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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 latest edition of the JMGC. As promised, this issue will start to expand the JMGC's offerings to include discussions of new ideas that we may have not thought of yet, and older ideas that we may have forgotten as we continue to gain experience working with military and first responder populations, their families, and their communities. We hope that you will find these manuscripts informative and thought-provoking.

So, keep those manuscript submissions coming in and contact us if you are interested in being a reviewer for the JMGC. As always, thank you for the work you do in support of our military, first responder and emergency service personnel, and those that work in and with government agencies.

The procedure for submitting articles is available at JMGC Guidelines for Authors (https://trojan.troy.edu/education/counseling-rehabilitation-interpreter-training/jmgc/index.html) and the contact email is JMGCEditor@troy.edu.

The JMGC Editorial Team

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Towards a Trauma-Informed Cognitive Processing Therapy (TI-CPT) with Veterans

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Since its conception, Cognitive-Processing Therapy (CPT) has gained a significant amount of empirical support evidencing its apparent effectiveness in treating Post-Traumatic Stress (PTS) among Veterans receiving services at Veteran Administration (VA) hospitals. While being trauma-focused by nature of the intervention's emphasis on the treatment of PTS, aspects of the approach appear incongruous with the six core principles of Trauma-Informed Care (TIC) laid out by the National Center for Trauma-Informed Care (2018). This paper attempts to explicate both where they appear divergent, as well as how elements of humanistic counseling praxes might serve to enhance the currently existing intervention towards the creation of a Trauma-Informed Cognitive-Processing Therapy (TI-CPT).

Keywords: Veterans, trauma-informed, humanism, cognitive-processing therapy, counseling

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From the Stoic's early writings on embracing suffering (Aurelius & Hays, 2002) to the theories of existential-humanism proffered by the likes of Frankl (1959), Bugental (1964), May (1975), and Yalom (1980), it has long been posited that while suffering in life is inevitable, humans remain free and responsible autocrats, capable of transmuting even the most challenging of life's circumstances into opportunities for meaning and growth. Contemporarily, Veterans have become a sub-population within the United States that has been at increasingly high risk of trauma exposure since the initial invasion of Afghanistan in 2001. One large population cohort study, for example, found that 15.8% of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OEF/OIF) Veterans (n = 1,032,547), as well as 10.9% of non-deployed Veterans (n = 816,660), met the minimum thresholds for a diagnosis of Post-Traumatic Stress (Dursa, Reinhard, Barth, & Schneiderman, 2014). Modern treatments of PTS generally tend to fall within one of two categories: trauma-*focused* or trauma-*informed*. Trauma-*focused* simply suggests that the purpose of the mental health intervention is the treatment of trauma. Trauma-*informed*, however, suggests that the intervention, itself, was developed with the explicit intent of not recreating traumas throughout the counseling process. Specific principles of trauma-informed care (TIC) were developed by the National Center for Trauma-Informed Care (NCTIC, 2018) to assist all counselors in promoting clinical theories and praxes that consider the impacts of trauma on perceptions of power and control, promoting safety and empowerment as essential elements of post-trauma care.

A large percentage of Veterans that receive treatment for PTS will receive 12-weeks of Cognitive Processing Therapy (CPT) (Resick, Monson, & Chard, 2016), one of the most frequently used manualized treatments of PTS for military service personnel seeking services through TRICARE and the Veterans Administration (VA). Though there is some empirical support for the approach's effectiveness in altering maladaptive thought-processes related to the trauma (Ford, Grasso, Greene, Slivinsky, & DeViva, 2018; Rutt, Oehlert, Krieshok, & Lichtenberg, 2018), CPT's wide usage among Veterans, alone, makes it deserved of critical scrutiny. Towards these ends, this article sought to explore answers to three

important questions. First, via examination of the intervention's training practices and manual, it will examine how congruous the theory and praxes of CPT appear to be with the six principles of TIC (NCTIC, 2018). Next, this article will examine whether humanism—a school of mental health that has recently seen its usage wane (Hansen, 2009)—better aligns with the principles of TIC (NCTIC, 2018). If CPT is found to have disparities in theory and practice with trauma-informed practices (NCTIC, 2018) and if humanism aligns more closely with TIC-based values, then this article will explore whether an infusion of humanism might allow CPT to operate more closely with best practices in TIC (NCTIC, 2018). The authors will further explicate what a trauma-informed CPT (TI-CPT) might look like, including an exploration of potential implications for counselors, counselor educators, and researchers, inclusive of some key limitations. The authors will attend to implications for multiculturalism and social justice. Finally, the authors intend to charge all counselors with advocating for the usage of trauma-*informed* approaches and for innovation of existing trauma-*focused* interventions such that they might more closely align with TIC-based principles (NCTIC, 2018). The authors close by noting that for these missions to succeed, it may require systemic level advocacy that pushes back against managed care organizations like TRICARE, helping to ensure that clients have adequate interventions and number of sessions to allow for truly trauma-informed (i.e., client-driven) healing.

Introduction

Prior to examining potential congruence between CPT and the principles of TIC (NCTIC, 2018), we must first explicate the core presuppositions and practices of CPT and TIC. A brief look will also be given to the most recent extant research examining CPT outcomes with Veterans prior to exploring TIC. Then, as aforementioned, if CPT is found to have wide disparities in theory and practice with trauma-informed practices (NCTIC, 2018), the authors will examine humanism as a potential tool capable of more closely aligning CPT with TIC-based values.

CPT

According to Resick, Monson, and Chard's (2016) treatment manual for Cognitive Processing Therapy (CPT), the intervention is, "a cognitive-behavioral treatment for Posttraumatic Stress Disorder (PTSD) and related problems," (p. B1). True to this definition, it uses a combination of Cognitive Therapy and, at times, Prolonged Exposure (PE), to gradually help Veterans process progressively more details of their traumatic experiences and their subsequent impacts. It is highly manualized and uses the Posttraumatic Stress Checklist for the DSM 5 (PCL-5; See: Weathers et al, 2013) to track clinical outcomes. With 12 highly structured, 90-minute sessions, Veterans are taught that *avoidance* of trauma-related stimuli disrupts the natural psychological healing process resulting in the symptoms of PTS. Across 12 weeks of homework and intensive cognitive-behavioral sessions examining how the impacts of trauma(s) may have also affected their thoughts, behaviors, and emotions, Veterans are asked to challenge the underlying thought processes that may underlay the various aspects of their lives impacted by the trauma and, accordingly, should begin to see a reduction of PTS symptoms, as measured via the PCL-5 (Weathers et al, 2013).

Consider a Marine Veteran who lost a leg after a Vehicle-Borne Improvised Explosive Device (VB-IED) detonated while serving in Syria. If the Marine had previously held a belief that the world was safe prior to the trauma and now believes that the incident suggests that the world is not *ever* safe again, the Veteran might be challenged to see greater nuance in the situation via examination of the observable evidence. If no other significant traumas have happened throughout life, then the Veteran might extinguish the cognitive "stuck-point" that the world is *always* unsafe by accepting that the opposite is more likely the 'truth', given that a far greater percentage of their life had been lived relatively incident-free. This process is aided with an assembly-line of worksheets—and so the process goes. In this example, many of the cognitive stuck-points that might been targeted for re-processing would have been identified via a multitude of narratives derived by the Marine, both written and read aloud in-between and during

their sessions. There are also structured sessions focusing on themes that have found to be of frequent import to survivors of trauma, such as perceptions of safety, power, and control, as well as struggles with relationships and intimacy (Resick, Monson, & Chard, 2016).

Sessions titles include: Introduction and education (to the symptoms and causes of PTS); the meaning of the event; identification of thoughts and feelings; remembering traumatic events; second trauma account; challenging questions; patterns of problematic thinking; safety issues; trust issues; power/control issues; esteem issues; and, finally, intimacy and meaning of the event (Resick, Monson, & Chard, 2016). The manual's commitment to structure is also evidenced by the presence of a commitment contract for clients to sign, practice assignments for review, surveys and forms, certificates of completion, and supplementary material—all aids intended to simplify the path towards healing for the Veteran and provider. True to CPT's presupposition that *avoidance* is a primary cause of troubling PTS symptoms, PE is used throughout, requiring Veterans to recreate written accounts of their traumas in progressively greater detail. Veterans must write several iterations of their trauma-narrative in-between subsequent sessions; however, if they fail to do so, CPT providers are taught to conceptualize and communicate this to Veterans as *avoidance*—something they must overcome during the 12-weeks of treatment to be eligible for a certificate of completion upon termination. Finally, the CPT manual can be adapted to leave out the trauma-narrative assignments (i.e., Prolonged Exposure), focusing only on the cognitive elements (i.e., referred to as CPT-C), and can also include a 12-week group work component (Resick, Monson, & Chard, 2016). This paper focuses on the individual, one-on-one version of CPT that includes Prolonged Exposure (PE); however, elements of relationship-building, symptom normalization, and meaning-making apply to CPT-C, as well.

CPT and Veterans. Several studies examining the effectiveness of CPT treatment on Veterans in the past few years have yielded positive results, though they are not without reservations. Holliday, Holder, Meredith, and Suris (2017) found that among 36 African-American and

Caucasian-American female Veterans who had experienced Military Sexual Trauma (MST), all appeared to respond well to CPT, having experienced a reduction of symptom severity that was maintained up to six months past treatment. A second study also examining both male and female Veterans with a history of MST (n = 45) found that those that received CPT reported higher physical functioning compared to those receiving a control intervention consisting of Person-Centered Counseling (PCT) (Holliday, Williams, Bird, Mullen, & Suris, 2018). However, it was also found that CPT was not effective in affecting positive change to social functioning or general health, relative to the control (i.e., PCT). Researchers commented that this result may be an indication that CPT may be insufficient at addressing these issues in the treatment of MST specifically (Holliday, et al., 2018).

One of the strongest pieces of evidence supporting CPT within the past few years is a study by Lamp, Avallone, Maieritsch, Buchholz, and Rauch (2015) which examined the effectiveness of individual versus group CPT in a sample of 465 Veteran-participants across two VA PTS clinics. Individual therapy was found to be more effective, but both groups experienced a significant reduction of PTSD symptoms. It was additionally found that CPT achieved better results with participants identifying as Caucasian-American than with those identifying as African-American participants. Researchers suggest that because CPT appeared more effective with Caucasian-American clients, a more culturally-competent approach would likely be more efficacious with people of marginalized identities. Given the extant research evidencing that while CPT has been found to be effective in reducing PTS symptoms for some groups, its effectiveness may vary based on type of trauma (Holliday, Holder, Meredith, & Suris, 2017), and race/ethnicity (Lamp, Avallone, Maieritsch, Buchholz, & Rauch, 2015), among other potential factors. As TIC was developed with the specific intention of maximizing the safety of counseling services for all stake-holders, let us now turn our attention to the framework's core principles (NCTIC, 2018).

Trauma-Informed Care

All interventions that claim to fall within the TIC umbrella generally accept that for treatment to be effective, "survivors need to be respected, informed, connected, and hopeful regarding their own recovery," and that mental health professionals should also seek to acknowledge the more ancillary correlates to trauma like substance use, eating-related struggles, and anxiety (NCTIC, 2018). An identifier of a multitude of different interventions, TIC involves recognizing that healing from trauma involves a collaborative therapeutic *relationship* with survivors, as well as, potentially, their families, friends, and other professionals. Finally, because trauma is inherently disempowering, all clinical efforts to assist in healing should have an *empowerment*-based focus (Herman, 1997; NCTIC, 2018).

Towards these ends, NCTIC (2018) explicated six key tenets of TIC: Safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical, and gender issues. Throughout TIC, there is an emphasis on, "physical, psychological, and emotional *safety* for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment," (SAMHSA, 2014). TIC aligns with the ACA's (2014) Code of Ethics moral principles of veracity (truthfulness) and fidelity (e.g., faithfulness, honoring commitments) by positing that clients should be informed consumers of the therapeutic process and, as such, counselors must be transparent about what clients should expect (i.e., *trustworthiness and transparency*; NCTIC, 2018).

TIC interventions understand the importance of social support in healing the various impacts of trauma (i.e., *peer support*; NCTIC, 2018). Counselors work *with* clients and work towards collaboratively agreed upon treatment goals (i.e., *collaboration and mutuality*; NCTIC, 2018). Clients are viewed as the ultimate experts of their own lives and so counselors take time to weigh their clients' phenomenological perceptions of safety throughout treatment. Clients should also be reminded that they are able to refuse any intervention they deem unsafe (i.e., *empowerment, voice, and choice*; NCTIC, 2018). Finally, and perhaps most importantly, TIC

(NCTIC, 2018) involves use of interventions that were developed to minimize the likelihood of recreating cultural, historical, or gender-related trauma narratives (e.g., such as highly directive interventions that utilize heteronormative language), while also considering how identities impact the treatment process (i.e., *cultural, historical, and gender issues*).

Critical Analysis

Again, the grand stature of CPT as a primary mode of intervention for Veterans that may be experiencing PTS means it also warrants frequent analysis to ensure it aligns with emergent best practices like TIC. Further, there is a substantial body of empiricism in support of the effectiveness of CPT in treating PTS among Veterans (Monson et al., 2006), so it is not the contention of this article that wide-spread changes to the existing intervention's framework should be affected. In spite of this support for CPT's efficacy in treating one aspect of PTS (i.e., the cognitive impacts of trauma), there may still be opportunities for growth, especially when using the six tenets of TIC outlined by NCTIC (2018) as a point of comparison. Towards these ends, the authors examined both areas of convergence as well as divergence between how TIC is operationalized and how CPT is explicated in its manuals provided to mental health providers to guide their work attempting to ameliorate the symptoms of trauma in the lives of Veterans (Resick, Monson, & Chard, 2014; 2016).

Areas of Potential Convergence

The central premise of this article is that the current frameworks of Cognitive Processing Therapy (CPT) are not adequately aligned with the principles and practices of trauma-informed care (NCTIC, 2018), and that an infusion of humanism—a set of values governing mental health practices—might help to alleviate this incongruence. The reality, however, is that CPT does have aspects of practice (as opposed to theory) that do appear to align with the principles of TIC (NCTIC, 2018). These areas of convergence appear mostly to be practice-related, though, versus specific to the theory. The spirit of trauma-informed practices is that they are intended

to protect clients from further trauma during the counseling process and, towards this end, CPT possesses some alignment with the following principles of TIC (NCTIC, 2018): safety, trustworthiness and transparency, peer support, and usage of Socratic dialogue and psychoeducation.

Though not planned for being attended to (directly) until the eighth session, CPT does incorporate structured information and session-time for exploring ways in which perceptions of *safety* may have been impacted by traumatic events. Safety, as mentioned throughout, is a core postulate of TIC (NCTIC, 2018); however, what is of greater import to TIC is that the techniques of counseling, themselves, engender a sense of psychological and physical safety (NCTIC, 2018), a potential point of divergence discussed in the next section. Another practice-related item that CPT appears to do well is engender a sense of transparency about the treatment process and what is to be expected. As a manualized treatment protocol, it is largely inflexible to deviations from CPT's standard operating procedures, so clients essentially are provided a highly detailed, cognitively-based road-map for recovery. CPT, like TIC, does acknowledge the importance of *peer/social support* throughout the counseling process, evidenced in part by the presentation of materials to clients' families (if ethically appropriate) regarding how they can support their loved ones throughout the treatment process (National Center for Posttraumatic Stress Disorder, 2016). Further, CPT itself seeks to address intimacy-related issues directly in the final session (i.e., session 12). This is not to suggest that CPT disallows attending to issues of intimacy or social connectedness earlier in the process if the client makes these concerns apparent earlier on (e.g., during identification of cognitive stuck-points during session four, that could potentially relate to a willingness to seek or use social support resources). Further, when CPT includes the group component, opportunities for peer support arise—consistent with the spirit of TIC (NCTIC, 2018). While outside the scope of this article, CPT providers should seek to ensure the actual praxes of group work, however, also seek to avoid recreation of trauma narratives for group work to evidence peer-support.

CPT and TIC, alike, promote the usage of psychoeducation to help normalize the various impacts of trauma. In CPT, psychoeducation is

strictly constrained to a singular, cognitively-based model of the causes and symptoms of PTS (e.g., autonomic nervous system hyperactivity, sleep disturbances, etc.) and occurs as early as session one. TIC, however, promotes a wider model of psychoeducation attending to various impacts of trauma outside of just cognitive stuck-points and their associations with Posttraumatic Stress (NCTIC, 2018), such cultural, historical, or gender-related factors, among others. Next, CPT does promote usage of a commonly used existential-humanistic technique known as Socratic dialogue (Resick, Monson, & Chard, 2016) that appears to strongly align with the principles of TIC (NCTIC, 2018). Socratic dialogue, according to holocaust survivor and existential-humanist Viktor Frankl (1959), refers to a technique of questioning that attempts to draw out a client's own healing knowledge. It aligns with TIC via the technique's adoption of a stance that recognizes clients as experts, empowering them to direct their own insights and healing (Frankl, 1959). Finally, both TIC and CPT endorse usage of psychoeducation about the expected impacts of trauma as a means of normalizing these effects for clients.

Areas of Potential Divergence

Humanistic researchers (Norcross, Wampold & Hilsenroth, 2011; Wampold, 2015) and theorists (Frankl, 1959; Hansen, 2012; Rogers, 1957), alike, posit that the extant empirical evidence supports a belief that positive treatment outcomes arise in the context of therapeutic relationships marked by characteristics that engender a sense of safety and client empowerment —consistent with the principles of TIC. CPT, however, may not share these values. The following sub-sections examine potential areas of divergence between Cognitive Processing Therapy (CPT) and the principles of TIC outlined by NCTIC (2018), beginning with the principle of *safety*.

Safety. In the previous section, *safety* was noted as an area of potential convergence, especially as clients are given an opportunity to process safety-related issues directly. This parallel extends only as far as it appears as topic of inquiry in the CPT manual (Resick, Monson, & Chard, 2016). Consider, though, that safety is not explicitly addressed until session

eight. What if failing to address safety-related concerns early on in treatment stymies clients' willingness to *approach* trauma narratives? Approach-coping is a critical component of nearly every session throughout the traditional CPT process. Further, the principles of TIC (NCTIC, 2018) are less focused on the importance of addressing safety and more intent on ensuring that the actual techniques used in counseling help to engender it. For example, Veterans are then asked to consider their "beliefs before experiencing [the] event and how the event changed or reinforced those beliefs," (Resick, Monson, & Chard, 2014, p. C66). Using the Challenging Beliefs Worksheet (CBW), they are then asked to consider any stuck-points around trusting themselves or others, including any remaining ancillary safety-related concerns. Addressing safety-related anxieties is promoted by the authors of this article as being a critical component of healing the effects of trauma. Further, it would seem intuitive that the tools used to achieve such ends should be used to address this both early on in the treatment process and actively seek to avoid recreating trauma-related narratives throughout their healing.

