinct individual embedded within the unique military culture, Participant 6 was offended at the "cookie-cutter" nature of the VA's insistence on standardized therapy. Instead, Participant 6 felt stifled in her discussions with her counselor to fit a proscribed formulary rather than fully engaging in discussion and reflection regarding her own traumatic experiences. She said, "I had so many things that I had to talk about at the VA and never got a chance to…just very generic questions".

Participant 6 was frustrated with her counseling and felt that this approach oversimplified her experiences, dismissing the complexity of her identity. Rather than demonstrating competency in military culture and realizing that one's military training and subsequent identity are inextricably interwoven into a veteran's personality, the clinician's failure led Participant 6 to question the validity of the process and reinforced her resistance to it. She explained her thought process following that initial clinical session, "I did it because I was supposed to do it…". Additionally,

Participant 6 shared that she was not offered the full gamut of mental health treatment available because she was not actively suicidal. Subsequently, she felt her pain was minimized because she was not imminently at risk at a time when she felt like she actually likely needed the most help. When reflecting back on this, she said, "I was so disheartened at how it went…".

Collectively, these participants' experiences reveal that clinicians' ability to view them as individuals within a particular context (that of the military) facilitated positive therapeutic outcomes. Participants felt supported by and motivated to work with clinicians who were knowledgeable about the impact of their military status without reducing them to only consisting of those experiences.

Rapport Building

Some participants appreciated the structure associated with navigating mental healthcare within the VA system, suggesting that the VA system may have actually facilitated improved mental health. Participant 3, for example, stated he felt fortunate to find someone to help him with the VA system due to it being so standardized, "I was lucky enough to…to find people who were like, 'OK well then let's just talk about this and figure this out.'". Participant 2, who also attempted suicide, suggested that having a civilian provider within the VA environment was not a barrier to his recovery, as his counselor was able to understand the influence of his military background and subsequent experiences on his current presentation. In fact, Participant 2 identified his counselor's understanding of his culture to be paramount to his recovery and allowed him to view his experiences outside of a typical military mindset. He stated, "…someone who isn't from the military mindset can be helpful…". He even went on to suggest that his provider's varying perspective may have actually facilitated insight, which may have otherwise been absent. He explained, "While he (civilian provider) may not have the same experience, he can provide benefits…."

Participant 2 indicated that while a familiarity with military culture is helpful in the therapeutic process, it is the counselor's ability to engage in empathy and create a trusting therapeutic bond that is of paramount importance. He explained, "… just because someone doesn't…experience

your trigger doesn't mean they can't empathize with you.". Participant 2 found benefit in having a counselor who understood his military culture without reducing him to the broad assumptions typically associated with that culture.

Participant 7 stressed the importance of including veterans in the treatment planning process rather than simply mandating them to divulge intimate thoughts for analyzation. He suggested the failure to incorporate the veteran in this decision-making process may cause the person to shut down rather than engage within the therapeutic process. Participant 7 felt pushed away by the excessive probing exhibited by his counselor. He recalled it making him count the minutes until he could leave the session:

> (quick) to ask questions and you're kind of…poking and at that point…you're actually further pushing them away to the point of they're looking at a clock… got to create the buy-in of, 'This is what I think the end product can be.'

Participants emphasized the need for counselors to focus on building rapport at the onset of treatment. One participant explained, "They (veterans) are hard people to reach" and, "…they won't open up or they won't until they, they feel a relationship like that (one that can relate)." Another veteran stated, "…a lot of it is understanding…." Participant 6 concluded, "You're not (going to be able help veterans). If they don't want it, they're not going to reach out to the VA…". Each of the participants expressed a general resistance in pursuing counseling services among military personnel, suggesting that veterans may be at a breaking point by the time they receive help. Participant 3 explained:

> … too many people are too proud and self-reliant and they don't want to admit when they need to take help… by the time they get there some are too far gone and they (think they) can't… never be able to move past it… if they can't find that, that value in their life, then we have to find it for him…

Recognizing that the pursuit of counseling services is frequently contrary to the implicit messaging prevalent across military branches, some personnel may be hesitant to fully delve into the process. Participants' experiences suggest that counselor providers may want to titrate the assessment process and not to risk overwhelming the veteran. Participant 5,

for example, recommended instead to "You know maybe the first way (ask only the necessary questions to continue treatment) in your first session and then work your way to that (the other questions).

