Vol 7, Iss 3
Jul-Sep 2019

ISSN: 2165-7726

Journal of Military and Government Counseling

In this issue:

Military and Government Counseling Association
A Division of the American Counseling Association

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 we continue our exploration of the myriad environments and cultures of 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.

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The JMGC Editorial Team

ISSN: 2165-7726

The Journal of Military and Government Counseling

 ISSN: 2165-7726

The Journal for Military and Government Counseling (ISSN: 2165-7726) is published quarterly in March, June, September, and December by the Division of Counseling, Rehabilitation, and Interpreter Training (DCRIT) at Troy University and the Military and Government Counseling Association.

October, 2019

Journal of Military and Government Counseling

Effectiveness of Cognitive Behavior Therapy for Chronic Pain Among Veterans

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We investigated the effectiveness of cognitive behavior therapy for chronic pain (CBT-CP) for decreasing the symptoms of chronic pain among veterans. Data from 7 between-groups comparisons representing 1,718 veterans who received either CBT-CP (n = 604) or a viable alternative treatment (n = 1,114) were subjected to methodological review and meta-analysis. We found an average methodological quality rating of 6.85 (SD = 1.95) with most frequently reported features related to participant attrition, randomization practices, group similarities at baseline, and statistical power. Few studies described blinded treatment allocations, intent to treat analyses, and reliability estimates for included samples. The sample of 10 effect sizes resulted in a statistically significant mean effect (-.19 [CI95 = -.370, -.004], p =.04), suggesting that participants receiving CBT-CP report about a 19% of a standard deviation fewer pain symptoms than those receiving alternative treatments. Moderators of treatment effects, implications for counselors, and suggestions for researchers are provided.

Keywords: veterans, chronic pain, meta-analysis

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Chronic pain is any significant pain which causes distress, lasts longer than three months, and may limit someone's ability to complete everyday life tasks (Treede et al., 2015). As many as 25.3 million American adults report daily pain, with 65.5% of veterans describing a need for pain management during the last 3 months and 9.1% indicating severe pain during that time (Nahin, 2015, 2017). Recent epidemiological data suggested that Medicare, Medicaid, and the Department of Veterans Affairs report more than $100 billion in medical expenditures related to treating chronic pain with associated tax revenue losses due to decreased productivity (Gatchel, McGeary, McGeary, & Lippe, 2014). Bosco, Murphy, and Clark (2013) suggested that these proportions are likely to magnify over time within the veteran population as instances of polytrauma, including traumatic brain injury, continue to increase. Researchers have also identified several deleterious psychosocial outcomes associated with the experiences of pain and chronic pain among veterans. For example, Bair, Robinson, Katon, and Kroenke's (2003) literature review found that clinical depression symptoms occur between 3 and 5 times more among veterans who were experiencing chronic pain. Crosby, Colestro, Ventura, and Graham (2006) found similar associations between quality of life impairments and decreased engagement in meaningful life activities. Blakey et al. (2018) suggested that these variables were strongly associated with greater risk of suicide and violence. Historically, pain experiences and the related effects have been treated through frontline prescription and monitoring of opioid medications. However, given the recent growth in opioid abuse, dependence, and overdose, it is imperative to explore alternative treatments including cognitive behavioral therapy applications.

Cognitive Behavioral Therapy for Chronic Pain

Cognitive behavioral therapy for chronic pain (CBT-CP) is a treatment method that is evidence-based, time-limited, and acknowledged for its practical use within the Veterans Affairs system. CBT-CP assists clients in adopting an active, problem-solving approach to coping with the many challenges associated with chronic pain (Murphy et al., 2014). CBT-

CP is intended to support clients' development of self-management pain coping skills that increase the quality of life while focusing on the relationships between cognitions, emotions, and behaviors (Murphy et al, 2014). CBT has become increasingly innovative and shows promise in other formats, such as web-based or telephone-delivered, allowing for expanded access to reach a greater number of participants (Ehde, Dillworth, & Turner, 2014). The US Department of Veterans Affairs (VA) has created a veteran-specific CBT-CP manual (Murphy et al., 2014) and has been actively training therapists within their system with feasibility and broad dissemination activities conducted in routine, non-pain, specialty VA clinic settings (Stewart et al., 2015).