For example, consider a Veteran that is being asked to not only re-tell (i.e., *approach*) their trauma narratives, but to do so repeatedly until they can "successfully" do so without significant emotional activation—a frequently used tool when Prolonged Exposure (PE) is used conjunctively with CPT (i.e., traditional CPT). If, according to the Veteran's own phenomenological standpoint, this request is appraised as unsafe, resulting in a failure to comply with the counselor's request, CPT practitioners are taught to then remind the Veteran that (from a CPT framework) *avoidance* is the reason they continue to experience negative symptoms—a contraindicated plea to question the veracity of their own gut-instincts regarding safety. The principles of TIC (NCTIC, 2018) assert that both clients and counselors must first feel psychologically and physically safe *as a pre-requisite* for treatment. Thus, practices of interventions like PE, from a TIC-based framework, may violate one of the more core postulates—core because it is a *necessary* but insufficient condition for actively avoiding recreation of trauma-based narratives.

Collaboration and mutuality. According to the principles of TIC (NCTIC, 2018), *collaboration and mutuality* occur in the presence of relationships that seek to equalize the inherent counseling power hierarchy, as much as is possible. In the section on areas of convergence, it was noted that CPT promotes usage of Socratic dialogue (Resick, Monson, & Chard, 2016), a technique that seeks to reduce this power-hierarchy through use of strategically formulated questions that attempt to elicit or evoke the clients' own healing-knowledge. Though not entirely non-directional, Socratic dialogue can enhance collaboration by tapping into clients' phenomenological worldviews and using the resultant insights to direct their own healing. What may, however, begin to diminish these efforts are CPT's reliance on structure and treatment fidelity. To maintain CPT's claim as an empirically-based treatment (EBT), it must ensure that the same lab-conditions that were used during its initial testing, and developments are replicated and controlled in a clinical environment. CPT providers must maintain relatively strict adherence (i.e. fidelity) to the processes meticulously outlined in the CPT resources manual (Resick, Monson, & Chard, 2014), or else they are not necessarily tapping into the same causal mechanisms that were used to help explain the intervention's apparent effectiveness in treating the symptoms of PTS (i.e., confrontation of cognitive stuck-points that arise due to trauma). This leaves little room for spontaneous, emergent, or organic therapy to take place—treatment truly driven by the client—and as a result, true collaboration and mutuality is minimized.

Empowerment, voice, and choice. The intended consequence of *collaboration and mutuality* is *empowerment*, *voice*, and *choice*. According to TIC (NCTIC, 2018), interventions should seek to empower clients, in part, by giving them opportunities to inform and direct their own insights and healing as much as possible. According to postmodern feminist Judith Herman (1997), empowerment, voice, and choice are of particular importance with survivors of trauma that may feel less powerful and less in control over their own wellbeing in the wake of challenging life circumstances. This principle goes part and parcel with each of the other

five postulates (NCTIC, 2018). CPT, especially when used in conjunction with Prolonged Exposure (PE), not only requires clients to retell their trauma narratives (unsafe for some), but the merits of such an approach are not supported by the extant research. Kolk (2006) also notes that requiring clients to be exposed to trauma-related stimuli as a mean of desensitization can exacerbate and complicate the processes of recovery.

Cultural, historical, and gender issues. Empowerment, voice, and choice may be especially important elements of the counseling process among those that experience systemic relegation. Trauma-informed practices recognize that clients enter counseling with idiosyncratic experiences around privilege and oppression (NCTIC, 2018). It recognizes that, oftentimes, people of marginalized identities' (e.g., cultural, historical, and gender-related, among others) past experiences of trauma have been at the hands of people of privileged identities, such as people that are cisgender, white, and monolingual (i.e., English-speaking). As such, for CPT to align with the principles of TIC (NCTIC, 2018), it should in some way seek to ensure that power-related dynamics are not creating the contexts for further identity-related disempowerment. Using content-analysis of the impact statements used at the beginning of CPT, Marquez et al. (2016) examined the influence of Latino culture on posttraumatic cognitions among 29 clients receiving counseling in community mental health settings. A test of CPT's application across cultures, it was concluded that while the content of their cognitive stuck-points appeared to be similarly relative to non-Latino clients, fewer overall stuck-points were identified among clients that identified as Latino. Among the cross-cultural variance in themes that did emerge for clients of Latino descent were: past exposure to violence, poverty, and religion, among others. Marquez et al. (2016) note that due to variations in cross-cultural worldviews and the importance of identifying and addressing cognitive stuck-points to the fidelity of CPT, counselors should seek to do two things. First, they should, "validate the lived experience of the client" (Marquez et al., 2016, p. 104). Then, they should seek to, "build rapport and foster trust and engagement," (Marquez et al., 2016, p. 104), so as to explore areas of traditional CPT that

may be negatively affected by cross-cultural factors. According to TIC (NCTIC, 2018), it is not just cross-cultural issues that may affect the treatment process, but also histories of oppression related to gender- and sexuality-related struggles, among others. Given the extremely recent research finding that CPT's effectiveness may vary based on race/ethnicity (Holliday et al., 2017; Lamp et al., 2018), attending to the cultural appropriateness of selected interventions intended to treat trauma is likely imperative for their relative success—especially among people of marginalized identities.

Implications for Counselors, Counselor Educators, and Researchers

As shown, CPT may be trauma-*focused* though not necessarily trauma-*informed,* at least as defined by the National Center for Trauma-Informed Care (2018). Further, some important implications of this disparity were discussed (i.e., TIC was intended to help protect survivors of trauma from re-traumatization during counseling and, especially, people of marginalized identities). Next the authors turned their attention to operationalizing humanism, assessing its apparent alignment with the principles of TIC (NCTIC, 2018), and proposing a series of minor, humanistic amendments, of import in as much as they serve to align the theory and praxes of CPT with those involved with trauma-informed practices.

Enhancement of CPT via Humanism

Humanism denotes a collective of mental health theories that share some common core presuppositions. Among these beliefs are ideas such as the irreducibility of the human experience (i.e., non-reduction), non-determinism (i.e., people are free and responsible), an acceptance that human beings are generally orientated towards wellness, a belief that clients are the best experts of their own experiences, and promotion of meaning-making and relationships as core aspects of the mental health treatment process (Bugental, 1964; Hansen, 2012; Lemberger, 2012). Further, humanism posits that when certain conditions are met (e.g., positive regard,

empathy, counselor-authenticity, etc.), the therapeutic relationship can act as the primary causal mechanism of change (Norcross et al., 2011; Rogers, 1957; Wampold, 2015), as opposed to riskier approaches involving frequent exposure to trauma-inducing stimuli (e.g., Prolonged Exposure).

Humanism is also largely congruous with the principles of TIC. Humanism's foci on non-determinism and the client-as-expert helps promote empowerment, collaboration, voice, and choice (NCTIC, 2018). Humanism's focus on empowerment also presents opportunities to enhance safety throughout the treatment process for people stemming from historical and currently marginalized groups, such as people that do not identify with the gender binary, people of color, or people that identify with the LGBTQ+ community, among others. Further, irreducibility and non-reduction, or the ideas that human-beings are overwhelmingly complex and greater than the sum of their individual components, may help to ensure that mental health assessments also attend to the wider scope of mental health-related impacts of trauma (NCTIC, 2018) by prioritizing a holistic, bio-psycho-socio-spiritual assessment of the various impacts of trauma (Frankl, 1959).

Towards a Trauma-Informed CPT (TI-CPT)

Frankl (1959) once opined that, "When we are no longer able to change a situation, we are challenged to change ourselves," (p. 112). If entirely protecting Veterans from trauma exposure is a fool's errand, then we must be willing to continuously develop new approaches and critically examine contemporary clinical praxes used to help warriors heal in trauma's aftermath. Many researchers, such as Hansen (2009; 2012), Lemberger (2012) and Yalom (2012), posit that the influences of Managed Care (MC) and Health Maintenance Organizations (HMOs) have had a weighty effect on the lenses and interventions used to conceptualize and treat clients. This influence has tended to result in an over-reliance on medically-focused, reductionist lenses, with TRICARE and the VA acting not as exceptions to these influences but largely as proponents. With symptom extinguishment as their primary goal, CPT limits itself to 12-sessions (Resick, Monson, & Chard, 2016); however, what if there were

other components to trauma treatment that may have been largely overlooked? Aspects of treatment that align with humanism, though, may offer an opportunity for CPT to align itself with the principles of TIC. This paper promotes a three-pronged approach, culminating in what the authors refer to as trauma-informed CPT (TI-CPT): relationship-building, symptom normalization and reduction (i.e., via traditional CPT), and meaning-making (i.e., development of noetic tension).

Relationship-building. A core tenet of humanism is that relationships are the primary vehicle for which people develop meaningful change (Gergen, 2015; Rogers, 1957). In 2011, an interdivisional APA task force on Evidence-Based Therapy Relationships (EBTR) examined a series of more than 12 meta-analyses of studies that looked at the predictive role of relationship factors on counseling outcomes (Norcross et al., 2011). The Task Force found that the therapeutic relationship, "accounts for why clients improve (or fail to improve) at least as much as the particular treatment," (p. 98). As such, it was recommended that mental health professionals, "make the creation and cultivation of a therapy relationship … a primary aim in the treatment of patients," (p. 98). According to Norcross, Wampold, and Hilsenroth (2011), they also endorsed the conclusion that, "concurrent use of evidence-based therapy relationships *and* evidence-based treatments adapted to the patient is likely to generate the best outcomes," (p. 98). Thus, it may be especially efficacious to invest time and resources in relationship construction and maintenance with an evidence-based treatment such as traditional CPT. Admittedly, many of the studies looked at by these meta-analyses used cross-sectional designs with correlational statistics; regardless, the evidence is overwhelming that relationships have an important role in the healing process.

A TI-CPT would allow the quality of the therapeutic relationship, as perceived by both the client and the counselor, to assist in guiding the usage or timing of specific interventions based on their appraised degree of safety. Towards these ends, TI-CPT should spend *at least* one session, post-intake and assessment, both educating clients on the importance of relationship factors in treatment, as well as, attempting to enlist them as collaborators in

the development and maintenance of the therapeutic alliance throughout therapy. Finally, the authors of this paper posit that counselors should not only remain reflexive to the effects of various CPT interventions (e.g., Prolonged Exposure) on the therapeutic relationship throughout treatment, but that counselors should also spend a brief period of time informally exploring each clients' own phenomenological perceptions of its quality at the end of every session.

Symptom normalization and reduction. As the research is plentiful evidencing symptom reduction via CPT among Veterans with PTS (Resick, Monson, & Chard, 2016), this paper does not advocate for wide-spread changes to the treatment's primary protocols. This said, there is still room for improvement, especially when attempting to create an alignment with the principles of TIC (NCTIC, 2018). A TI-CPT would prioritize symptom *normalization* by promoting awareness that, "an abnormal reaction to an abnormal situation is a normal reaction," (Frankl, 1959; p. 38). Humanizing CPT also includes more than just a focus on safety, relationships, and meaning-making; but also minimizing deleterious, pathologizing interpretations of normal and, hence, *expected* responses to trauma. While contemporary CPT does not promote shaming a client that fails to *approach* their trauma narrative homework in-between sessions, for example, it does train its practitioners to communicate to the Veteran that this is problematic *avoidance* (Resick, Monson, & Chard, 2016). While this may be true, it should be normalized as an expected response to distressing experiences. Increased flexibility (i.e., adding *a* session if they are not yet willing to *approach* the trauma narrative) may promote further avoidance; however, it also enhances *safety*, *empowerment*, *voice*, and *choice*—key elements of TIC (NCTIC, 2018). Increased flexibility should also enhance CPT's overall effectiveness, as the meta-analyses examined by the APA Task Force on evidence-based relationships found that treatment-*rigidity* negatively affected outcomes (Ackerman & Hilsenroth, 2001; Norcross et al., 2011). A TI-CPT would recognize avoidance as an important means of coping early on after an incident but, unfortunately, may also extend the length of one's struggles over time. Thus, clients would be *invited* to begin

approaching their traumas within the relative safety of the therapeutic relationship, knowing that they will be positively regarded by their counselors even if this process includes some valid trepidation and apprehension.

Meaning-making (i.e., development of noetic tension). Finally, the authors recommend a two-session existential-humanistic intervention prior to termination where the counselor and client explore two capstone topics: meaning-exploration and development of noetic tension. First, some (Fabry, 1988; Frankl, 1959) have suggested that meaning-based treatments may have longer-lasting positive treatment outcomes because they not only extinguish troubling symptoms, but also replace them—as methods of coping—with an awareness of the responsibility to act towards a meaning yet to be fulfilled (i.e., filling the existential void). Frankl (1959), a holocaust survivor and psychiatrist, posited that the basic human motivation is the search for meaning, that meaning exists and can be discovered under all circumstances, and that human beings are free and responsible autocrats capable of working towards self-actualization (i.e., ultimate-meaning). Meaning-making (i.e., the process of seeking out meaning in life) has been implicated as both a protective factor (Frankl, 1959; MacDermott, 2010), as well as a curative factor (Lantz, 1992; Tedeschi & Calhoun, 2004) in Veterans that survived trauma, according to the extant clinical literature. The presence of meaning has also been found to predict psychological growth in the aftermath of trauma (i.e., posttraumatic growth) in a number of studies with diverse groups (Tedeschi & Calhoun, 2004; Zeligman, Varney, Grad, & Huffstead, 2018).

Session one of the capstone experience (i.e., meaning-exploration) would begin by providing brief psychoeducation on *meaning* and its relationships to trauma and the healing process. Meaning is defined phenomenologically (i.e., by the client); however, it can be conceptualized as being both general and situational. A general meaning, referred here as an *ultimate meaning*, refers to the life-legacy the client wishes to leave the world at the end of their life (Frankl, 1959). Frankl (1959) proposed that instead of humans asking life what its meaning is, it may actually be life

asking each person what the meaning of the person's life will be from moment to moment, as it pertains to their relative *ultimate meanings*. *Situational meanings*, then, are humans' responses to being asked by life what their meaning will be—the ways in which they act freely and responsibly towards their chosen life-legacies. Once clients have a firm grasp on the concept of meaning and its importance to the healing process, TI-CPT counselors could then, with the client's permission, begin exploring the Veteran's ultimate meaning. How would they like (and not like) to be remembered once they are gone? Since life is finite, and humans are free to choose either actions or attitudes towards their circumstances, they are ultimately responsible for fulfilling their chosen life-legacies.

Session two of the meaning-making capstone to TI-CPT would be a process of Socratic questioning helping Veterans seek answers to the question, *"Now that you are nearing termination, what is being asked of you moving forward to ensure that you get to leave the kind of legacy you wish for yourself?"* Development of existential (i.e., noetic) tension towards a goal (e.g., ultimate meaning) yet to be fulfilled is intended to serve as a potential replacement coping mechanism now that CPT has worked to diminish clients' usage of *avoidant*-coping styles (Fabry, 1988; Frankl, 1959). It is important to note that counselors should act only as fellow sufferers on the path towards meaning and self-actualization and, as such, should refrain from telling clients how they should make meaning of their lives now that they are preparing to terminate treatment. Further, counselors should be culturally sensitive to the fact that, for example, some clients serve a collective purpose. Reliance on minimally directive Socratic questioning of each client's unique perceptions of meaning and its search are of prime import. It should not be expected that any 'real' or concrete answers to such questions as the ultimate meaning of one's life are to be found in these two sessions. Rather, it is the hope that the cultivation of existential curiosity, alone, would help promote what Frankl (1959) referred to as the *will-to-meaning* (i.e., the search for meaning). Counselors that want to add a relatively objective component as a point of conversation with clients might consider using Steger, Frazier, Oishi, and Kaler's (2006) Meaning-in-Life Questionnaire (MLQ), a 10-item self-report measure with

strong internal reliability examining the presence and search for meaning. Going beyond mere symptom extinguishment, it is the hope of this brief, two-session meaning-making section to also prevent symptom recidivism by replacing *avoidant*-coping with meaningful pursuits.

Southwick, Gilmartin, McDonough, and Morrissey (2006) present three case studies from a Connecticut VA hospital that has used Frankl's (1959) meaning-based Logotherapy to treat combat-related PTS among service members and Veterans. They note that Logotherapy—a meaning-based approach helping to inform some of the suggestions in this article—not only appeared to help Veterans *approach* their trauma narratives, per CPT's own guidance, but helped to alleviate concurrent substance use (i.e., another form of avoidant coping) through exploration of meaning and purpose in the aftermath of the Veterans' traumas. According to the latest estimates by the National Institute of Drug Abuse (NIDA, 2013), as many as one in 15 Veterans experience a Substance Use Disorder (SUDs)—commonly conjunctive with Posttraumatic Stress (PTS).

A Testable Research Hypothesis

For assessing the potential utility of the premises presented in this article, researchers might consider testing the following research hypothesis: TI-CPT will have a larger (i.e., statistically significant), longer-lasting positive effect on symptoms of PTS (as measured via Weathers et al. [2013] PCL-5) relative to outcomes from traditional CPT. Statistical analyses of clinical outcomes using an outcome-measure like the PCL-5 to measure changes over time relative to a control may seem antithetical to the anti-reductionistic presuppositions of humanism. In opposition of this view, however, the humanism posited in this article aligns with Lemberger (2012); namely, that quantitative social science has meaningful utility when taken as only a part of the whole clinical picture (i.e., holism). As such, it might also be increasingly congruous with humanism, per Hansen (2012), for researchers seeking to test this hypothesis to also include mixed-methods, qualitative protocols allowing for greater attention to the phenomenological nuances (i.e., rich description of subjective perceptions)

present within the sample population throughout the change process, so often lost in the proverbial statistical weeds.

Conclusion

Thus far, the authors defined CPT and TIC and critically assessed their apparent degree of theoretical congruence. The authors, having identified a number of important areas of divergence between CPT and TIC defined humanism as a potential means of re-aligning CPT with TIC. Limitations of this project will be examined, as well as some remaining considerations for multiculturalism and social justice. Finally, counselors will be challenged to engage in systemic-level advocacy to help ensure that CPT providers are adequately supported to employ trauma-informed clinical approaches by critical third-parties such as reimbursement providers like TRICARE.

Limitations

Beginning with some key limitations, an infusion of humanism into the currently existing CPT framework may enhance its ability to work from a TIC-based lens; however, there are some ways in which their philosophic presuppositions are antithetical to one another. For example, CPT (Resick, Monson, & Chard, 2016) promotes the idea that *avoidance* is a cause and symptom of lingering PTS symptoms, acting to inhibit a person's natural ability to heal over time. Humanism, taking a holistic approach to understanding the impacts of trauma, might look at a person's *avoidance* as a cause of lingering distress, but it also extends the potential utility of *avoidance* as a protective mechanism, such as early on after a traumatic experience, when the timing may not be right to begin safely approaching the trauma narrative. Even then, conceptualizations of the role of *avoidance* in the development and maintenance of PTS may vary, too, across the various theories within the wider paradigm of humanism (e.g., Individual Psychology, Person-Centered Counseling, Existential-Humanism, etc.). For example, CPT interprets client avoidance of trauma-related stimuli as only serving to inhibit their natural recovery process. Rogers' (1957) Person-

Centered Counseling might suggest that such an interpretation is tantamount to applying a condition of worth on the client and, potentially, causing them harm. Frankl's (1959) Logotherapy (i.e., existential-humanism) might interpret *avoidance* as a means of coping with the existential void left in the wake of trauma (Frankl, 1959). Humanism allows for multiple perspectives on both the pragmatic utility of, or problems associated with, human phenomenon like *avoidance*, taking a look through both deficiency- and strengths-based lenses.