Participant 3 suggested that the professional's reactions to the veteran's initial revelations is likely to affect how that individual proceeds to engage in the counseling process. Counselors may be able to use metacommunication to display their understanding of the common fears of engaging in the therapeutic process, especially in light of mental health stigma in the military, thus facilitating the veteran's sense of safety within the therapeutic relationship. He suggested that counselors may want to consider:

> …normalize their reactions. They have to understand that what they're feeling…and it's not to be dismissed…. Normalize their experience by relating to them uniquely,…find these, these things that drive that individual and that person that can move them past that moment and help them reconcile that and continue…you're (the veteran) never going to lose those things. That it's always going to be a part of who you are….

For Participant 3, his support system was the most beneficial intervention. Also, being able to realize that he was having a normal reaction to an abnormal situation helped him. He thought providers should support veterans by normalizing experiences and by withholding judgment.

Military Culture Familiarity

Again, participant veterans emphasized the need to be viewed as individuals with unique perspectives and needs. While recognizing them as individuals with unique needs was important to each of the participants interviewed, so too was understanding the ongoing influence of the culture unique to military personnel. Participant 2 stated, "It's important for therapists to at least brush up on military culture…. [so] you're not spending half your session and having to explain to them what acronyms (mean)…." In line with Participant 2's assertions, Participant 6 also identified language as a fundamental component of military culture. In the absence of familiarity with military terminology, she suggested, the depth

of clients' experiences may be misunderstood, and the therapeutic process may be stalled or compromised. She explained,

> I don't have to try to explain to you (a veteran and therapist) what a peppered vehicle full of shrapnel looks like… now you've lost a whole lot of worth in my books because I'm having to explain to you what an IED is….

When discussing the implications of language within sessions, participants suggested that counselors avoid the use of clinical jargon. They suggested talking to veterans instead in a language they understand. Similarly, session content should align with their knowledge set as well. Sometimes, veterans see therapy as being soft and therefore unappealing. Participant 2 explained it as:

> I can't sit there and picture myself on the beach. It's a barrier for me…. Sounds soft… explain it to them (veterans) in terms they understand, because most of them have been through at least basic first aid, or they have some understanding of shock.

Participant 6 recommended an approach that is not so standardized. She suggested counselors leverage veterans' high levels of training and motivation. She prefers an intensive, interactive approach to understanding her own mental health not limited to talk therapy. She also preferred to be provided the knowledge and tools that she could utilize outside of therapy sessions.

A very important aspect of working with veterans is knowing that they may like to come in from a position of power as this may be typical of their position within the military setting. Participant 5 offered a suggestion:

> I think that would be the best way to approach somebody. Don't come as equal… just slightly below, but not too much below. And then, then you can work your way up to the peer to peer…. Further, never, never tell the decision-maker (veteran) something that you can't back up. Because once you, once you've lost that credibility, you've lost it."

Summary

Analysis of participants' experiences highlighted the need for counselors to view veterans as unique individuals embedded within a strong

military culture. Counselors need to understand the stigma regarding pursuing mental health services is common among military personnel, and aid veterans via the normalization of symptoms and care. Knowledge of vernacular and interpersonal dynamics particular to the military positions counselors to effectively establish rapport, build trust, and engage veterans in counseling services in the pursuit of increased wellness. Similarly, veterans' willingness to trust providers and share the responsibility in their treatment also facilitates positive therapeutic outcomes.