It might also be argued that allowing for a multiple-truths (i.e., humanistic) perspective on *avoidance*, a key issue in contemporary CPT (Resick, Monson, & Chard, 2016), might also lengthen the symptoms of PTS by normalizing *avoidance* when clients perceive that it might be unsafe to *approach* the trauma narrative or its related stimuli. Alternatively, Frankl's (1959) Logotherapy (i.e., existential-humanism) would interpret clients as the best experts of their readiness to *approach* the trauma narrative, based in part by factors such as perceptions of safety. Finally, Berliner and Kolko (2016) note that one limitation of TIC is that, "much remains to be learned about how TIC is defined and evaluated," (p. 171) making it difficult to draw research-informed comparisons between trauma-*focused* approaches and trauma-*informed* ones. The authors of this paper chose to use NCTIC (2018) principles of TIC, due largely to the fact that they are both evidenced-based, as well as pre-operationalized, potentially lending themselves to greater falsifiability in future studies.

Multicultural and Social Justice Considerations

As noted above, TI-CPT's infusion of humanism may promote a more holistic, nuanced conceptualization of trauma and its treatment. As NCTIC's (2018) principles for TIC include a need for providers to be educated in the cultural and historical roots of oppression and privilege, a TI-CPT provider would aspire to that same goal. For example, there should be an awareness among trauma-professionals that some professional praxes that minimize clients being able to have voice and choice (NCTIC, 2018) might run the risk of recreating trauma narratives, promoting disempowerment. A potential example of this might be a counselor of

privileged identity telling clients at the intersections of multiple marginalized identities that they, "need to quit avoiding [their] problems and thinking about them in the wrong ways, as these are the causes of their continued struggles," as opposed to an acknowledgment that people of privilege generally also have greater access to resources (e.g., capital, social, etc.) when grappling with the often far-reaching impacts of trauma. Trauma-informed doctrines must be irrevocably linked with the postmodern principles of the multicultural and social justice counseling movements and, as such, a TI-CPT must follow suit.

Need for Systemic-Level Advocacy

According to Ratts, Toporek, and Lewis' (2010) Advocacy Competencies adopted by the American Counseling Association (ACA), there are occasions where meaningful client advocacy must occur on a systemic level (e.g., affecting laws, policies, procedures, best practices, etc.). Towards these ends, increasing the number of sessions to allow for relationship-building (Norcross et al., 2011; Wampold, 2015), meaning-making (Bugental, 1964; Frankl, 1959; May, 1965; Yalom, 1980), and general flexibility, when reimbursed by HMOs (like TRICARE) through the VA, requires a willingness by these organizations to invest more heavily in the health and wellness of the nation's warriors. Making these changes would represent an investment in the potential for greater long-term recovery from challenging life circumstances, supported by both historical paradigms of wellness (Bugental, 1964; Frankl, 1959) and contemporary mental health research (Norcross et al., 2011; Wampold, 2015). While imprisoned during the Holocaust, Frankl (1959) also opined that, "Everything can be taken from a [person] but one thing: the last of human freedoms—to choose one's attitude in any given set of circumstances, to choose one's own way," (p. 75). While operating from a trauma-informed place might be enhanced via more sessions and though the current mental health zeitgeist may not be inclined to allow for this, it does not require extra time with a client to *choose* to utilize theories and interventions that were developed with the principles of trauma-informed

care (NCTIC, 2018) in mind. And it is a choice that all counselors should critically weigh the merits of in this age of cost-efficiency, medicalization, and managed care.

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An Interpretive Phenomenological Analysis of Shelter-in-Place: The Fort Hood Shooting

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We conducted an in-depth, idiographic study aimed at exploring the emotional experience of individuals mandated to shelter-in-place (SIP) during the April 2, 2014 active shooter event on the Fort Hood military base in Fort Hood, Texas. Semi-structured interviews were conducted with five individuals who sheltered-in-place during the shooting. Employing Interpretative Phenomenological Analysis (IPA), three superordinate themes—impact of the shooting, coping during SIP, and internal and external factors—emerged. Subthemes for each superordinate theme were also identified. Our analysis points to the need for mental health counselors to attend to issues related to the shooting, including anxiety, organizational issues, and post-traumatic growth. This study also provides information related to factors which support coping and resilience following an active shooter event. Recommendations for future research and implications for counseling professionals as well as emergency management personnel are included.

Keywords: shelter-in-place, lockdown, active shooter, interpretative phenomenological analysis

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On April 2, 2014, an active shooter fatally injured three individuals and injured 14 persons, before taking his own life, on the Fort Hood military base in Fort Hood, Texas. Fort Hood officials ordered both civilians and military personnel to shelter-in-place (SIP) during the event. These recent acts of violence have heightened our awareness of active shooters as a pervasive problem throughout the United States (Fox & DeLateur, 2014). As attentiveness to these events increases, so does the need for evidence-based response protocols. Routinely used during active shooter events, SIP is a protective action strategy that encourages individuals to stay inside the building they are in or near when the outdoor environment is unsafe (Dailey & Kaplan, 2014).

Despite widespread acceptance of SIP as a protective action strategy, there is a lack of research on the emotional impact of sheltering. Research on quarantine, confinement, social distancing, and isolation support the idea that individuals who shelter may experience adverse emotional and/or mental-health responses (Burkle, 1996; North, Hong, Suris, & Spitznagel, 2008). Emotional reactions to SIP vary from boredom and discomfort (Mannan & Kilpatrick, 2000) to distress and fear (Dailey, 2011). Other common reactions include anxiety, particularly when separated from loved ones; frustration; uncertainty; and concerns about physical safety (American Red Cross, 2010; Dailey & Kaplan, 2014).

The extant research indicates that SIP is a safe protective action strategy, particularly when individuals who shelter together have high levels of cohesion (Dailey & Kaplan, 2014). Emerging as a significant factor in sheltering, group cohesion plays an essential role in helping to mitigate mental health issues (Dailey, 2011; Forsyth, 2006; Lauring & Selmer, 2010). Grounded in the work of Yalom (1985) and Lewin (1951), Dailey (2011) found that SIP groups who have higher levels of group cohesion perform better than groups who have a lower level of group cohesion. Moreover, SIP groups that lack cohesiveness report decreased levels of well-being. While promising, this was a simulated investigation and may not accurately represent sheltering groups.

Purpose

Considering the limited empirical data on sheltering during active shooter events, this qualitative phenomenological study sought to explore the emotional experience of individuals mandated to SIP during the Fort Hood shooting on April 2, 2014. In addition to capturing lived experience, we wanted to understand protective factors, such as group cohesion. We were particularly interested in how groups who had an established culture of cohesion, such as the military, would respond to SIP. Questions that guided our inquiry were: (1) what was the personal and social experience of individuals who sheltered during the 2014 Fort Hood shooting? and (2) what elements influenced an individual's experience both during and after SIP?

Method

To explore how participants made sense of their personal and social world during the Fort Hood shooting and subsequent SIP, we used interpretive phenomenological analysis (IPA; Smith, Flowers, & Larkin, 2009). We chose idiographic inquiry to allow for detailed perceptions and understandings of each participant's experience, both during and after SIP. The interpretation process of IPA is described as double "hermeneutic" (Smith & Osborn 2007, p.53), in that it involves a dual process of understanding on the part of the participant and the researcher. As part of these two stages, we were able to search for themes and patterns, as well as any changes or shifts in thinking (Conroy, 2003). Figure 1 outlines the inquiry process.

Participants

Since IPA uses a purposive, homogeneous sample, participants were selected based on the following inclusion criteria: 18 to 65 years of age, proficient in reading/writing English, enlisted as a member of the Army at the time of the shooting, and sheltered-in-place on April 2, 2014 at the Fort Hood military base. We recruited a convenience sample of

participants through contacts and, consistent with snowball sampling techniques, acquaintances and peers made referrals for participants (Creswell, 2009).

Five participants were eligible to participate. All were in the United States at the time of the study and ranged in age from 35 to 50. Three participants identified as African American/Black and two as Caucasian. Two participants identified their rank as a Major, one as a Colonel, and one as unidentified. All reported at least 11 years of military service, with three to five deployments. While one participant had experienced SIP five times while deployed to Iraq in 2005-2006, no others had previous SIP experience. All participants reported at least two SIP trainings. Table 1 summarizes demographic information for participants.

Procedure

Following approval from the Institutional Review Board (IRB) Office of the United States Army as well as a university IRB, a research monitor was appointed. A licensed professional counselor who specializes in trauma and military population filled the role of the research monitor. The research monitor's duties were to protect the rights and well-being of the participants, and to ensure reported data was accurate, complete, and verifiable from source documents.

Potential participants were contacted via e-mail or telephone, based on the participants' expressed preference, to screen for eligibility, discuss study procedures, and review the informed consent. After receiving consent, we administered a pre-screening survey, the Post-Traumatic Stress Disorder Checklist (PCL-M; Weathers et al., 2013), to assess for pre-existing trauma. Individuals within the military are at greater risk of post-traumatic stress disorder (PTSD) than those in the general population (Reisman, 2016); with estimates ranging from 13% to 20% of post-combat service members and Veterans (Galea et al. 2012). Therefore, those who met the criteria for PTSD were only determined eligible if a diagnosis of PTSD was documented prior to the SIP order and participants were currently receiving or had received treatment. Participants selected a pseudonym to ensure confidentiality.

The researchers obtained data over the phone using an in-depth, semi-structured interview guide with 10 questions and prompts. The guide allowed participants an opportunity to explore and expand upon their experience. In alignment with the interview guide, each participant was asked to describe his or her SIP experience after being informed of the active shooter on base. Opening questions asked participants to describe how they initially responded to the SIP order. Prompts focused on, behavioral (i.e., "What actions did you take?") and interpersonal (i.e., "How did you feel?") responses. Participants were also asked about the impact of the experience on their personal and social world. All interviews were audio recorded and ranged between 60 to 90 minutes in length. Interviews were transcribed by a transcription service.

Data Analysis

Our investigation follows Smith's (2011) characteristics of an IPA study: defined focal point, strength in data, thoroughness, room to provide detailed descriptions of each theme, interpretive and descriptive analysis, convergent and divergent analysis, and vigilance in writing. To maintain rigor, we revisited the research question throughout the various stages of data analysis to ensure a focal point. We consulted with experts in IPA, to ensure the analysis process was thorough and detailed. Following prescribed steps for IPA (Smith et al., 2009), we engaged in the following data analysis process: 1) reading and re-reading, 2) initial noting, 3) developing emergent themes, 4) searching for connections across emergent themes, 5) moving to the next case, and 6) looking for patterns across cases.

In the first step of our analysis, we focused on the participant and became actively involved with the data by reading and re-reading the interview transcripts (Gee, 2011; Smith et al., 2009). We noted thoughts that may "crowd" our ability to focus on the data (Gee, 2011, p. 12). The second step involved examination of semantic content and language (Gee, 2011; Smith et al., 2009). We were open-minded during this step, making exploratory comments or notes that highlight the participant's key words, phrases, or explanations. During the third step, we searched for emergent

themes essentially decreasing the quantity of data. On the transcript, themes were noted.

Following the search for themes, we searched for connections among the data by utilizing abstraction, polarization, contextualization, numeration, and function (Gee, 2011; Smith et al., 2009). In this fourth step, we created a graphic visual of how the emergent themes were structured, organizing these into superordinate themes as appropriate. In step five, we moved on to the next participant interview and repeated steps one through four. Lastly, in step six, we methodically searched for patterns across all interviews and achieved consensus on superordinate themes and subthemes.

In addition to examining the transcripts independently, we used NVivo (QSR International, 2014) to review the transcripts line-by-line to discover connections, themes, and patterns and to help the research team interpret the meaning of the content of the participants' experiences (Smith et al., 2009). NVivo also assisted the researchers in coding the one-on-one interviews with participants by organizing and analyzing verbatim extracts obtained from transcripts of the audio recordings.

Researcher positionality. This research utilized a constructivist paradigm (Guba & Lincoln, 1994). Thus, the researchers assume that knowledge and reality are socially developed by all individuals involved in the research process. Information is experientially gathered through conversation, and meaning is made within a context. Both researcher and participant are involved in an iterative process, each influencing the other. All researchers are licensed professional counselors and nationally certified counselors. Two researchers hold doctorates in counselor education and supervision and, at the time of this study, the primary researcher was a doctoral candidate in counselor education and supervision. Collectively, the research team has over 30 years of experience as professional counselors. As part of the double hermeneutic expression inherent to IPA, themes from this research were paired with the researchers' interpretations of the data.

Validity and Rigor

Utilizing Yardley's (2000) criteria for assessing validity in qualitative research, we implemented the following principles: 1) sensitivity to the context, 2) commitment and rigor, 3) transparency and coherence, and 4) impact and importance. We demonstrated sensitivity to context by being aware in the interview process and ensuring all participants felt comfortable and safe during the interview, using participants' words to provide their "voice" (Yardley, 2000, p. 180). We viewed participants' experiences within a culturally appropriate context (e.g., race, gender, military, geographic location). We demonstrated transparency and coherence by explaining the stages of the research process in a clear and organized manner (Smith et al., 2009). Trainor and Graue (2014) suggest documenting three types of transparency: methodological, interpretive, and narrative. Accordingly, we recorded these details and sent them to the research monitor for further examination. Lastly, we attained impact and importance by presenting information to help enhance the area of disaster mental health, specifically SIP as a response protocol, and taking an active role in the dynamic, double hermeneutic process (Smith et al., 2009).

We used triangulation, including sending participants a copy of the transcript from his/her interview, calling each participant for a follow-up, and providing all participants with the opportunity to communicate any discrepancies, issues, or any other comments about the interview process. Bracketing also ensured rigor, providing an opportunity to examine and reexamine preconceptions (Chenail, 2011). Reflexive journaling was used during the development of the research questions and throughout the data gathering process.

Results

All participants were able to recall what they were doing at the time of the SIP order, who was with them, and what they did in response. Each described their emotional and psychological reactions and how their role as a service member impacted their experience. Three superordinate themes and multiple subthemes emerged: 1) impact of the shooting, 2) coping

during SIP, and 3) internal and external factors. Subthemes for impact of the shooting are: a) feelings of anxiety, b) organizational issues, and c) personal growth. Subthemes for coping during SIP are: a) roles and responsibilities, b) previous training, c) communication, d) group experience, and e) feelings of disconnect. Subthemes for internal and external factors are: a) demographic factors, b) mental health, c) military culture, and d) emotional support. Figure 3 illustrates these superordinate and subthemes.

Impact of the Shooting

All participants reported, in detail, the personal impact the shooting and SIP experience. While adverse emotional reactions and organizational challenges were unanimously described, individuals also unanimously reported personal growth. We begin with a verbatim account from one participant, illustrating the impact of the shooting and subsequent SIP order. We selected this passage because it reflects the emotional impact of the shooting and SIP order, organizational issues, and interpersonal growth identified by all participants. This passage by John (pseudonym) cumulatively reflects the central premise of this study – the shooting and subsequent SIP order had a significant impact on participants as well as Fort Hood as an organization.

> It was about 1600 in the afternoon and we were about to go outside to take a photo…we heard the shots…We're like is this the drill?... After we realize it is an active shooter, we went back in the building…Everybody was confused trying to find out what was going on… During that whole time, we didn't know what was going on. We just talked… It had a silver lining because your attention was brought to some systemic issues that probably needed attention. At the end of the day, I probably was just able to deliver better care and make people more sensitive to the needs of our soldiers.

Feelings of anxiety. Across all cases, each participant mentioned the word "anxious" or "anxiety" to describe their feelings both during and

following SIP. One participant said, “We had no idea what was going on, which worsened the feelings of anxiety.” Another participant described feeling anxious and needing to “pace” while sheltering. Higher levels of anxiety were indicated when participants were not engaged in an activity, such as searching for supplies or ensuring others were accounted for.

Following SIP, participants ruminated on fears of “what might occur.” One participant said she “worries about what will happen to her colleagues”; another mentioned “racing thoughts” when not preoccupied with another task. Participants described having a “heightened state of awareness” after SIP and being “more alert and cautious” because of the experience. A lack of perceived safety and worry were frequently described. One participant reported a sense of fear when on base. The following accounts, from participants renamed Mike and Kelly, reflect typical feelings of anxiety both during and after the SIP order.

> I don't know how many licks you can take to the center of the Tootsie Pop before you're traumatized for good. It was certainly one more lick that I didn't need. But, because I wasn't directly affected by this one, it wasn't as bad for me. I have lost friends during combat and things, so it brings up some grief responses of things. It didn't have the lasting effect it might have had on me if it were a bit closer to me, like if I had been shot or a friend of mine had been shot. I don't know why that matters, but it seems to.

This next account is reflective of a heightened sense of awareness following the SIP order.

> I got locked out of the office one day and I knocked on the door pretty hard … to make sure someone heard me and somebody rushed to the door and they said, ‘What's wrong?’ And I said, ‘Nothing. I'm locked out.’ And he says, ‘Don't knock on the door like that anymore. We're all traumatized.’

Organizational issues. All participants noted organizational issues during and after the shooting. The Fort Hood Emergency Management Plan (Department of the Army, 2013) mandates a base-wide alert system in a

state of emergency. While all participants focused on the need for communication improvements, four out of five did not feel the alert system worked. Participants felt too much time passed between the onset of the shooting and the alert notification. Only one was "notified right away," however, this individual was in a high leadership position. Mike, a major, said, "I think it took them [military leadership] longer than it should have. This was one of the discussions we had when we pushed up the formal review from our end." Another participant, who did not disclose their rank, noted, "We got word from somebody to tell us to stay in the building. The word that goes out on that mass system, but that didn't happen until an hour later."

Personal growth. Following SIP, all participants explained interpersonal processing, problem solving or goal setting, and trying to make positive personal and organizational changes moving forward. Jane said, "As a leader, you want to know that you are developing yourself to be the type of leader that can be effective. That can make a difference in where you command. That you can make a difference wherever you are." Similarly, Mike stated:

> It was a positive impact for the active situation because, very simply stated, I did the right thing [accessing mental health and receiving treatment]. How important it is to listen to someone when they're starting to have those really bad days.

Coping During SIP

Based on participant responses, immediate action following the SIP order was an important factor in mitigating adverse emotional responses. Participants focused on protocols, collecting information, and, in general, any distractions to relieve or manage their feelings. Interwoven in all participant reports was the significance of communication, sheltering with others, and using detachment to manage their emotions both during and after the event.

Roles and responsibilities. All participants focused on their role in the military, generally stating these responsibilities dictated their immediate response. Universally, participants focused on their immediate responsibilities and the safety of others, noting, "We did exactly what we were trained to do." All participants held a rank requiring them to supervise or manage other service members. Bob reported,

> When they first ran up to us and said, 'There's an active shooter.' At that point, we weren't a hundred percent sure until they said, 'No. We actually heard the shot'…We got people inside, got the unit inside, all of our office mates…We need to execute appropriately in regard to sheltering in place and what the command had established as the procedures. Which is lock the doors, lock the windows so people can't see inside our building.

Another participant stated, "My first reaction was not one of emotion, but, 'okay, I've got to take care of business.' I think that's normal for military, almost the more important the mission."

Previous training. All described the importance of preparedness in helping navigate crises in a productive manner, specifically noting the frequency and regularity of routine drills. One participant stated, "We're constantly rehearsing. We're going to have a chemical attack exercise here tomorrow, but we're rehearsing it all the time. We're always planning for contingencies." Bob noted the critical nature of SIP training:

> The drill does help. Because without the drill, everybody would jump in their cars and try to drive off, or probably running around outside trying to take cover. And then we would lose accountability…so the drills are important. They help.

Communication. The importance of timely communication and accurate information facilitated coping during the event. Conversely, the lack of information increased tension while sheltering. Participants explained the "need to search for information," or "fact-finding." One

individual stated, “The worst part is not knowing.” Another said, “The stress was high because everybody didn’t know what’s going on.” Participants talked about watching the news, listening to news reports, browsing through the internet, and reaching out to others on base to obtain information. Participants consistently stated that obtaining and communicating information was critical. All made phone calls, sent texts and/or e-mails to family members and friends, trying to communicate what was happening and that they were safe.

Group experience. Four out of five participants were with others during the SIP order. Being in a sheltering group seemed to help participants cope and manage feelings of anxiety. John said, “I was alone for a good amount of the crisis. I supposed I was more vulnerable than those folks. A group can be beneficial if they are calm and postured in a healthy way.” Jane has maintained friendships with several of the individuals she sheltered with. She stated that they became close because of their shared experience.

Feelings of disconnect. Participants described myriad forms of detachment as a means for coping with adverse thoughts and feelings regarding the shooting and SIP experience. Most common was the need to disconnect from events, such as the shooting, in order to function as a service member. One participant noted that service members are encouraged to “hold everything in and move on.” Another participant reported being “desensitized to loss.” Bob noted his reaction when he first heard about the active shooter on base, “You get the fight, flight, or freeze. I don’t freeze, but I get into this weird numb.” Participants referenced disconnection during deployments as a common way to deal with “things that are just indescribable.” John discussed his own desensitization and compartmentalization.

> One of the things that surprised people in combat is…that I ‘went on’ in places where massacres had occurred, and things like that. I think those are really, really horrible things; dead children, people mutilating each other. It's just horrible…then, to my own surprise, because I'll cry at a good commercial, yet

> I'm wading through some of the worst evil on earth, and I'm not affected as much.

Internal and External Factors

A meaningful theme that emerged was the importance of individual and contextual factors that impacted participants' experience. Although the individual interview questions did not specifically inquire about these individual factors, participants highlighted how demographic factors, mental health services, the military culture, and external supports were critical.

Demographic factors. All participants highlighted demographic factors, including pre-military background, family status, military rank, and years in the military, as an important part of their experience. Jane noted a lack of support because she was single, "Those who had a family had a reason to go home. Apparently, I didn't." Kelly described the impact of her childhood environment:

> You also got to take into account, possibly, my background. I grew up in I would consider a nice enough neighborhood, but I grew up hearing gunshots. Here [at Fort Hood] I was, I wasn't even hearing any [gun shots]. To me it was like, 'Whatever,' these things don't affect me. That's what I was thinking.

Bob mentioned family:

> In Asia, I was exposed to lots of dead kids and it didn't bother me so much at the time for similar reasons. But then, when I became a father, I had intrusions of it later, like six years later. I suppose it's possible that if there's another shooting it may bother me more than I realize.

Mental health. All participants agreed that mental health support was a critical component of managing adverse emotional responses following the shooting, but only those who had previously accessed mental

health treatments felt it was an important coping resource. Three participants, previously diagnosed with PTSD, had accessed mental health support services. These participants had more awareness regarding the type of assistance they needed. All but one participant mentioned supportive services following the SIP order, including a "telepsychiatry" system deployed to facilitate access to mental health support services and an increase in family life counselors (counselors available to service members and their families) on base.

One participant explained how the shooting helped him feel "validated" for accessing mental health treatment because he initially felt shame. Mike explained mental health as a preventative strategy, emphasizing the significance of mental health assistance in helping him manage his own traumatic stress symptoms. He described his own homicidal ideations, prior to the shooting event, and his own counseling and supportive services.

> The shooting, when that happened, I was like this [being the shooter] could have been me if I hadn't gotten the help that I needed. This whole event, the active shooting, could have been me on the other side of it. It could be my family now being told I was the bad person that did all these things to all these families. Hurt and killed and ended lives. Things like that. I would say it really hit me home. It took me several days to feel like I'm glad I did what I did [seek counseling]. I'm glad the command was receptive, and said, 'You need treatment. Let's go and get you the help you need now'.

All participants mentioned stigma surrounding mental health in the military culture. Jane said, "Everyone will know [if you access mental health resources] and you won't get promoted." She admitted this mindset has deterred her from reaching out to behavioral health. While all participants said they felt supported after the shooting, only those who had prior experience with mental health support services felt unrestricted to access these services.

Military culture. Participants described the military in various ways but, collectively, descriptors focused on issues of compartmentalization and following command protocol. When asked about her experience following the SIP order, Kelly noted that in the days afterward:

> No one was crying. People talked about it as people would, but I didn't get any sense of acute fear or someone having to go to counseling behind it or anything like that. It was a topic of discussion for maybe 72 hours and then it was over. We're over it with the [2009 attempted shooter] thing, and then this one. Everybody's done and over it.

Others reported, “It [the aftermath of the shooting] was annoying for about two or three weeks; then, it was back to normal,” and “We got back to normal, as soon as possible, so it was almost as if it never happened.”

In terms of following protocol, Bob said, “Do what you are told, do not ask questions, there is a process for everything.” Mike stated, “We did exactly what we were trained to do.” Participants noted the importance of rank and the serious nature of insubordination, “Not only is there a protocol for most situations in the military, there is also a ‘superior’ person, a person who is above their rank. Individuals must obey their commander’s orders.”

Emotional support. All participants emphasized the need for emotional support systems. Participants highlighted the importance of being connected with family, friends, coworkers, and supervisors or higher ranking officers. They mentioned the support from supervisors or higher level leaders was especially significant, but highly individualized and challenging. The following excerpt describes the importance of emotional support within military ranks, but the organizational complexity involved:

> If the military could find a way to genuinely humanize its efforts in dealing with its members, and not purely from the basis of feeding the machine…If they could find a way to genuinely take care of them while getting the mission done, and that's difficult to do…No one's buying the kinder, gentler

army. It is a kinder, gentler army in the protocol that people have to do.

Discussion

The purpose of this study was to explore the experience of individuals mandated to SIP during the Fort Hood shooting. This study is relevant to counselors, disaster mental health professionals, and military personnel who support active shooter preparedness, response, and recovery efforts. Our investigation is unique, in that we explored active-duty service members who sheltered during an active shooter event. Given the role of service members' prior training and the military culture, it is not surprising that some of our findings contrast with the literature on SIP and active shooter events. Despite these differences, initial emotional responses of anxiety and frustration and the benefits of problem-focused coping, social supports, and group cohesion while sheltering are common to all individuals who SIP.

Uniformly, during the SIP order, participants described feelings of apprehension, uncertainty, anxiety, and concern for the safety and wellbeing of others. These findings support prior SIP research, which highlights anxiety and feelings of discomfort as common during SIP (Dailey, 2011; Halpern & Tramontin, 2007; Norris & Elrod, 2006). Mannan and Kilpatrick (2000) reference, at a minimum, individuals who experience SIP feel uncomfortable and most individuals experience indicators of distress, anxiety due to separation from loved ones, and frustrations regarding communications. Our findings also demonstrate that reliable communications and systematic protocols for information, especially during active shooter events, cannot be understated (Heath, Lee, & Lemon, 2019).

All participants emphasized that during SIP they focused on emergency protocols and their specific responsibilities, often influenced by rank: "We need to execute appropriately in regard to sheltering-in-place and what the command had established as the procedures." Wilson (2008) described the military as an institution of "collective coherence" (p.14). Although members of the military may differ in terms of characteristics,

personality, ethnicity, sex, and other aspects of individual identity, the expectation is that all service members follow specific norms or rules. Cole (2014) presented "visible and invisible" (p.497) aspects of military culture and discussed the importance of rank and order, compliance with supervisors, and a strong sense of rules and regulations. She emphasizes that service members value personal strength and emotional control. Putting others above oneself is the norm (Cole, 2014). This supports research on problem-focused coping, which has been associated to positive adaptation and post-traumatic growth (Linley & Joseph, 2004; Tuncay & Musabak, 2015). For these reasons, military personnel are likely more prepared to manage SIP.

Findings from this study highlight the impact of the military culture in how members react, cope, and manage stressors. Accounts from participants emphasized individual background, family support, military rank, and military experience. These findings support the literature on resilience within the military. Litz, Steenkamp, and Nash (2014) attributed high rates of resilience within the military to the self-selection and screening of service members, extensive training for high-threat experiences, and continuous operational debriefing. The authors identified family support as critical to promoting resilience but also highlight, as Bob did, that individuals have a threshold for traumatic exposure.

In alignment with military culture, participants were able to manage their emotions and "get by," indicating detachment as a means of coping. Service members often try to "tough out" (Vogt, 2011, p. 30) challenging emotions. The idea of detachment as a coping skill is interesting, as symptoms of detachment following a traumatic stressor have traditionally been associated with trauma- or anxiety-related disorders (Briere & Scott, 2014). While feelings of anxiety are not comparable to traumatic stress, history of traumatic exposure warrants consideration.

Recent research has identified detachment as prevalent in Veterans with combat trauma (Graham et al., 2016). However, it is important to note that participants in this study all indicated emotional detachment upon notification of SIP and the reported experience did not indicate markers of traumatic stress. Moreover, relevant to military culture, Shapiro (2010)

discusses adaptive dissociation as helpful to service members, and training on dissociation allows individuals to focus on their mission. Clinicians are advised to not regard this adaptive response as pathology.

Other coping factors include demographics, such as family status, childhood experience, positive mental health experiences, and access to emotional support systems. These findings align with research on coping following a disaster event, which document the benefits of receiving support from loved ones, accessing mental health support services, and the moderating influence of trauma exposure and resilience (Bonanno, Westphal, & Mancini, 2011; North, Smith, & Sptiznagel, 1997).

Unlike participants in this study who claimed that, within a few days, base operations were "back to normal," civilians impacted by active shooter events express a desire for normalcy after the tragic event. They also feel conflicted about wanting to forget the experience (Norris, 2007). This was not the case in this study and is likely due to the uniqueness of the military culture, which promotes adaptation, obedience, and dedicated focus to the mission of the entire unit (Hayden, 2014). Military culture also encourages individuals to continue routine operations following a negative event. Moreover, related to our discussion on detachment, minimalizing situations in an effort to cope with stressors or trauma is common (Westphal & Convoy, 2015).

Another factor identified in this study was that common membership in a social group, such as the military, was important. Unlike civilians who SIP, participants in this study have the common ground of being in the military. This shared experience increased connectedness, or the tendency to "bond" under stress, particularly among sheltering groups. This result supports research that found the significance of social support, especially in intense experiences, and cohesive experiences connect service members together (Greentree, 2013; Sayer et al., 2009). The importance of connectedness also supports Yalom's (1985) research which defines group cohesion as the tendency for group members to be drawn together. Yalom (1985) posits that groups with a greater sense of camaraderie highly value group members and are more likely to protect and support one another.

Findings from this study support research that group cohesion mitigates distress and supports coping during SIP. Dailey (2011) found high levels of social cohesion among sheltering groups may "serve as a protective element, mitigating poor functioning, and adverse group experiences" (p.184). Further, our results support the importance of group cohesion (Evans, 1986; Mudrack, 1989) and effective communication among group members (Lauring & Selmer, 2010; Mullen & Copper, 1995; Tziner & Chernyak-Hai, 2012).

Based on the results obtained from this study, there appears to be a connection between a member's mental health history and their experiences with accessing mental health resources. A person may be more likely to access mental health resources and/or encourage others to seek treatment if he/she had a positive experience. One participant reported feeling "validated" in terms of seeking and utilizing mental health resources because he could empathize with what the shooter was experiencing. This participant described positive experiences with the military mental health system and has since encouraged others to seek assistance as needed. Of those who had not previously accessed services, we believe the primary reason was stigma.

Research supports the idea that service members are less likely to seek mental health treatment because of the stigma associated with seeking treatment (Szpunar, 2013; Vogt, 2011). This includes being viewed by others as "weak" or unable to fulfill their duty (Gibbons, Migliore, Convoy, Greiner, & DeLeon, 2014; Greene-Shortridge, Britt, Castro, & Andrew, 2007). Christensen and Yaffe (2012) found, despite the significant need for mental health services, the negative stigma associated with mental health issues was the primary reason service members do not seek treatment. Similarly, Vogt (2011) reported public stigma as the main reason service members did not seek mental health care. Service Members fear exclusion from the military culture if they seek treatment (Greene-Shortridge et al., 2007). Service members may view themselves as responsible for their mental illness, which furthers the idea of stigma for needing treatment.

Numerous studies have identified that service members are more likely to access mental health resources if they receive encouragement from

others and if treatment would not adversely impact their position in the military (Quartana et al., 2014; Westphal & Convoy, 2015). Participants in this study universally agreed that the military can improve their support of service members, specifically concerning accessing and receiving mental health treatment. Although protocols exist for service members to receive psychological treatment, as noted in the availability of resources following the Fort Hood shooting and sequent SIP order, there are considerable barriers for them being able to access this assistance, including limited rights to confidentiality.

Finally, there appears to be a relationship between years in the military and participant's perspective on the military. Findings from this study suggest the longer an individual is in the military, the more positive feelings the individual had towards the military. Alternatively, individuals who have negative feelings towards the military may potentially leave the military sooner in comparison to the individuals above (Allen, 2017). A passage from John's interview supports this theory:

> I love it [the military]. I keep saying that they'll have to throw me out when it's not fun anymore…I don't want to be one of those guys who stays too long and then walks around grouchy all the time. Now I've actually committed to another five to six years. I'll have been in probably over 30 years by the time I leave now.

Implications for Counselors

Counselors working with service members who experience SIP should be educated on the military culture of the unique factors of service members who SIP (Hayden, 2014). While service members are encouraged to utilize adaptive detachment, as appropriate, counselors may need to ethically explore the impact of detachment on their social and emotional functioning within a culturally informed manner.

Based on the information obtained from this study, there should continue to be an emphasis on education and normalization of mental health services for all service members. Participants stated emotional support should be received not only from peers, family, and friends, but also from

supervisors and higher ranking individuals. Psychoeducation and training, such as Force Health Protection (Department of the Army, 2016), can facilitate a reduction of stigma around mental health symptoms and seeking support. Force Health Protection, which focuses on all aspects of physical and mental health, emphasizes that drills and trainings include information on emotional reactions and coping. Counselors are uniquely positioned to encourage high ranking officials to educate and encourage subordinates to access mental health resources.

Counselors can defuse stigma associated with seeking mental health support services by educating all service members about the benefits of counseling; increased education that mental health symptoms do not define an individual or adversely impact their identity within the "warrior ethos" of the military culture. Outside of individual counseling, group counseling and/or peer support groups may also be helpful in providing support and improve coping strategies. Finally, counselors are encouraged to assess service members' support systems and encourage individuals to access these supports on a consistent basis.

Findings from this study indicate that a positive group experience during SIP is helpful in coping and may serve to mitigate adverse effects. Therefore, leaders, counselors, educators, and disaster mental health professionals should encourage individuals to consider the benefits of sheltering groups and plan emergency response plans accordingly. In preparedness trainings, individuals can be informed about the potential benefits of working in a group, especially when trying to obtain information and problem solve. Not only will these activities facilitate stress management, but they also create a space for problem-focused coping.

All organizations should ensure communication strategies during a SIP event are consistent and timely. Public and private institutions should routinely assess or reevaluate their communication systems and regularly inform stakeholders about communication protocols. We cannot overemphasize the importance of timely and accurate communication.

Limitations and Future Directions

Findings from this study provide useful insight into the experience of individuals who SIP during an active shooter event, yet they are not without limitations. Results are limited to study participants and are unique to a military population. A 12-month interval between when the SIP event occurred (2014) and when participants were interviewed (2015) and may have altered their perspective. This time lapse could also have impacted recruitment, as many personnel had relocated or deployed. As active duty service members, participants were located in different time zones from the research team and frequently did not have accessible internet and/or phone services. Characteristic of phenomenological inquiry is the potential for response bias. Phone interviews may also have limited the type and amount of information participants were willing to disclose.

Another limitation may have been the subjective component of this qualitative study, and potential various interpretations or perspectives. Specifically, since IPA is the "analysis of someone else's experience rather than one's own" (Smith, 2011, p.10). To ensure validity and increase rigor, we adhered to methodological coherence, or ensuring congruence between the research question and the components of the method (Morse, Barrett, Mayan, Olson, & Spiers, 2002) as well as methodological consultation.

Problem-focused coping as a means to mitigate feelings of anxiety is not a new phenomenon. Future research should seek to understand the influence of problem-focused coping in individuals who SIP. Additional studies need to focus on personal growth outcomes in individuals who have sheltered during an active shooter event. Research on group cohesion within sheltering groups is warranted, specifically the relationship among group connectedness during SIP. The connection between the level of connectedness with others and ability to cope with active shooter events which warrant SIP should also be examined. The idea of detachment as a coping strategy also warrants further investigation.

Conclusion

The purpose of the study was to explore the personal and social experience of service members mandated to SIP during the Fort Hood shooting that occurred on April 2, 2014, in Fort Hood, Texas. Our findings supplement other research findings on SIP, which posit that people who shelter with others experience less distress, higher levels of resilience, and exhibit fewer traumatic stress symptoms as a result of being with others. Outcomes support the idea that individuals typically experience feelings of stress due to fear (American Red Cross, 2010; Dailey, 2011; Halpern & Tramontin, 2007; Norris & Elrod, 2006), but interpersonal reflection and growth is also common (Bonanno et al., 2011). This research also emphasizes the importance of emotional support and mental health resources following a sheltering event.