Discussion

Past literature confirms that a strong therapeutic alliance is a predictor of positive clinical outcomes (Ardito & Rabellino, 2011). Bordin (1979) suggested that the counselor and client maneuver the therapeutic relationship by establishing an emotional bond and agreeing on treatment goals and objectives. The results of the current study suggested that this correlation seems to apply to counseling with military veterans as well. While military functioning is marked by standardization, compliance with orders, and a sense duty to authority, veterans seeking counseling desire an authentic connection with their mental health providers. It is important for counselors to set aside their preconceptions and assumptions regarding veterans' needs and to look at veterans as the experts of their own experiences capable of co-leading the therapeutic process. Counseling, by default, is a relationship that requires openness, depth, and trust (Litwack, 1974). In order to fully engage in the counseling process, veteran participants needed to know that they mattered.

While the literature dedicated to trauma recovery highlights that a comprehensive treatment approach consists of a thorough assessment, treatment for neurobiological symptoms, and a person-centered approach to therapy, most veteran participants described a much less thorough approach to their care. All participants described experiencing an abbreviated screening that consisted of nothing more than a series of questions, presented in a non-conversational manner and few remembered ever meeting with a prescribing physician to discuss symptoms or address desired treatment outcomes. For most participants, this impersonal and often manualized approach to treatment pushed them away from continuing

treatment. Those whom continued with and benefited from treatment felt connected to their counselors, and believed that their particular providers provided a holistic approach to their care.

In addition to feeling as if their particular experiences mattered, participant veterans also desired that their counselors maintained an implicit understanding of their worldview, which is typical of those competent in military culture. Several participants mentioned feeling as if their providers were inexperienced in working with veterans as evidenced by their unfamiliarity with military terms, ranks, and practice. This lack of familiarity served as a barrier to treatment as much clinical time was sacrificed to acclimate the counselor to military verbiage as to set the setting to explain the veteran's present struggles. Given that therapy sessions are constrained by time, veterans felt explaining military acronyms and similar constructs to their counselors was a waste of time. Participants expressed a sense of sacrificing their own clinical interventions in an effort to train their providers. This exchange was often perceived as burdensome to veteran participants and impeded their motivation to engage in the therapeutic process.

Some participants left and did not return to treatment once they perceived their counselors to be inept in serving veterans. Other participants completed treatment out of a sense of obligation or in an effort to follow direct orders; however, this typically frustrated veteran participants or compromised the quality of their treatment. Participants felt it imperative for counselors to seek formalized training or continuing education to ensure they have a working knowledge of military language and culture.

The promotion of a client's autonomy within the treatment process often facilitates buy-in from the client within counseling (Barnert et al., 2020). Yet, the veterans included in the present study felt professionals frequently mandated what treatment they would receive versus being allowed to be a part of decision-making process. These circumstances were often prohibitive, leaving veterans to either participate minimally or completely disengage from the counseling process. They are also contrary to phase-based models of treatment often deemed appropriate for trauma-based treatment. These models advocate for a client's active participation in the counseling process, including increased decision-making regarding

treatment trajectory by the client over time (Carroll et al., 2017). These models not only serve to empower the client, but also allow for optimal tailored treatment for each individual.

While those within the military are accustomed to taking orders, such responses are not appropriate for a clinical environment. Recognizing that rigidity in counseling may not be the optimal approach to counseling the combat veteran population, the VA shifted toward a recovery-oriented approach (Zuehlke et al, 2016). However, in spite of some positive outcomes, the persistent high rates of suicide coupled with the findings within the present study suggest additional efforts need to be made to further empower veteran clients within the counseling process (Zuehlke et al., 2016).

One way to facilitate client empowerment among veterans may be to increase their ability to select their providers. Sherman et al. (2015) concluded provider compatibility is essential to increased functionality of veterans. Not one of the participant veterans included within this study felt he or she had the option of finding a compatible provider. Re-evaluation of current policies and practices within the VA and other behavioral health systems may provide increased opportunities to increase veterans' autonomy in this regard.