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Figure 1. Steps when utilizing an IPA research design (Smith et al., 2009)

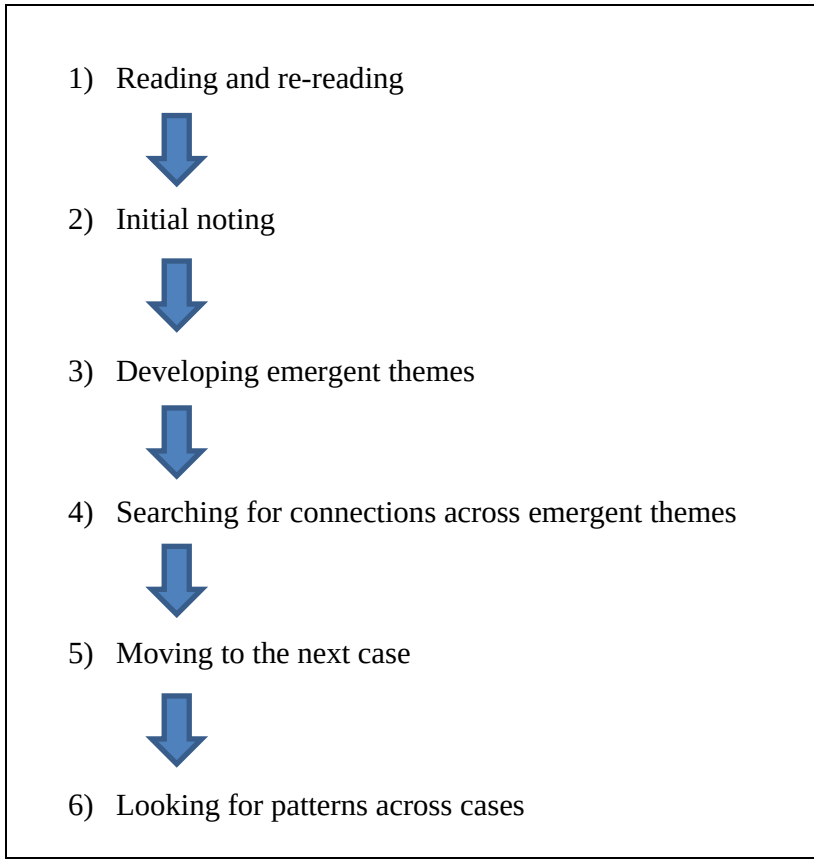
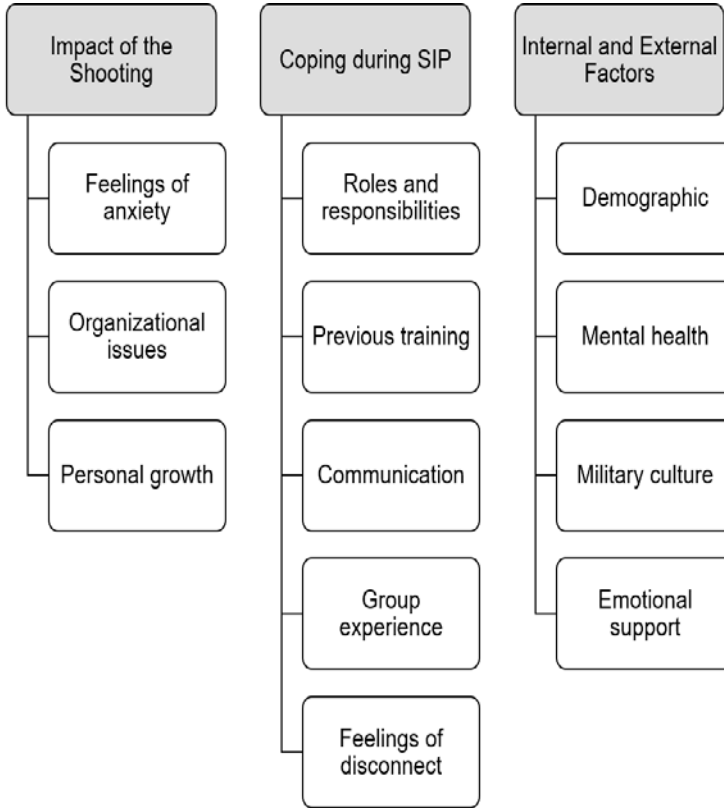


Table 1. Demographic Information.

Participant	PCL-M Criteria	Age	Ethnicity	Gender	Rank	Yrs. of Service	Number of Deployments	SIP Trainings
Bob	No	35-50	African American /Black	Male	Captain	16+ years	3-5	3+
Mike	No	35-50	Caucasian	Male	Major	11-15 years	3-5	3
Jane	No	35-50	African American /Black	Female	Major	16+ years	3-5	2
Kelly	Yes	35-50	African American /Black	Female	Unknown	16+ years	3-5	2
John	Yes	35-50	Caucasian	Male	Colonel	16+ years	3-5	6

Figure 2. Superordinate themes and subthemes.



Promoting Self-Regulation Skills for Individuals Working with Victims of Crisis Situations

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This article aims to provide suggestions and guidance specifically for promoting self-regulation practices for emotional responses in professionals working with victims of crisis. As a key executive function, self-regulation is a wide ranging metacognitive skill that can be improved with appropriate and consistent supports.

Keywords: Executive functions, crisis situations

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On a beautiful fall day at a small town elementary school in the Southeastern United States, it was early in the morning and students were being dropped off to enter the school. The drop off line was, as usual, quite long, as many parents, grandparents, uncles, aunts, sisters, and brothers were bringing these young children to the school. One such grandmother stepped out of her car to wish her grandchildren farewell, and was struck and killed by a passing motorist. For the next several days the school had extra counselors on hand to support any students, faculty, or family members who may have needed emotional support after this tragedy. The counselors all agreed the aftermath of the tragedy required them to be at their best professionally, but also that it was an emotionally exhaustive few days.

The above scenario is based on an actual event. Such tragedies do occur at schools from time to time, and the counselors who stepped up in that situation are representative of many professionals who deal with individuals affected by direct or indirect traumatic events. The question the

above event may further pose is, how do the counselors themselves cope with the emotional stress enacted by their role in the aftermath of the tragedy? Those who provide emotional support to victims of trauma are not immune to the potential emotional toll providing support may exact. And research does suggest that providing a high level of emotional support for a continuous amount of time may prove detrimental to those charged with giving care (Leiter & Harvie, 1996).

One possible negative result of being overburdened by providing emotional support is the development of burnout in professionals who provide support to victims of traumatic events. Burnout, a concept which will be discussed later in this article, does not simply spring forth in these professionals; it is often preceded by compassion fatigue (Figley, 1995a) (akin to the "emotionally exhaustive" state from the preceding school tragedy scenario) and vicarious traumatization (McCann & Pearlman, 1990). Compassion fatigue and vicarious traumatization are often used interchangeably, and have multiple similarities in regards to characteristics (Bride, Radey, & Figley, 2007). Any of these—compassion fatigue, vicarious traumatization, or burnout—may cause crises for the professional caregivers themselves, and these professionals need methods and strategies for coping with the emotional strain their jobs may instill.

The variance in how this emotional strain may register is great, and there are numerous methodologies available for helping crisis responders deal with various debilitating issues associated with the strain (Freudenberger, 1981, Pines & Aronson, 1988). This article will focus specifically on strategies to support self-regulation of emotional response in those who support individuals recovering from crises, as the executive function of self-regulation is one of the most important metacognitive skills at play when dealing with situations that cause distress. Before covering these strategies, a very brief review of compassion fatigue, vicarious traumatization, and burnout is appropriate, as these concepts overlap and impact overall counselor performance. This is followed by a brief explanation of the metacognitive skill of self-regulation.

Compassion Fatigue, Vicarious Traumatization, and Burnout

Compassion Fatigue

The concept of compassion fatigue relates to a caregiver's reduced willingness to provide empathy to a crisis victim (Adams, Boscarino, & Figley, 2006), and is primarily the result of a caregiver having to deal regularly with a large number of crisis victims (Figley, 1995b). The continued stresses of having to provide emotional support to victims of crisis requires great expenditures of empathy, even if a practitioner or responder attempts to maintain a clinical approach to this care. Over time the level of compassion these professionals provide may begin to lag, and compassion fatigue may develop, which in turn may set the stage for an individual to begin feeling vicarious traumatization (Jenkins & Baird, 2002).

Vicarious Traumatization

The concept of vicarious traumatization refers to the negative views of themselves and others that may develop in professionals after repeated exposure to the graphic traumatic events of their clients (Baird & Kracen, 2006). Literature has been consistent in describing the symptoms of vicarious traumatization as quite similar to those of post-traumatic stress disorder (PTSD), as defined by the *Diagnostic and Statistical Manual of Mental Disorders* (5th Edition; American Psychiatric Association, 2013). These symptoms, from the DSM-5 (APA, 2013), include:

1) Recurrent intrusive distressing memories of a traumatic event
2) Recurrent distressing dreams related to a traumatic event
3) Dissociative reactions in which a person feels the traumatic events are recurring
4) Intense psychological distress at exposure to internal or external cues associated with the traumatic event, and marked physiological reactions to those same internal or external cues

The DSM-5 (APA, 2013) further elaborates how PTSD can lead to persistent avoidance of antecedents associated with the traumatic event, and negative alterations in thinking and dispositions associated with the traumatic event. Based on this symptom profile, it is clear that anyone displaying signs of vicarious traumatization may find their professional performance negatively impacted, especially in regards to individuals charged with providing care and support to the direct victims of trauma. Still, it should be noted that the degree of impairment for those experiencing vicarious traumatization was not, in general, as great as the impairment experienced by persons experiencing PTSD (Brady, Guy, Poelstra, & Brokaw, 1999; Lugris, 2000).

Burnout

> Maslach (2003) wrote the following to describe burnout: Burnout is a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who do "people work" of some kind. It is a response to the chronic emotional strain of dealing extensively with other human beings, particularly when they are troubled or having problems (pg. 2).

As detailed by Maslach above, the concept of burnout can have serious consequences for any professional whose primary role is supporting an individual or group experiencing some type of problem. Burnout can compromise job performance, or make a person feel as if they have no personal stake in an outcome, or that they are accomplishing nothing by their efforts. Burnout has been more fully described as a prolonged response to continuous stressors on the job that lead to exhaustion, cynicism, and inefficacy (Maslach, Schaufeli, & Leiter, 2001). Any of those last three descriptors can be viewed as an impairing condition when it comes to providing care and support.

Burnout and job stress are not synonymous. However, burnout is "a psychological syndrome in response to chronic interpersonal stressors on the job" (Maslach, Schaufeli, & Leiter, 2001, p. 399). Certainly job stress is

a predisposing factor for burnout to develop. Work stress can occur in any work environment. However, the interplay between counselor and client can take job stress to the level of job burnout (Maslach, 1982).

Counselors, by definition, work with individuals who are experiencing trauma or extreme stress of some type. Those tasked with being a source of comfort, guidance, and relief for victims of traumatic events, by necessity, must develop coping skills to avoid falling victim to compassion fatigue at best and, at worst, burnout or vicarious traumatization.

Teaching Self-Regulation as Prevention

The effects of vicarious traumatization and burnout impact the counselor's ability to provide ethical, beneficial services to clients as well as having detrimental personal implications for the counselor both mentally and physically (Thompson, Amatea, & Thompson, 2014). For this reason, it is vital that counselors have ways to combat the stresses that can lead to more substantial personal and professional effects. Strengthening the executive function of self-regulation of affect is one potential path caregivers may follow, as having better metacognitive sense about one's thinking is a positive step in handling distressing situations.

Self-Regulation of Affect (Emotion)

Executive function is a concept involving cognitive processes required to direct activities, and includes task initiation, working memory, sustained attention, performance monitoring, and behavioral inhibition processes (Dawson & Guare, 2018). Cognitive scientists have been studying executive functions for many years, and have identified multiple subtasks associated with the overarching concept of executive function. One of these subtasks includes self-regulation of affect/motivation/arousal (Barkley, 1997); in other words, the ability to self-regulate one's emotional state. Individuals experiencing difficulties with self-regulation often have issues with controlling emotions, taking proper social perspectives, and controlling motivation (Barkley, 1997). Deficits in these areas can lead to

significant impairments in many life activities, and may be particularly deleterious to individuals tasked with supporting victims of traumatic events.

An important concept closely associated with self-regulation is self-awareness. Self-awareness was first described as a theoretical concept by Duval and Wicklund in 1972, who focused on what came to be known as Objective Self-awareness (OSA). Duval and Wicklund described the core of their theory when they described self-awareness as "When attention is directed inward and the individual's consciousness is focused on himself, he is the object of his own consciousness—hence 'objective' self-awareness" (Duval & Wicklund, 1972, p. 2). The OSA theory served as a springboard into numerous psychological research activities over the past four decades, including research into the idea of self-focused attention (Pryor, Gibbons, Wicklund, Fazio, & Hood, 1977). Both OSA and self-focused attention pertain to the concept of self-regulation because each requires an acknowledgement of the processes involved in being aware of higher order thinking processes in the moment. Therefore, when talking about self-regulation, talking about self-awareness is a natural progression.

Having strategies at hand to deal with the various subcomponents of self-regulation of motivation/affect/arousal can be of great value in helping individuals avoid negative stress and emotions. Any such strategies will require the practice of self-awareness, which, as previously mentioned, does associate naturally with self-regulation. Fortunately, there are such strategies available to practice and enhance the various subcomponents associated with self-regulation. Below we will address ideas for how to better control emotions, take proper perspectives, and controlling motivations. Additionally, following each description we will provide a brief application vignette from the perspective of the practitioner who may seek to utilize these strategies.

Controlling emotions. The concept of emotional regulation has been further described as, "the ability to inhibit, subdue, minimize, maintain, accentuate, or prolong a particular emotional state'' (Multi-Health Systems, 2003, p. 1). Noting that inhibiting an emotional state is part of the

process of managing emotions, one of the first steps in helping to better control one's emotions involves improving the ability to inhibit responses to certain stimuli. Response inhibition is one of the most important aspects of self-regulation of affect (Barkley, 1997), and is the ability to think before you act. Furthermore, it is the ability to evaluate multiple factors that may be influencing a situation (Dawson & Guare, 2018). Response inhibition in turn can support the ability to manage emotions, especially any emotions that come into play that affect achieving goals, completing tasks, and, perhaps most importantly, directing behaviors.

The following are strategies that can be applied to help improve self-regulation of emotions, paraphrased from Barkley (1997), and Dawson and Guare (2018):

1) Identify triggers/antecedents to specific negative emotions. This process requires a self-analysis of the specific environmental stimuli that cause a negative emotional state. It is important to note that the causes for these triggering events may occur in different settings, so it is necessary to take a holistic view when identifying these triggers.
2) Determine whether or not the identified triggers may be removed or avoided. Not all antecedents can be avoided, nor can all triggers be removed. This step in better controlling emotions will require an acknowledgment of how much control one may exert over his or her environments. The key factor is determining what triggers can be removed or avoided, and then taking the necessary steps to actually avoid them.
3) If a trigger cannot be avoided or removed, identify a specific replacement emotion to initiate in the presence of that trigger. This step requires a strong level of self-regulation and a commitment to practice the replacement emotion. The suggestion is not to replace anger or sadness in situations that truly justify those emotions; rather, the idea is to engage in an emotion in those situations that is less damaging and less likely to heighten the stress and anxiety the situation may produce. It is not practical to laugh in the face of tragedy, but when certain stimuli provoke the memory of a tragedy,

and those stimuli cannot be removed, one must find better emotional responses in order to better respond emotionally to those stimuli.

4) When successfully applying the first three steps, identify a "reward" for that success. The concept of self-reinforcement comes into play with this last step. Acknowledging the success of a strategy and rewarding that success can help continue the implementation of that strategy. This practice is closely tied to the ideas of behavioral theory promoted by B. F. Skinner (Zimmerman, 2013), and notes that one cannot always depend on others to reinforce or reward particular behaviors.

The preceding steps are one approach to controlling emotions, and are clearly tied to self-awareness. They cannot be successfully applied unless an individual takes the time to complete the first step (identifying triggers) because the remaining steps all follow from that initial foundational step. Replacing negative emotions is not an easy process and will require commitment and practice. If the appropriate effort is given, positive outcomes should occur.

Application Scenario: Diana is a counselor. She has been working in the field for just short of a decade, and lately has noticed her anger flaring up at home. This is unusual for her, and her husband and two daughters have started to notice her outbursts. Diana begins to wonder if her anger is being influenced, subconsciously, by her work. She has been working with several survivors of domestic abuse for the past few months and has been helping them identify specific triggers that lead these patients to feel depressed or angry. Diana decides to apply a four-step process to help her better manage her own emotions.

First, Diana takes stock of her environments to see if there are particular antecedents to her outbursts. Since most of her anger has been expressed at home, she spends the most time examining routines at her house and her interactions with her family. But she also looks at her other environments, including her workplace, her church, her parents' home, and her in-laws' home, as she wants a full accounting of what might be causing

her anger to show. She begins to conclude that her outbursts often follow her being interrupted or cut-off during a conversation.

Realizing she cannot remove conversation from her environments (the second step of her process), Diana decides to identify and implement a replacement emotion (the third step) for her anger if she is interrupted while speaking. She realizes happiness is not logical, and neither is sadness, or surprise, or frustration. She chooses to focus on trying to replace anger as an emotion with the emotion of being grateful. That is, she chooses to try and think thoughts of gratitude about the person who did the interrupting, which she expects will cut off her anger. She sets a goal for this particular emotion replacement strategy for one week, and if she finds that her anger does seem more under control, she will reward herself (the fourth step of the process) and her family by baking everyone's favorite dessert, a butternut cake.

Taking proper perspectives. Being able to "maintain a proper perspective" is a phrase often heard when dealing with troubling situations. The concept of perspective has no absolute definition in the literature, but is often referred to as the "point of view" one takes when regarding a situation, or the thoughts and feelings one has when considering an event or other people. Perspective is therefore a very personal concept, and often egocentric in the sense that our perspectives are usually unique unto ourselves, based on our own life experiences (Epley, Keysar, Van Boven, & Gilovich, 2004). For those tasked with helping individuals recovering from traumatic events, the ability to take proper perspectives and maintain them is very important when trying to avoid negative emotions the wrong perspective may generate. A few themes in perspective taking have been noted (Gerace, Day, Casey, & Mohr, 2013), and three of those will guide the strategies proposed for maintaining proper perspectives.

1) Use of Self-Information:
   The process of applying self-information to the perspective-taking process involves acknowledging past experiences that pertain to current situations. Using this information can make it possible to switch places with another, figuratively speaking, allowing an

individual to take a different point of view of particular circumstances. The strategy to deploy when using self-information is to be mindful, at an executive function level, of the information at play when viewing events and circumstances. This heightened level of self-awareness of one's perspective can help mitigate the negative emotions that may arise when troubling situations occur.

2) Use of Other-Information:
Use of other-information in perspective taking consists of knowing about another person's traits and predominant behaviors in specific situations, and also awareness of the contextual information regarding another's situation. As with using self-information, the strategy to deploy is again mindfulness at an executive function level of how using other-information is influencing perspective. A caution in use of other-information is to avoid assumptions or prejudices; either of these can be faulty and cause poor or ineffective decisions. The key to keeping proper perspective when using other-information is to be self-aware of how that specific information is influencing perspective and attempting to let that information properly inform one's response to a situation.
3) Use of General Information:
This third theme in perspective taking has been noted as having the least effect on one's perspective (Gerace et al., 2013), and involves the application of one's general knowledge about a situation to the perspective one takes on that situation. Individuals are much more inclined to consider self-information or other-information when perspective taking, but in situations where little of those two sources of information is available, the general knowledge base comes into play. Again, it is necessary from an executive function viewpoint to be mindful when such information is influencing the perspective being taken. When individuals have to rely on other sources of information, rather than personal experience or what is known about another person, then they must be careful that the information they utilize is indeed pertinent to the situation. Everyone will encounter novel situations where general information

will heavily influence a perspective; acknowledging that occurrence in a metacognitive fashion is important.

To summarize, the strategy suggested for taking and keeping a proper perspective is to practice self-awareness of those factors influencing the perspective. Those factors can be either internal, with the use of self-information or other-information, or external when general information is required. Regardless of the type of information used to take a perspective, it is critical that self-awareness of perspective be kept in mind.

Application Scenario: Miguel is a high school math teacher. He works at an urban school with a diverse student population and a large percentage of students who qualify for free and reduced lunch (an indicator of poverty when considering student demographics). Miguel has been teaching for four years and is growing increasingly frustrated with his students' apathy and misbehaviors. He has found himself yelling at his classes when the noise level gets high or too many students are off task. He wonders how he can better control his negative feelings about his students and stop those feelings from impacting his work.