Additionally, past research suggests providers use a combination of treatments to help reduce the impact of trauma. Experiences across veteran participants included in the present study align with this recommendation. Participant veterans who reported the most improved functioning after seeking counseling for moral injury were the ones with a full treatment team representative of a myriad of professional perspectives and offered variable treatment options. Unfortunately, access to such treatment opportunities do not appear to be the norm. One participant veteran, for example, felt the need to threaten suicide and another attempted suicide prior to getting the full treatment team they needed.

Researchers postulated providers must help veterans reintegrate after combat to help them learn to survive in a civilized society, to transform energies from a life and death scenario to a safe environment, and to work with memories and emotions resulting from war (Coll et al., 2011; Figley, 2012; Wilson & Thomas, 2004). Although some of the veteran

participants (3 out of 7) in the current study found CPT and Cognitive Behavioral Therapy (CBT) to be helpful, this was not true for the entire sample, suggesting that these interventions may not be as effective for combat veterans as they are for the civilian population. "Back and forth" probing and "cookie-cutter" approaches to therapy caused some veteran participants to feel unsupported and triggered them to disengage with therapy, emphasizing the need for personalized counseling interventions. Counselors and other providers must not assume a treatment protocol will be effective for combat veterans if based on research with civilians, but rather continually engage in an ongoing assessment process to determine the particular needs of the individual veteran client (Zuehlke et al., 2016).

Further, when a disconnect is found between what works for the civilian population and what works for veterans, providers are charged to adapt evidence-based treatment (Wilk et al., 2013). It may make sense to assign more experienced providers who may be more adept in assessment and multiple treatment modalities to work with the veteran population. Similarly, such an assignment may not be an appropriate for entry-level practitioners. Finally, all providers are tasked with remaining abreast of the published literature regarding the best practices in mental health care of veterans to help facilitate their own competency in servicing this population. Similarly, members of the counseling profession must continue to develop research focused on enhancing current practices to adapt treatment for veterans' unique traumas (Brenner et al., 2015; Freytes et al., 2017).

Implications for the Counseling Profession

While each client should be assessed for his or particular treatment needs and goals, the use of a person-centered approach may be particularly well-suited for work with veterans (Alase, 2017; Cooper et al., 2007; Currier et al., 2018; Rogers, 1959). Findings from the current study highlighted the detrimental impact viewing clients as 'just another number' and reinforced veterans' need to be treated uniquely and to be provided a thorough assessment.

Participant experiences revealed the nuanced and complex presentation typical of military personnel. Some veterans will present from

a position of power while concealing self-perceived weaknesses. Combat veterans appreciate providers who present slightly below this position of power and have the skill set to build up to an equal level. Conversely, providers whom present themselves as too far below are equally ineffective and may be perceived as patronizing. While appreciative, veterans often feel uncomfortable when an acquaintance gives them praise and accolades they may view as undeserved. This dynamic may be too much for a new counselor or counselor-in-training to handle effectively. As such, more seasoned counselors with refined assessment skills may be better positioned to competently serve members of the veteran population.

Rapport serves as the foundation for the counseling relationship and is the best predictor of therapeutic outcomes (Safran & Muran, 2009). In line with their civilian counterparts, building rapport before engaging in a treatment protocol is vital to engagement with combat veterans and helps facilitate increased buy-in to the counseling process (Barnart et al., 2020). Findings indicated veterans may be open to trying interventions they would normally refer to as "soft", but that building rapport is essential prior to introducing them. Engaging combat veterans requires providers to develop a level of competency with military language (including basic acronyms), culture, and impacts of combat on the veteran. Veterans prefer providers to have at least a brief knowledge of experiences common to most military personnel in a combat environment as opposed to what someone may uniquely experience. Veterans are distracted when questioned about occurrences they view as routine (e.g., scanning for IEDs).