During a conversation with one of his school's guidance counselors, Miguel mentions his recent feelings of frustration. The guidance counselor responds, "Always keep in mind your perspective when working with our students." Miguel ponders this bit of advice and evaluates the perspective that he takes when dealing with his students. He does some research and finds that perspective taking can involve using information from his own experience, or using information he knows about others, or using more general information if either his experience or his knowledge of someone else's experience does not apply to a situation. He realizes he has never consciously separated this three different types of information involved in taking a perspective.

As his semester continues, Miguel begins to make a conscious effort to maintain a proper perspective in dealing with his students' behaviors. He realizes that in the past he almost always looked at how his students were acting based on his own experience and expectations, and therefore was applying only information about himself to his perspective.

He began to try and look at things more from his students' perspective based on what he knew about their home lives and personal experiences. Very quickly he began to notice that his negative feelings about his students' actions and attitudes began to lessen.

Controlling motivations. Motivation involves the idea that someone is moved to do something, to take action. Individuals often have to ask themselves how much motivation he or she may have to accomplish a particular task, and certain tasks even involve motivating others (Ryan & Deci, 2000). Motives are as varying as perspectives in that they, too, are very uniquely personal. The notions of intrinsic and extrinsic motivation have been thoroughly discussed for many years, and both types come into play for those working with those impacted by crisis events. Noting that executive functions play a significant role in managing motivations, the implementation of appropriate self-talk is a strategy that can improve and maintain motivation.

Self-talk is more closely tied to the internalization of speech portion of Barkley's model of behavioral inhibition (Barkley, 1997), and is closely tied to the concept of self-management. Individuals should apply specific scripts to their self-talk when dealing with motivation, and the following is a common sample script of questions one may pose, either internally or with a "think aloud" approach (Ness & Kenny, 2016):

1) "What is my task, specifically?"
2) "Do I have a plan for accomplishing this task?"
3) "Am I implementing the steps of my plan appropriately?"
4) "Did my plan achieve my task?"

There are variations of the above script, including one proposed by Ylvisaker and Feeney (2010) meant to assist adolescents displaying executive skills deficits. Their model is labeled Goal-Obstacle-Plan-Do-Review, and the core content of their questions applies to anyone trying to maintain motivation to complete a task:

1) "What do you want to accomplish, and what will it look like when you're done?"
2) "This might be hard because…."

3) "We need a plan. First we'll do this, then this, and so on."
4) "Do it."
5) "Review it. How did it work out? How could we make it better?"

There are multiple variations of the above script, but the goal remains the same, helping individuals accomplish tasks. Both of the above scripts, if applied consistently, inherently involve a self-assessment of motivation levels (Question 3 in the first set and Statement 5 in the second, specifically). For individuals working with those negatively affected by a crisis situation, maintaining motivation is of great significance. And using self-talk is a very viable option to self-assess that motivation remains at a level necessary to do the job well.

Application Scenario: Toni is a paramedic who works the night shift for her local Rescue Squad. She has been on the job for not quite three years, and over the past two months has been involved in responding to twice the average number of fatal accidents. In many of these events, she has been the one tasked with talking to car crash survivors, or speaking to family members of the victims of fatalities. She is particularly troubled by two drownings, and the tremendous grief she witnessed by the family and friends of the two victims in those incidents. She is beginning to feel a lack of motivation, as she is no longer confident she can help others to the degree she wants while doing her job.

Toni speaks to her supervisor about her growing lack of motivation, and her supervisor recommends she speak to a counselor available to the Rescue Squad staff. The counselor tells Toni her feelings are very common. The counselor also suggests Toni consider using self-talk strategies before and during shift, and emphasizes the need for Toni to be self-aware that she is using the strategy. Toni is unfamiliar with this practice but agrees to give it a try. She takes a short list of questions to ask herself before her next shift. Though she has the script at hand she is not called to the scene of any fatal accidents over her next two shifts. On the third shift after her meeting with the counselor, she has the chance to apply the strategy.

When she arrives for work that night, Toni asks herself to define her tasks for the evening, acknowledging those tasks are variable based on the

calls her squad may receive. She, furthermore, asks herself if she has a plan for dealing with her tasks. She believes that she does, and when her squad responds to yet another car accident she is very conscious of how she does her job. She even finds herself thinking, "Am I doing everything I'm supposed to do the right way?" After her shift, she thinks back to how she did her job and evaluates her own performance. She continues this practice for the next several weeks and begins to find that her motivation for her job is gradually improving.

Conclusion

Many types of jobs create stress, and this is especially true for those who provide care and counseling to individuals affected by traumatic situations. Compassion fatigue, vicarious traumatization, and burnout are possible effects of long-term exposure to, and attempts to support, those impacted by crises. For professionals trying to help those negatively affected by trauma, having strategies available to manage the job stress is of great significance. Self-regulation strategies that incorporate a degree of self-awareness offer a viable avenue to help these professionals mitigate the negative emotions their jobs may create. Considering the executive function of self-regulation of affect/motivation/arousal, applying a few strategies to help support self-regulation of emotion can be of great benefit to anyone supporting individuals who have experienced traumatic events. Being mindful, or practicing self-awareness of the thoughts and feelings that are present in particular situations that induce stress, is the first step towards applying strategies to better handle that stress.

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"The Butler of Healthcare": Exploring Trauma Narratives of Emergency Medical Services Personnel

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Emergency medical services personnel respond to community medical crises. Exposure to trauma, risk of harm, and a demanding work environment create higher likelihood of burnout, compassion fatigue, and posttraumatic stress disorder. Personnel often struggle to cope with work stressors and trauma, but are unlikely to seek counseling supports due to stigma. In order to explore the career experiences of emergency medical services personnel, the current study used narrative qualitative research through semi-structured interviews with 11 individuals to learn about stories from field experiences and perceptions of supports in the community. Themes discovered included the culture of EMS, exposure to trauma, and lack of appreciation. Discussion of findings provides implications for mental health professionals and future research.

Keywords: Emergency medical services, paramedic, emergency medical technician, trauma, public health

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Exposure to trauma and potentially hazardous working conditions represent typical work experiences for Emergency Medical Services (EMS) personnel (Molnar et al., 2017). Camaraderie among EMS personnel becomes a natural place for support and coping as individuals often spend 12 to 24 hours with co-workers during each shift (Shakespeare-Finch & Daley, 2017). Exposure to trauma represents a risk for compassion fatigue, burnout, and posttraumatic stress disorder (PTSD) (Pirrallo, Levine, & Dickison, 2005). Concern for perceived weakness in seeking mental health supports and peer pressure to not discuss work-related stress and trauma leave EMS with few avenues for coping (Rusch, Angermeyer, & Corrigan, 2005). This increased risk for mental health issues for EMS providers represents a need for professional counselors to seek avenues to address mental health stigma and provide increased supports for workers in this career field. To increase awareness of trauma exposure and the need for mental health supports within the EMS career field, the current study sought to explore EMS narratives about experiences in the field.

Emergency Medical Services

EMS personnel receive training and certification to perform life-saving medical procedures in the field, often working with other community services providers such as firefighters and law enforcement officers to support community crises (USDOT, 2007). The National Highway Traffic Safety Administration (NHTSA; 2011) reports 40% of EMS personnel are based in fire departments, and one third of states in the US use volunteer EMS personnel. Overall, EMS licensing follows a tiered system including Emergency Medical Technicians (EMT) and Paramedics with a scope of practice designated by the NHTSA (USDOT, 2007). EMTs receive training in basic life-saving (BLS) procedures focusing on comfort and safety for non-life threatening medical issues during patient transport. Paramedics receive further training for invasive medical procedures in advanced life-saving (ALS) situations in the community, for example serious physical trauma, heart attack, or stroke. The Paramedic serves as medical control on a scene to direct patient care and safety (Bigham, Kennedy, Drennan, & Morrison, 2013). Some states offer additional

training for a critical care designation for Paramedics to support high-need patients, for example transporting those in intensive care units (USDOT, 2007). All EMS personnel work primarily in the community to provide medical interventions when called for help by patients or their families.

Impact of Career on Wellness

A career in EMS includes some of the highest rates of work-related stress of any profession (Johnson et al., 2005). EMS personnel commonly describe their typical day at work as the "worst day of their patient's life" (Jahnke, 2018). EMS personnel must make critical life and death decisions on scene to diagnose, treat, and support a patient during transport to the hospital (Palm, Polusny, & Follette, 2004). Especially for EMS working in rural communities, these transport times to the hospital can be long with more opportunity for additional health emergencies to occur in route (Young et al., 2003). Typically, EMS personnel work over 50 hours per week in high-stress environments (Collopy, Kivlehan, & Snyder, 2012). Long shifts, poor self-care habits including sacrifice of sleep, food, and other basic needs on shift, physically intensive work, and risk of personal safety represent challenges for EMS personnel (Patterson et al., 2012).

Over a career, EMS personnel experience exposure to infectious diseases, back injuries from years of lifting patients, irregular sleeping and eating schedules, and environmental hazards such as car accidents and fires (Donnelly & Siebert, 2009). Additionally, to perform their job duties EMS personnel routinely perform life-saving medical procedures in ambulances moving at a high rate of speed without wearing a seatbelt (Blau, Eggerichs-Purcell, & Bentley, 2012; Weaver et al., 2015). These hazards are largely unrecognized or realized by the general public (NHTSA, n.d), partially due to a strong camaraderie including pressure to minimize the emotional impact of occupational hazards (Rusch et al., 2005). Sustained high-stress environment with frequent exposure to trauma over a career leads to frequent instances of unhealthy coping such as substance use or emotional detachment.

EMS personnel routinely experience both direct trauma, in threats of physical safety and emotionally taxing experiences, and exposure to the

trauma of patients and their loved ones throughout a career (Johnson et al., 2005; Trippany, Kress, & Wilcoxon, 2004). Exposure to trauma through others' experiences over a career, known as vicarious trauma, can have long-term negative impacts on health care providers after their interaction with the patient (McCann & Pearlman, 1990). EMS training includes pressure, and often hazing from experienced team members, for personnel to minimize their own emotional reactions on scene in the interest of attending to patients and their loved ones in crisis (Palm et al., 2004). In practice, EMS personnel experience the juxtaposition of minimizing their own emotional reactions, while still needing to express empathy for patients on scene (Boyle & Healy, 2003). As such, trauma experiences impact the lives of EMS personnel resulting in high rates of substance use, divorce, and PTSD (NEMSMA, 2016).

Mental Health Stigma

A career in EMS represents a risk-factor for mental health issues including anxiety, sleep disorders, addiction, and suicidal ideation (Jones, Nagel, McSweeney, & Curran, 2018). Despite the increased risk, EMS personnel worry about the perception of peers and supervisors in seeking help for such mental health issues (Rutkow, Gable, & Links, 2011). Especially for women, pressure to demonstrate strength and resilience after critical incidents is immense (Russ-Eft, Dickison, & Levine, 2008). Access to care can also be limited, as workers' compensation programs may not always cover mental-health related treatment, and volunteer EMS personnel do not often have access to benefits (Rutkow et al., 2011). Integration of peer supports and access to professional counseling resources, like Employee Assistant Programs (EAPs), represent best practices in supporting the ongoing trauma exposure of EMS personnel (Scully, 2011). However, EMS personnel often avoid use of mental health supports, especially EAPs, for fear of ridicule from co-workers or consequences from employers, for example, concern for being labeled as sick or weak or being removed from service for a period of time or fired (Rusch et al., 2005).

In order for mental health professionals to provide adequate support measures for EMS workers, researchers and counselors need to better

understand the perspective and experiences of first responders in the field. Mental health professionals must also understand and employ trauma-responsive approaches to counseling when working with populations exposed to frequent trauma (Webber, Kitzinger, Runte, Smith, & Mascari, 2017). This knowledge will provide valuable insight as to the EMS experience, informing future development of emotional support mechanisms and creating connections to help address the stigma of seeking mental health support. Further, exposure to professional counselors may help dispel myths or unfounded concerns about seeking mental health supports, and may help EMS personnel see professional counselors as invested in supporting EMS.

Method

The purpose of this study was to explore the experiences of EMS professionals to understand more about supports needed for this group of individuals dedicated to community service. Hoping to connect with the natural storytelling aspect of EMS culture, the current study used narrative (Clandinin & Connelly, 2000) qualitative interviews to address the following research question: What are the experiences of EMS professionals in the field? Researchers conducted semi-structured interviews (Squire, 2013) lasting, on average, one to two hours with questions inviting EMS personnel to tell stories from their field experiences across their career.

Participants

Participants were all employees of one county EMS service in the southeastern United States. Thirteen individuals expressed interest in participating in the study; however, two respondents were unable to schedule interviews due to time conflicts with work shifts. Three participants identified as female and eight identified as male. All participants identified as Caucasian. Participant age ranged from 22 to 42 with an average age of 31. Participants reported years of experience in EMS, with a range of two to 23 years. Participants had an average of 8.86

years of experience. Regarding licensing, four participants held an EMT license, six held a Paramedic license, and one participant was a Paramedic with advanced certification in critical care. Participants also reported current relationship status. Two were divorced, seven were married, and two were single at the time of the interview.

Data Collection

After obtaining IRB approval from the local university, researchers approached the director of services for a nearby county for permission to invite county employees to participate in the study. The director was very supportive of the research study, and thus shared with employees an email invitation to participate. Interviews occurred on the university campus to protect the confidentiality of those who agreed to interviews. Further, participants interacted directly with researchers to coordinate interviews so the director would not know who chose to participate. As the university held a prestigious status in the local community, participants had a brief tour of campus and a free campus parking pass on the day of the interview. To further protect confidentiality, researchers scheduled interviews so participants would not overlap with others who were coming to campus as participants. Interview questions centered on inviting participants to share stories from their career in EMS. Interviews were audio taped and transcribed verbatim. After transcription of all interviews, researchers scrubbed identifying information including names and locations from transcripts before analysis.

Data Analysis

The current study used thematic analysis (Riessman, 2008) in multiple rounds of Narrative Coding (Cortazzi, 1993). The first round of coding provided insight as to participant experiences, with focus on story and narrative for each participant separately. Coders included one doctoral student in Counselor Education and two Counselor Educators. Only one of the coders had actually conducted the interviews. All coders first coded interviews separately, and then met together to reach consensus on

emerging themes for each participant. Then, the coders compared dominant codes across participants to derive overall themes from the transcripts.

Trustworthiness. Narrative qualitative research includes the co-creation of a narrative with the voices of the participant and researcher (Clandinin & Connelly, 2000). In qualitative research, reflexivity is critical to provide trustworthiness to findings (Morrow, 2005). Reflexivity allows researchers to understand their own lens and practice awareness of this lens in qualitative analysis to preserve the participant voice and perspective in findings. The researchers held ongoing dialogue to explore their own experiences and perceptions of EMS to gain awareness of potential biases (Tracy, 2010). Further, coding procedure gleaned trustworthiness and reflexivity by including coders who had not conducted participant interviews to provide an outside perspective. While only one coder had conducted the interviews, the two other coders did not interact with the participants and thus were not part of co-creating the narratives represented in the transcripts. During the coding process, co-coders considered both the researcher and participant dialogues to consider how the researcher might have influenced the narrative. In coding separately, and then comparing themes for each participant and then across participants, researchers were able to practice reflexivity and provide strength for findings. Finally, participant quotes provide focus on participant voice, and thus became an important part of deriving and presenting themes.

Researcher stance. The primary researcher actively engages with the EMS community through her professional research, but also through her spouse who is a paramedic. Her research interest began in witnessing her spouse and colleagues struggle with trauma exposure over a career. The second author currently identifies as a Counselor Educator, but was an EMT in a previous career. This experience led to his desire to become involved with the research into and insight about EMT experiences. Two other researchers interacted as doctoral students with the current research, having no interactions with participants and lending outside perspective. The last researcher is an instructor of qualitative research, who first fostered

a passion for EMS research through her narrative inquiry course and offered support and mentorship throughout the research process.

Findings

Findings, told using participant narratives, provide a unique look into the career experiences of EMS first responders. The stories of the career experiences of EMS professionals revealed a conflict between the need for mental health services and the need for protection of professional reputation. The opportunity that arose when the professionals had space to tell their stories provided insight in to the career of EMS and possible ways of reducing the stigma surrounding mental health services. Following the analysis process, the themes that emerged across participants from the data were: culture of EMS (Our Culture of EMS), exposure to trauma (Dead Babies), and lack of appreciation (Ambulance Driver). Researchers further named these themes using participant quotes representing the common experiences of stories shared.

"Our Culture" of EMS

The first theme in the collective stories focused on the norms of the profession. All of the participants talked about a sense of camaraderie in many ways. Participants described unspoken rules and about keeping experiences within the EMS profession. They discussed how often co-workers became supports in the field, as co-workers understood the experiences of professionals in EMS when outsiders cannot. They also discussed spoken and unspoken expectations to maintain the reputation of the profession in the community. Participants mentioned frequently how the profession encourages you to "toughen up," embrace a "hero mentality," and to remain silent about your emotional reactions, keeping experiences and feelings private. One participant articulated:

> You can talk to your partner in the truck about some stuff but you don't want to be seen as weak and so you kind of compartmentalize and you see all kinds of horrible shit but you can't talk about it to anybody. And you, you can start to

> see how that surrounds them with like, they put up emotional armor.

Participants described how becoming acclimated to the EMS culture is to develop an "armor," showing one is capable of supporting the community in the face of any disaster, then washing their hands and being immediately ready for the next crisis. Experienced EMS personnel quickly test new EMTs and Paramedics to learn if they can develop this armor through "hazing."

> They have this attitude of you kind of harass the newbie and make them tougher so they can handle the amount of stress and nasty things that we have to see, so it's like toughen them up, if they're not tough enough they'll leave because they hate the harassing treatment that we would treat them with.

One EMT stated, "Our culture doesn't want to talk to anyone about anything, that is, you know you just keep it to yourself, you're a wuss if you talk about it." Especially female participants described feeling extreme pressure to minimize emotion and acclimate to the culture, calling this "[being] one of the guys."

Often the culture of the EMS profession discourages talking about and expressing emotions. Participants identified acceptable forms of coping, including: emotional avoidance, dark humor, tobacco and alcohol use. A participant described this as "disconnect." "I always try to maintain a level of… disconnect is the best way to put it, you know I don't, I don't try to get too close to patients." When lacking connection with patients and potentially family, EMS personnel might seek connection within their profession, for example through physical intimacy. One participant talked about how sexual intimacy sometimes becomes a coping mechanism:

> … you're in a very stressful situation and you have that one person that you rely on all the time, and… they're with somebody of the opposite sex who they rely on to save their lives who they depend on to help save other people's lives and they go home and their husband or their wife doesn't

> understand, so they end up like cheating or being in, and you know having infidelity with that one person [at work].

Within this culture is a fierce sense of loyalty and purpose, a unique career identity apart from other first responders (e.g. firefighters, law enforcement). Within this purpose are the skills and capability to support community members in life-threatening emergencies. This comes out in the narratives often as a "hero mentality." Many of the participants talked about seeking adrenaline; wanting the intense calls as they can shift their mindset from calm to chaos quickly. Participants enthusiastically shared stories of pulling victims from burning cars, delivering babies in a moving vehicle, and performing invasive medical procedures to save a patient's life. Several participants lay down on the floor or rearranged furniture in the interview room to act out and illustrate how they maneuvered to attend to the patient in crisis. Participants expressed a sense of purpose in the ability to save another human being, and feeling like the only person in the scenario who was capable of doing so.