It is hard for the traumatized brain in survival mode to be able to conceptualize a creative scenario thus emphasizing the need to actively engage veteran clients in the treatment planning process. In general, veteran participants preferred the opportunity to develop coping skills they can use to manage harmful symptoms versus pharmaceutical interventions that numbed them. Veterans also want to understand their treatment and be a part of the decision-making process. Promoting autonomy through on-going psychoeducation may open veterans up to considering additional treatment modalities. Participants' testimonies indicate that a full treatment team serves as the most effective way to increase positive outcomes.

Participant veterans' experiences highlight the importance of normalizing trauma as a typical, if not expected, reaction to abnormal events. Their experiences suggest that veteran peers are likely to be respected for asking for help despite assumptions suggesting otherwise. Veteran participants also suggested their peers be willing to be open to counseling professionals and receiving mental health support. Veteran participants revealed that regaining full functioning and establishing a renewed sense of hope is possible following trauma, but not without help and a full commitment to the healing process. By participating as active members of their own treatment teams, veterans have the opportunity to improve their own future functioning. Much has been done to create new and improved systems for veterans, but there is still much work to do. Results of this study provide stakeholder actions that may be implemented immediately in the way of enhancing treatment outcomes for combat veterans.

Strengths and Limitations of the Study

This study addresses a gap in the current counseling literature by providing insight into the lived experiences of veterans seeking treatment for impacts of trauma. While qualitative research endeavors do not aim for generalizability, it is important to note that the experiences captured in the present study may not be representative of all military personnel. The study did not target any particular race or ethnicity and relied upon veterans who met specific demographics to volunteer. All participants were Caucasian, negating input from veterans of diverse backgrounds. As such, the findings may not adequately represent issues unique to females in the military. The experiences of members of other marginalized populations are also not explored. Researchers also did not examine the experiences of those associated with designated ranks, roles, or branches within the military. With that said, the small sample size allowed an intimate interaction between the primary researcher and participants ensuring ample opportunity for prolonged engagement. This proved invaluable in creating an opportunity for rich interactions and allowed maximum time to analyze each data set. However, the small sample size did not allow for a wealth of diverse experiences from one branch versus another. For instance, all

experiences mentioned were based on trauma from combat while on active duty, but may not truly be representative of the larger active force in each branch. Further, all participants lived in Kentucky at the time of the study even though their deployments were to diverse locations. This may limit the study to occupations only found in units based out of Kentucky regardless of service branch.

Suggestions for Future Research

The examination of how these phenomena occur within particular groups (i.e., based on gender, military role, rank, race, etc.) may further inform treatment recommendations for members of those groups. Issues with loss and grief were present in all participant accounts and should be considered for further research within this population. Findings indicate a need for training development on military culture, language, and impacts of trauma to better prepare providers for work with this population as well. Trauma-informed training is also necessary for other stakeholders in an effort to educate all on the impacts of trauma and to reduce the stigma of help-seeking among veterans.

Conclusion

In this study, veterans of OIF/OEF, Operation Desert Storm, and Operation Phantom Fury (Al Fajr) shared their lived experiences of navigating treatment for trauma due to posttraumatic stress disorder (PTSD), moral injury, and other impacts of trauma and their recommendations for stakeholder competencies. Results indicated that veterans' therapeutic needs remain nuanced and complex, requiring a high level of provider competency. Of particular note, providers must be adept in assessment abilities and educated regarding military culture. In the absence of these qualities, veterans often perceive their providers to be incompetent in serving them leading them to remain disengaged in the counseling process, which compromises their mental health status and could lead to increased detrimental outcomes. A concerted effort on the part of stakeholders toward enhancing their clinical competencies may positively affect the number of veterans seeking treatment within the VA and even

from civilian providers. Until then, there may continue to be a gap in the number combat veterans who need treatment and those who seek and follow through with counseling.

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