Participants described a unique culture of EMS which provided supports and also pressure to adhere to cultural values of strength and resilience. EMS personnel take great pride in their skills and the service they are able to provide the community. Yet providing this service comes with exposure to trauma through emergencies and crises to which they respond.

"Dead Babies"

A career in EMS brings high stress with a regular exposure to trauma. A theme to come to life in the participant stories was the normalcy of trauma and how EMS personnel cope with trauma. All of the participants discussed self-identified coping methods, acknowledging most of them as unhealthy. In sharing stories from their career experiences, most participants selected stories that represented trauma through threats to personal safety, or often through the death of a patient. One participant talked about patients and their families, stating, "They're in the worst times

of their lives, you know they're seeing their loved ones passing away, their father, parents, their children you know it's very difficult for them."

Several participants reported feeling unprepared in their training for the reality of the calls they would run in their career. One participant stated, "You get into [EMS] and then you run a call, and you're like holy crap I was not expecting that." Another shared, "I went directly from classroom to emergency truck. 24 hour shifts, somebody calls 911, you're it." Yet another described himself as an "accident magnet." He stated, "all of a sudden people start having car wrecks everywhere you go." The pressure of attending to community crisis translated into having to cope with trauma experienced every time participants went to work.

While participants reported wanting to have serious and potentially traumatic calls, as they felt they would then use their skills and training, these calls included instances of emotional reaction to severe physical injuries, death, emotional pain, and helplessness of patients and their families. Participants' recounting of calls during their career included, "a couple that was car jacked, and they were tied up and thrown in the trunk… and then they took the car in an alley way and covered it in gasoline and set it on fire." Another shared an experience when they "watched that baby die in my arms." Yet another shared a time "we went in and found this little girl who was basically burnt up," later describing the child's hair and clothes in great detail. In fact, several participants recounted stories of children or babies dying during a call as especially impactful. One participant invited the researcher to view photos on their smart phone of mangled body parts from calls they had, describing, "A car wreck, roll over, this mother, daughter, she was intoxicated, big time intoxicated, she had rolled her car over the fence, onto the embankment, up against the tree rolled over and this little girl is in the back seat." Another participant vividly described the sensory details of a call early in their career:

> You don't forget the <u>smell</u>, you don't forget, you know, seeing the shooting when I was at the ambulance and then seeing the result of what happened to the people in the car as I'm getting off of work. Those images don't go away, and

> they're kind of reminders of like when you're that young I didn't know what to do with the stress.

With this discussion of trauma also came discussion of coping. One of the main avenues of coping was finding a way to dehumanize patients to avoid emotional investment in the patient outcome. One participant stated, "I don't view people as people. That is my mechanism of coping. [I] got an award; it's on my wall, my dead baby award for teamwork." This humor may seem crass to those outside of the profession, yet the EMS professionals talked about the need for this separation and a dark humor to cope with the intense trauma, especially around negative patient outcomes. Another coping mechanism that emerged was the use of substances to numb the trauma.

> I'd get to sleep all day, stay up all night long, go out and party, and that was how you dealt with blowing off that stress. Which is obviously not a healthy way to deal with it and so for that first five years or so it was very, I don't know if traumatic is the right word, probably more like stressful and the, the EMS culture I think has a lot of negative effect on this.

Several participants described social drinking a part of the connection and culture of EMS, encouraging coping through alcohol use instead of seeking supports outside of the profession. Many of the participants mentioned how coping through social drinking was two-fold, alcohol use was a way to forget calls and connect with their peers. They described family members who disapproved of drinking, yet their "work family" understood the need to numb the emotional toll of the trauma.

> I didn't realize I was absorbing a lot of stress and, my personality changed a little bit. I drank and smoked more, I definitely became a partying alcoholic so I never drank at home but I'd go with friends and drink until I blacked out and that was normally acceptable amongst the group.

Participants also talked about the negative impact trauma would have on their relationships, especially when substance use took them away from their families. The impact of the profession hurt many relationships, most of the participants touching on how hard it was to maintain romantic and personal relationships in their career field. Participants described not wanting to relive trauma outside of work, as "my wife/husband doesn't understand what it is like." Participants talked about worry for personal safety on scene. A participant described his fear and "the thought that my children may get a phone call [that] daddy's not going to come home no more." The emotional disconnection used in the career environment also hardened people outside of work, making it hard to feel compassion and empathy.

Participants described stories representing exposure to trauma throughout a career in EMS. Coping with this trauma included disconnection and substance use which are socially acceptable within the EMS culture. While participants did not express a strong need for recognition or gratitude, many felt misuse of EMS resources added to cynicism developed from the trauma experienced over a career and disregarded the purpose of the service they seek to provide in the community.

"Ambulance Driver"

Another clear theme to emerge from the data was the frustration EMS professionals feel when their services are misused, misunderstood, or unappreciated. As one participant described, "EMS is like a secret. I didn't know a damn thing about it until I started working it." One EMT talked about how they saved the life of a person in a severe car accident and the newspapers reported the following:

> What sucks about that whole situation is every single article that was written called me an 'ambulance driver'. I was not an EMT, I was not a responder, I was an ambulance driver. I even told the newspaper writer do not call me an ambulance driver I'm an EMT I'm not just a driver.

Several EMS personnel described this term of "Ambulance Driver" as derogatory and minimizing of the expertise and training EMS professionals have in life-saving medical procedures. Another participant described EMS as the "butler of healthcare," paid to be at the beck and call of whatever community members needed, regardless of urgency. All participants discussed a tendency for community members to call 911 services for minor issues, or even for simple transportation, and how this takes a toll on them over time:

> There's a lot of people who abuse the system. That, from my standpoint, that takes a bigger toll on me, than the stressors of the job, the death, the destruction, the broken glass, the twisted metal, the crying, that takes a toll on me, more so than, just like I said the stress. There's a lot of that, a lot of that now that we deal with.

Many other participants discussed feeling like a "Taxi Driver." The "abuse" of the EMS system by the public came up in every narrative as a contributor to the feeling of cynicism and emotional disconnection from patients:

> It burns out of us you know, if it's not a life threatening issue we feel like we're wasting our time. So you know vomiting [sic], you, you've got sniffles, really is that why you called 911 today? We have this very kind of hardened cynical attitude.

This misuse of services and misperception in the community left participants feeling unappreciated for the service they provide, stating that compared to other first responders, EMS "get[s] the stuff no one wants to deal with." Many participants described "regulars," or community members who often call 911 for non-emergency needs.

> …we have regulars, and they're lonely, people are lonely, have no family coming around, I understand that, I get that. But, somebody, they will call for an ambulance, because I'm lonely and my toes hurt. You wanna go to the hospital? Yeah? You have to take them up, you have to. So, you're technically

> dealing with bull, and you tie up this ambulance, for an hour… somebody has a true medical emergency, and they have to wait, that's what I have a problem with…. That angers me, that angers a lot of people, but that's just abuse of the system

Participants felt family members and the community-at-large did not understand the realities of a career in EMS. A participant shared:

> I think sometimes that its they don't realize that we go, I mean sometimes non-stop, some days, I mean there's some days I mean that we don't I mean even get to stop to sit down to even like go to the bathroom, to take a sip of water to like you know eat a snack or, I mean it's you know you're constantly like running the roads and I think sometimes they, they, they don't understand like why did it take you so long to get here?

Overall, participants felt the community took EMS for granted, which contributed to burnout and lack of empathy towards community members. Participants discussed enthusiasm for their career training, and frustration in frequent calls which did not require use of these skills. This misuse of emergency services seemed to contribute to cynicism and burnout within the EMS profession.

Discussion

EMS represents more than a career path, but a culture in and of itself. All of the participants demonstrated an awareness of the culture of EMS, and implications of a career marked by exposure to trauma. Participants found telling stories to be a safe way to express their personal experiences. Participants expressed enthusiasm in sharing stories with the researchers, and appreciation for the genuine interest of the researcher in their work. Awareness of the themes present in participant narratives can assist mental health professionals in supporting the needs of EMS professionals. In discussion of these themes below, mental health

professionals may gain valuable insight into the experiences and needs of EMS workers.

Culture of EMS

Participants described EMS as more than a career, but as a unique culture. The camaraderie among EMS professionals represents a source of support, but also a source of pressure not to express and process emotion (Rutkow et al., 2011). As participants explained, maintaining composure on scene and appearing "tough" is a critical part of the EMS culture. Hazing and pressure are used to determine who is worthy of initiation in this exclusive group. Over a course of a career with repeated direct and vicarious trauma, this culture becomes a deterrent for using available mental health resources and supports. The mentality of professionals in the EMS field is that those outside of the field could never understand their experiences, and likely do not care. Seeking mental health supports represents weakness and betrayal.

However, as the researcher is also a mental health professional, and was transparent about this identity in the informed consent process, EMS participants found they actually enjoyed the experience of sharing stories with someone outside of the profession. Most participants exceeded the initial time allotted for each interview, and several contacted the researcher asking to come back and share more stories if needed for the research. All participants felt and described this "Culture of EMS," representing a critical element of their career and the experiences of those who choose the EMS profession.

Exposure to Trauma

Through the stories shared, participants described direct and vicarious trauma. They described the difficulty of managing emotional reactions on scene and following a call. Further, they discussed how this trauma impacted their lives and relationships outside of work. EMS as a field correlates with high rates of divorce and infidelity (Pajonk et al., 2011). Participants described how family and friends outside of their

professional community may not understand the nature of their work, and how their need for emotional detachment was a deterrent from sharing work experiences at home. Further, as highlighted by one participant, sexual intimacy becomes a safe means of connection. EMS professionals may seek physical relationships or engage in social drinking within a community who understands trauma without the need to verbally recount it in order to cope without having to share about experiences.

Many participants discussed poor health habits, including sleep disturbance, poor eating habits, smoking, and alcohol use outside of work. Many also discussed calls involving substance use (e.g. overdose, accidents under the influence) and children as being especially challenging. Most participants shared stories in which a patient died, noting this as a benchmark time in their career. In recounting these stories, participants included vivid memory of sensory details such as the smell of burning flesh, and the color of a patient's shirt as they sat with them in an overturned vehicle. Participants felt through their trauma experience, they developed a cynicism and need for detachment from patients. Mental health professionals may have some awareness of this trauma exposure in the EMS field, but must be prepared to hear the vivid and detailed stories of these professionals to provide needed supports.

Lack of Appreciation

All participants described a lack of appreciation and misuse of EMS services in their community. Since the television show *Emergency* in the 1970s, public awareness about 911 services has increased while understanding of the training and purpose of EMS seems widely misunderstood (NHTSA, n.d). Participants described frustration over improper use of nomenclature for professionals, for example calling all EMS professionals EMTs despite different levels of training and expertise.

Overall, the greatest source of frustration was inappropriate use of the 911 system. Participants discussed that, in their state, this was partially due to the state Medicaid system. In expansion of Medicaid under the Affordable Care Act, their county services became eligible for use without direct billing to patients in most cases. As such, ambulances became

synonymous with taxi services, often inappropriately used for nonmedical emergencies or free transportation services with EMS lacking the ability to deny transport to community members. EMS personnel undergo rigorous training in life-saving medical procedures. Having community members call for minor medical issues better addressed in an outpatient setting feels like a waste of time and training for participants.

Some states have begun to adopt "paramedicine," an integrated care system allowing EMS to perform diagnostic exams in the field and recommend courses of treatment in an outpatient setting instead of transporting to the hospital (Choi, Blumberg, & Williams, 2016). This system allows EMS an option beyond mandatory transport to the local emergency room, and preliminary studies show promise in helping to more effectively use EMS services and decrease response time for serious medical emergencies. Several participants mentioned this system, and expressed hope that paramedicine may be nationally adopted by states to better use professional training and increase public awareness about EMS.

Implications

EMS personnel experience trauma throughout their career. The culture of EMS and perception of lack of community interest in their experiences lead to decreased willingness for EMS to engage with mental health professionals. High rates of substance use, burnout, PTSD, and suicide (NEMSMA, 2016) indicate strong need for increased mental health support for this professional community. Storytelling is a natural coping mechanism for EMS first responders (Tangherlini, 2000), and as such, therapy centered on storytelling may seem less threatening. Further, storytelling may represent an opportunity for rapport building when EMS professionals are reluctant to share about career experiences. Mental health practitioners inviting story sharing expresses genuine interest in an EMS career, which personnel take great pride to represent. Storytelling in counseling may help mental health experiences to feel more like natural expression in the EMS culture. Finally, mental health professionals must infiltrate the world of EMS (Vogel, Cohen, Habib, & Massey, 2004) and demonstrate interest in the work of EMS professionals.

Participants found the interview experience of sharing stories to be engaging and enjoyable, several offering to return for another interview if needed. One participant laughed that if counselors could come along when the paramedics went out for a drink together, EMS personnel would be more likely to talk to them. Exposure in a familiar setting, or beyond just a counseling environment, could help address apprehension about engaging with mental health professionals. Further, interacting with personnel in the EMS environment could help mental health professionals understand and perhaps become part of the EMS culture. Consideration of exposure, such as riding along for part of a shift to learn more about EMS, attending community events that support or include EMS personnel, or spending time at a fire station to meet EMS personnel may help mental health professionals be seen as allies.

Suggestions for Future Research

There are few studies focused specifically on the experiences, needs, and mental health of EMS professionals. Conducting further research on mental health stigma specifically with EMS would help to better inform efforts to connect EMS with mental health supports. For example, exploring EMS perceptions of mental health professionals and perceived barriers to seeking supports would be valuable to address systemic factors deterring use of mental health services. Further, researchers may explore with EMS supervisors and directors the amount of access to counseling supports among EMS agencies to inform advocacy for increased resources. Such research may also help to inform development of EAP programs more conducive to the culture of EMS. While more research exists related to firefighters and police, it is inappropriate to generalize these findings to represent professions beyond the participant professional identities as each carries a unique culture and need.

Limitations

The current study uses qualitative research methodology, and as such, the goal of this research was to explore the context of the participants

and not to generalize findings for the population. Sampling for the current study included only one county in which researchers received permission from stakeholders to recruit participants. This represents a potentially limited range of experiences shared by participants, although many shared stories from work in other locations in their career outside of their current setting. Inclusion of further counties may have provided broader context beyond the unique communities served by the participants of this study. Further, all participants identified as Caucasian and most identified as male, which represents lack of diversity in the participant sample. While several more participants expressed interest in the current study, timing disallowed inclusion of such participants which would also provide greater and richer context through participant narratives.

Conclusion

EMS first responders experience direct and vicarious trauma as a routine aspect of their work. Within the themes presented, EMS personnel described a unique culture within EMS. This culture becomes means for coping with both exposure to trauma in response to community crisis, and frustration about perceived lack of appreciation and respect in misuse of EMS supports. Mental health stigma represents a barrier for these professionals to seek counseling supports to address this trauma. Without intervention, prolonged exposure to trauma can lead to burnout, PTSD, and suicide. EMS personnel perceive a general lack of interest and investment in their community-based services from community stakeholders. As such, creating stronger and more consistent connections between counselors and EMS beyond EAP or employee support services can offer a needed source of support for first responders throughout a career.

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A Military Family's Loss: A Case Study Viewed from the Lens of the Multi-Dimensional Grief Theory

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Given the war time and unexpected loss of service members, it is important to consider the loss from the perspective of any surviving children and teens. This paper presents a case study utilizing Multi-Dimensional Grief therapy as the lens with which to view the loss of a service member from the perspective of a young boy and his teenage sister. The casualty notification process is briefly discussed before presenting a literature review, suggested interventions and implications for future practice and research.

Keywords: Childhood grief, loss of service members

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According to the US Department of Defense (2010), there were approximately 3,700 children under the age of 18 receiving benefit payments due to the death of a military parent. Children are resilient, and although many may recover from grief without professional assistance, others may need help to do so. Death of a parent is traumatic for any child (McClatchey, Vonk, & Palardy, 2009) but for a child or teen of a military parent, there are special considerations. Therefore, it is important for clinicians who work with military families to understand the specific issues children and teens of military families face before and after the death of a parent during military service. Issues may include life on base; frequent deployments and moves; secondary losses when a parent is killed; ambiguous loss if the parent's body was not recovered; and possible

posttraumatic stress disorder (PTSD) symptoms which may occur if a parent was killed in a violent manner or by suicide.

This article will present a case study of a child and a teenager facing grief through the lens of multi-dimensional grief theory, a newly developed grief theory for children and adolescents by Kaplow, Layne, Saltzman, Cozza, and Pynoos (2013). First, the authors will briefly review factors specific to military death notification, followed by a literature review on children and teens who have experienced the death of a family member connected to military service, and developmental understanding of death. Next follows a description of a newly minted theory on childhood grief, the multi-dimensional grief theory, the case, and the application of the multi-dimensional grief theory to the case.

Military Casualty Notification

Military life is a culture in and of itself. It is represented by a blended and often tight-knit community of service members and their families. Consistent with this life experience is a unique language, customs of behavior and association, and a structure of rank that is oftentimes difficult for the average citizen to fully comprehend and value (Duchac, Minor, Spitzer & Frye, 2016). Such life is rich in tradition and honor of service to one's country. Military life structure differs even within the various branches of service. Further military life differs in peace time and war time activities, military job occupations, and interpersonal dynamics (Redmond et al., 2015).

When a person dies during military service, the authorities follow special procedures. The process of casualty notification typically occurs within a four-hour window of knowing that a service member has died (US Army, 2014). The family or next of kin is notified by a chaplain and casualty notification officer (CNO). The CNO represents the Secretary of the branch of service and provides necessary support to the next of kin. Following this notification, the family is assigned a Casualty Assistance Officer (CAO). This individual is referred to in the Navy and Marine Corps as a Casualty Assistance Call Officer (CACO). The CAO/CACO is responsible for taking care of the immediate needs of the next of kin. These

officers facilitate the casualty process and guide the family through the resources and paperwork. Additionally, a Chaplain is sent with the CNO to assist with the immediate emotional needs of the family until additional family, friends, or a local faith leader arrives (US Army, 2015).

Further, this officer seeks to eliminate any delays in settling claims and paying survivor benefits to the family (US Department of Defense, 2009). It is important to note that the media is not notified of any names of members lost until at least 24 hours after the family or next of kin is notified. However, social media, the internet and other technological advances make the notification process more challenging. At times, the next of kin may find out about the loss through one or more of these technological advancements prior to the official notification process. The remains of the service member are escorted until they reach the funeral home (US Department of Defense, 2009).

Literature Review

Service members die from many different causes, such as combat, illnesses, accidents, suicide, homicide, and terrorism (Cozza et al., 2017). Although some die from non-violent causes such as illness, most die a sudden and violent death. It is estimated that 52% of service members who died between 2001 and 2011, died a violent and sudden death (accidents, suicide, homicides, terrorism) (Cozza et al., 2017). Not included in this number is the 32% who died in combat. The average age at the time of death was 28.5 years, with close to 95% being male. Fifty-five percent left behind a spouse, 56% of which had children, 84% of which were 18 or younger. It is estimated that between 2001 and 2010, more than 3,700 children aged 18 and younger lost a parent to death in the military (US Department of Defense, 2010). Most military children and teens will adapt and recover from the death of a parent in combat without professional intervention. However, others may experience a more complex grieving process (Soires, Maier, Beer, & Thomas, 2015).

How well children and teens cope with the loss is dependent on whether the family sees the death as meaningful or not, the mode of death, and available support systems (Holmes, Rauch, & Cozza, 2013). The way

the surviving parent copes has also shown to influence how the child will cope (Worden, 2018). A depressed or anxious parent may negatively impact the coping of the child after the death of the other parent. Warm and open communication between the surviving parent and the child facilitates the grieving process for the child, but poor discipline may instead exacerbate a poor outcome (Raveis, Siegel, & Karus, 1999; Wolchik, Tein, Sandler, & Ayers, 2006). The grieving process may be complicated for surviving military family members. There are several other losses connected to such a loss, i.e., the loss of life on the base which includes housing and friendships with other military family members (Holmes, Rauch, & Cozza, 2013).

Holmes, Raush and Cozza (2013) give suggestions on how to intervene and support families of deceased service members, one being the treatment of "mental health problems such as depression, anxiety, and PTSD" (p. 156). Few studies, however, have examined the effectiveness of such interventions with children and teens who have lost a parent in military service.

Although play therapy has been shown to decrease presenting symptoms in children who have experienced trauma (Friedrich, 2008; Ogawa, 2004), grief (Webb, 2003), and grief and trauma (Webb, 2011), only one outcome study using play therapy with a child who had lost a father in military service was found in the literature (Soires et al., 2015). At the age of five, a young boy and his mother attended family-based play therapy to help alleviate symptoms of nightmares and clinginess after the death of their father and spouse in combat. After several weeks of play therapy, the boy's symptoms decreased to a practical level where the boy was able to go back to school for half days (Soires et al., 2015).

Trauma-focused grief therapy has been successful with children and teens who have experienced a traumatic loss (Cohen, Mannarino, & Knudsen, 2004; McClatchey et al., 2009). Yet only one study where the authors applied trauma-focused cognitive behavioral therapy (TF-CBT) connected to a child's loss of a parent in the military could be found in the literature. An 11-year-old girl, whose father acquired a traumatic brain injury while on deployment and died from suicide shortly after returning home from duty, received TF-CBT after presenting with stress disorder

symptoms (Cohen & Mannarino, 2011). She found her father's dead body and had refused to visit the gravesite (Cohen & Mannarino, 2011). Initially, she scored over 40 on the UCLA PTSD Reaction Index (RI), but her scores declined to 14, which is in the normal range, after having attended therapy for several weeks. In addition to the trauma-focused grief therapy, she participated in Tragedy Assistance Program for Survivors' (TAPS) grief camps, where she connected with other children who had experienced the loss of a parent in relation to military service. At the completion of her program she scored 5 on the RI (Cohen & Mannarino, 2011).

Developmental View

The developmental stage of the child or teen has to be taken into consideration when assessing the grieving youth. Children and teens grieve differently from adults (Christ, 2000; Willis, 2002). Their understanding of death and its concepts, such as universality, irreversibility, non-functionality, and causality is dependent on not only individual factors but also the child's or teen's developmental stage (Corr, 2010). The cognitive stage of a child or teen can help explain how a bereaved child or teen experiences a death (McClatchey & Wimmer, 2018).

Very young children (under 2) have no concept of death but may react to emotions of others and may become clingy, cranky and/or regress (DeSpelder & Strickland, 2015). Toddlers ages 3-5 typically know that death is irreversible. Their concern is for their own well-being, and they fear abandonment (DiCiacco, 2008; Piaget & Inhelder, 1969). When children grow a bit older, around 6-9 years of age, they know the finality and irreversibility of death and often obsess about the health of the surviving parent (DeSpelder & Strickland, 2015). They commonly also develop 'magical thinking' (DeSpelder & Strickland, 2015). Magical thinking involves believing that they did or said something that caused the death. This is a common experience among children this age, but also older children and teens. Magical thinking creates feelings of guilt. Complicating the feelings of guilt is the difficulty children have in identifying feelings. Because of this difficulty, their feelings often come out in aggression and acting-out behavior or, the opposite, withdrawal (Corr, 2010). Pre-teens and

teens have a death concept similar to adults. This age group may also tend to identify with the deceased and may adopt habits, mannerisms, or hobbies of the deceased to keep the person alive (Clark, 2003). Magical thinking is common in this age group as a way to make sense of what has happened. Teens may become overly dependent in relationships in fear of losing the other person in the relationship, or the opposite, distant, to protect themselves from a perceived future loss of the other person (Balk, 2014). Teenagers will question life and its meaning (DeSpelder & Strickland, 2015). They also want to be like their peers, and when they lose a parent, they stand out which make them feel uncomfortable (Worden, 2014). Peers often do not know how to help, so the teen feels isolated and alone. Developmentally, teens are supposed to break away from their family and find their own identity (Erikson, 1968). Loss of a parent at this stage may pull the teenager back into the family and temporarily hinder self-identification (Balk, 2014). The teenager may also experience the opposite—an accelerated journey into adulthood (Balk, 2014)—especially if they have younger siblings and the teenager needs to work to help ends meet.

Multi-Dimensional Grief Theory

Multi-dimensional theory was recently developed to help assess how children and teens grieve (Kaplow et al., 2013). This theory looks at three dimensions of grief after a child loses a parent or other close relation: separation distress, existential/identity distress, and circumstance-related distress (Kaplow et al., 2013). A child may experience stress on one, two, or all three dimensions. The distress a child experiences goes along a continuum from adaptive to maladaptive. When a child loses a parent, it is important, then, to assess the child's grief on all three dimensions and assess where they place on the spectrum.

Separation Distress

A child who is experiencing adaptive separation distress may feel sadness, and miss and long for the parent. Suitable interventions include helping the bereaved child identify with positive traits or behaviors of the deceased, and promote their legacy (Kaplow et al., 2013). The clinician would also suggest holding mourning rituals and create scrap books. For small and middle-aged children, it is also imperative to help them identify feelings so that these do not get expressed in unwanted behavior (Corr, 2010). Maladaptive separation distress may lead to fear, especially among young children, of losing a surviving parent and, in older children, lead to suicidal ideation (Kaplow et al., 2013). For children and teens who are experiencing fear of losing a surviving parent, it is important to be honest; lies assuring the child that nothing will happen will not soothe a child but rather let them know you are lying because such promises are unrealistic (McClatchey, 2004). Plans for who will care for the child should something happen to the surviving parent need to be established and made known to the child (McClatchey, 2004).

Existential Distress

Adaptive existential distress can be expressed as a temporary inability to see meaning in life. To assist with this distress, it is helpful to identify strengths in the child (Kaplow et al., 2013). For a child who is experiencing maladaptive distress, such as jealousy towards other children and teens who still have their parents, it is important to help initiate other relationships to establish an identity without the deceased (Kaplow et al., 2013).

Circumstance-Related Distress

Examples of adaptive circumstance-related distress include a reenactment of the loss in play and drawings in young children, but also sadness, anger, and disgust (Kaplow et al., 2013). These decrease over time. However, in maladaptive circumstance-related distress these feelings linger.

Also, often common among maladaptive circumstance-related distress are intrusive thoughts of a painful or scary death (Kaplow et al., 2013). Children and teens may thus go to great lengths to avoid talking or thinking about the death (American Psychiatric Association [APA], 2013). Other common maladaptive responses include feelings of intense rage and revenge fantasies. Rage may extend to the deceased parent for not being present. This may cause feelings of guilt, and the child may not be able to express these feelings since death may have been seen as patriotic by others (Kaplow et al., 2013). To assist children and teens who are experiencing circumstance-related loss, children and teens need as many details as possible about the loss and be assisted to form a constructive social response (Kaplow et al., 2013). Such a response may include becoming a volunteer to help others in some form or study to work in a helping profession such as social work, medicine, or law. If circumstance-related death includes intrusion and/or other trauma symptoms, trauma-focused cognitive behavioral therapy or trauma-focused cognitive processing interventions may be included (Cohen & Mannarino, 2004; McClatchey et al., 2009).

Each dimension may have separate *causal precursors*, such as etiological risk factors, and *causal consequences*, such as acting-out behavior and functional impairment (Kaplow et al., 2013). The child's cultural context and developmental stage may serve as moderators. Other moderating and mediating variables include trauma and loss reminders, each of which can be either external or internal, and remind the child of the event or responses to the event, or memories of the lost person (Kaplow et al., 2013). External trauma reminders may include smells or tastes; internal trauma reminders may include images or physiological experiences. Also, the child's coping skills and how the child and family communicate need to be assessed and taken into consideration (Kaplow et al., 2013).

Case Study

The presented case study is based upon an actual family seen in clinical practice by one of the authors. Pseudo names and other personally identifiable information has been changed to protect the family.

John and Mary lived together on a military base in Kentucky. John was a Sergeant First Class in the United States Army for the past 18 years which coincided with the length of his marriage to Mary. Before the current base in Kentucky, the family had lived on two other bases. John had been deployed several times, twice to Iraq and twice to Afghanistan. Mary was a stay-at-home parent caring for their two young children, Johnny, 10 at the time of this writing, and Brittany, 13. John was by all accounts an attentive husband and parent, who loved spending time with his children. When he was home, he spent all his time with his family and picked up his children from school. Both children were good students with no issues. Johnny was at one time thought to have attention deficit disorder, but the family worked with him to self-monitor his behavior, and this took care of this issue. Both Mary and the children had many good friends on the base. Grandparents on both sides lived in North Carolina. In April 2017, at his fifth deployment, John was killed by an Improvised Explosive Device (IED) in Afghanistan. He was 36 years old at the time.

Mary learned of her husband's death from an Army chaplain who came to their home with the horrific news. Mary was the only one at home at the time. By the time the children returned from school, Mary had a friend of another soldier with her as support when she had to tell the children how their father had been injured and doctors and nurses did not think they could save him, although Mary knew her husband had died. The children's reactions were emotional. Daughter Brittany reacted by lashing out, breaking a few items.

The children eventually learned the truth. The whole family was distraught, in shock and disbelief. Their husband and father had come back from deployment four times before, and this time he would not. The family returned to North Carolina for the closed casket funeral and to live in John's and Mary's hometown where John is now buried.

Mary keeps pictures of John throughout the home, and the flag from John's coffin is in the living room together with a shadow box with all his military awards. Johnny keeps a picture of his father and himself on his desk while Brittany put her picture of her dad away. Mary visits John's

grave weekly. Johnny has gone a couple of times, but Brittany refuses to go.

Mary took a job as an administrative assistant for an insurance company to bring an income to the family. Although she loves the work, the hours are long. The family is supported by the two sets of grandparents and Mary's brother who has stepped up as a strong and supportive uncle. Grandparents speak of their loss often, but this creates discomfort for their grandchildren. Although the relationships with friends from the base have not ended, the frequency and level of support have decreased. The military is not an allowed topic in the household.

Recently, Mary has been receiving calls from the school regarding Brittany's behavior. Her grades have decreased significantly, and she was recently caught fighting with another girl in class. Previously, she had been suspended for a week for another fight. At home, Brittany has been angry and openly defiant. Johnny, though not openly angry and defiant, has become more reserved over the past six months. Mary has tried to talk to him, but he says that everything is okay and that he has nothing to say. His grades have dropped slightly, but he is still averaging C's and B's in his classes. Upon John's death, Mary had seen a counselor with her children to help them deal with their loss. At the time, the counselor said the children were fine and that what they were experiencing was normal. As a result, she and the children stopped seeing the counselor. Mary has now been diagnosed with depression and sees a counselor regularly.

Multi-Dimensional Theory Application to Johnny and Brittany

Adaptive and Maladaptive Separation Distress

As we apply the multi-dimensional grief theory and developmental lens to the above case study, we need to examine the three dimensions of the theory, starting with separation distress and where this falls on the continuum of adaptive and maladaptive distress among these children. Both children initially expressed disbelief and sadness upon the news of their father's death which is a natural reaction. Brittany's initial anger expressed through the breaking of some items would also be considered natural. Their

disbelief and consequent acceptance of their father's death may have been prolonged, however, because the father had been on several tours before his last one and had always come back. It is common for children and teens who lose a parent during active duty to have difficulty accepting the death since the parent is often absent from the home (Kaplow et al., 2013). The children and teens will be lulled into the fantasy that the parent is just away on deployment. Maladaptive separation distress is not obvious since the children are not regressing developmentally, and there is no talk of suicidal ideation. However, this needs to be further assessed. Also, the children do not show over-identification by hanging on to objects of their father's or by showing an interest in a military career. However, the military is a taboo subject in the household which may indicate maladaptive coping for separation distress.

Adaptive and Maladaptive Existential/Identity Distress

When examining the dimension of existential and/or identity distress, it appears that the children may experience maladaptive coping. Behavioral changes have occurred since the death of their father and still exist at the writing of this case study several months after the death**.** Brittany is showing indifference to her academic work and is getting into fights with her classmates. Johnny's behavioral reaction is the opposite—he has become more withdrawn. The children also experienced a secondary loss when they moved off the base where many of their friends lived. This may contribute to the anger Brittany is expressing.

Adaptive and Maladaptive Circumstance-Related Distress

The children's behavior may also indicate that they may be experiencing maladaptive circumstance-related distress. Brittany continues to get in trouble in school by getting into fights with other students and her anger at home shows in defiant and angry behavior. Her brother is becoming more withdrawn and denies that anything is going on when his mother tries to talk to him. They both show avoidance when they choose not to accompany their mother to the father's gravesite. Although the son

has been a couple of times, the daughter has refused to visit. Also, Brittany has chosen to take down the picture she had of her father in her room.

Further Assessment Needed

Separation distress. There are several unanswered questions in this case. A clinician would do well to assess all three dimensions of the grief theory by asking related questions. Maladaptive separation distress may show in yearning for the deceased to such a degree that there is suicidal ideation to get back together with the deceased. A child or teen may also show maladaptive separation distress by being overly concerned about the well-being of the surviving parent. These two possible concerns need to be assessed. It would also be important to assess both Brittany and Johnny for depression, which among children and teenagers often can present with anger, defiant behavior, and/or withdrawal (Ritakallio, Kaltiala-Heino, Kivivuori, & Rimpelä, 2005).

Existential distress. It is not known whether Johnny and Brittany feel jealousy towards other friends whose parents are still alive—which would show maladaptive existential distress.

Circumstance-related distress. There are also questions about maladaptive circumstance-related distress. Is Brittany's acting-out behavior a sign of rage against the military or whoever she thinks caused her father's death? Is her avoidance of the grave site and the taking down of her father's pictures signs of these being trauma reminders for her, creating maladaptive trauma-related stress? Does she have intrusive thoughts about how her father died? Or are the photo and thoughts of visits to her father's grave signs of loss reminders creating maladaptive separation distress?

Developmental concerns. A clinician needs to keep in mind, when assessing these children, the developmental stages of the children. Johnny is 10 years old. At this age, he does know that death is permanent, but he may experience magical thinking, a common event in this age group (DeSpelder & Strickland, 2015). He may think that there is something he

said, thought, or did that caused his father's death. Children in this age group are not able to use deductive reasoning or predict the outcome of an experience (Piaget & Inhelder, 1969). At this age, children have difficulty identifying feelings, which may lead to acting-out behavior (Corr, 2010), or the opposite, withdrawal. Johnny may experience a wide range of feelings, but his inability to articulate them may be his reason for withdrawing or telling his mother that everything is OK.

Brittany is a teenager in early adolescence, and as such, she needs to become more independent from her parents while her peers become more important. Therefore, some of her acting-out behavior is age appropriate, but hitting friends and slipping grades are not typical. Brittany had to leave her friends when the family moved, and her peer support has therefore dwindled. At her age, it is also important for teens to fit in with their peers (Worden, 2014). Losing a parent makes her different, which may also contribute to her pushing her peers away.

Discussion

Possible Interventions

In this paper, the authors have described a child and a teen who have lost their father while on deployment. The authors have used the lens of multi-dimensional grief theory to assess the children's grieving process (Kaplow et al., 2013). The authors will describe possible interventions separately for the young boy and his teenage sister.

Johnny, 10yo male. The military is a taboo subject in the household. This may have created some separation distress. This type of avoidance is likely to contribute to Johnny's confusion. Some suggested interventions would be to promote the legacy of his dad, share positive memories of him, and for Johnny to identify his father's positive traits. This could be done by creating a memory book of his life with his family. It would also be helpful to assist Johnny in identifying his feelings. Developmentally he is at an age where the inability to express feelings is common, often resulting in acting-out behavior or withdrawal (Corr, 2010),

the latter of which is seen in Johnny. Johnny's behavioral manifestation, disinterest in academic work, may be an expression of existential or identity distress. It would be important to identify Johnny's strengths, such as his ability to overcome his attention issues and his previous records of good grades. Johnny has visited his father's grave twice, but is no longer willing to go. This avoidance of what reminds him of his father may be signs of such activity serving as an external trauma and/or loss reminders, in turn, creating internal cues (Kaplow et al., 2013). To help with such reminders, it is important that any questions he has about his father's death are answered honestly and to the best knowledge of the adults in his life. It is also important that Johnny is allowed to create and share his narrative of his father's loss. In addition, to help with trauma and/or loss reminders, Johnny may be taught stress inoculation techniques, such as thought stopping, deep and mindful breathing, and relaxation techniques. Magical thinking is common in Johnny's age group (DeSpelder & Strickland, 2015), and this phenomenon must be assessed and addressed if present. Magical thinking can be addressed with cognitive restructuring.

Brittany, 13yo female. Brittany is a teenager, and as such, she is in the process of finding her own identity and figuring out who she is as a person (DeSpelder & Strickland, 2015). When a teenager suffers a parental loss, they may experience feelings of hopelessness and a blighted future, i.e., a future with no meaning (Kaplow et al., 2013). Signs that Brittany may be experiencing such feelings would be her acting-out behavior both at school and at home. Interventions would include making meaning of the death and build her relationship with her mother and friends to create an identity without her father. It would also be important for Brittany to identify her strengths, among which is the ability to survive up to this point without her father. Brittany is also showing some signs of maladaptive circumstance-related distress. She refuses to visit her father's grave, and she took her father's pictures down. These pictures may serve as external trauma and loss reminders. As with her brother, Brittany needs to get all details available about the circumstances of her father's death and could benefit from learning stress inoculation techniques. Any guilt feelings she

may have about her father's death also need to be attended to. These may be best addressed using cognitive interventions.

There are also important interventions to address with the family as a whole. The family may benefit from learning effective communication skills. Mary would do well to keep set routines and learn effective discipline methods, both of which benefit children by making them feel safe (Canadian Paediatric Society, 2004).

Implications for Practice and Future Research

When working with bereaved children it is important to accurately assess their grieving process because unresolved grief among children may lead to several unfortunate short- and long-term outcomes (Dopp & Cain, 2012; Ellis, Dowrick, & Lloyd-Williams, 2013; Li et al., 2014; McClatchey et al., 2009). In the quest to assist bereaved children, the multi-dimensional theory by Kaplow and her colleagues (2013) is helpful in assessing adaptive and maladaptive coping among bereaved children. Yet, the field of childhood bereavement is still in its infancy. Very little is known, especially about how children losing a parent or sibling during active duty are affected by their loss and how to best help them. Further research into this topic is needed to better assist this vulnerable population.

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