The CBT-CP for veteran's protocol consists of 11, 50-minute sessions and an optional booster session – the first session for the interview and assessment and ten active, skills-based therapy sessions, where clients are encouraged to adopt a problem-solving approach as a way to cope with the challenges associated with chronic pain (Stewart et al., 2015), though in research and clinical practice, specific techniques and number of sessions may vary (Ehde et al., 2014). Murphy et al. (2014) identified key components of the program which include: exercise (a walking program), pacing (accomplishing tasks in a sensible way), relaxation training (techniques to decrease stress and muscle tension), cognitive restructuring (balanced thinking), and behavioral activation (engaging in meaningful activities). Each session is structured to include agenda-setting, providing feedback, reviewing homework, the discussion and practice of the current skill, and a new issuing of a homework assignment (Stewart et al., 2015).

Structure of CBT-CP

Sessions one through three represent the initial treatment phase (Murphy et al., 2014). The initial session is for the interview and assessment. Session two begins to focus on the client's chronic pain – how it manifests in daily activities. Contact with their primary care provider is initiated for integration of care. Session three enhances client participation by collaboratively goal planning (Stewart et al., 2015). Sessions four through 10 are the cognitive and behavioral skill building stage (Murphy et

al., 2014). Session four begins to address exercise and pacing, including the development of a routine, while discussing the difference between hurt and harm. Session five focuses on relaxation techniques, such as diaphragmatic breathing, progressive muscle relaxation, and visualization/imagery. Sessions six and seven re-visit the client's goals to collaborate and implement other activities while remembering pacing and hurt versus harm. Sessions eight and nine include teaching and developing cognitive restructuring skills, such as automatic thoughts related to pain. It involves challenging those thoughts and proposing better adapted thoughts for cognitive coping. Session ten is when pain and sleep education is provided. The amount of focus on sleep can be altered depending on the extent of which disruptive sleep is an issue (Stewart et al., 2015). Sessions 11 and 12 are the discharge planning phase (Murphy et al., 2014). Session 11 is the termination session in which future barriers to success can be discussed, how to cope with future challenges, and overall discharge planning. The optional booster session would take place one month after session 11 to address any new challenges and reviewing previously learned skills in order to self-manage and problem solve (Stewart et al., 2015).

CBT-CP has been received auspiciously among VA mental health administrators, in part due to the precipitous rate in which both novice and more experienced practitioners demonstrate fidelity with intervention standards (Otis, Keane, Kerns, Monson, & Scioli, 2009). Murphy et al. (2014) suggested that the intervention may be effective as a standalone treatment, but also suggested that its impacts may be magnified by use as a compliment to other traditional approaches to pain management. Researchers have also found high levels of conceptual acceptability among clients as CBT-CP has a low drop-out rate (Otis et al., 2009; Stewart et al., 2015) with increased skill practice with CBT-CP was negatively correlated with pain intensity, pain interference, and depression (Edmund et al., 2017).

Purpose of the Study and Research Questions

Taken together, the development of an efficacious treatment for chronic pain among veterans has meaningful implications for individual quality of life, health care expenditures, and public health. There is some

burgeoning evidence for the feasibility of CBT-CP training outcomes and acceptability by clients (Otis et al., 2009; Stewart et al., 2015), yet methodological reviews and syntheses of evidence related to veteran-specific outcomes are unavailable for reference by practitioners, administrators, and policy makers. The purpose of this study was to identify published and unpublished studies eligible for methodological review and meta-analysis. Our activities were guided by three broad research questions: (a) what is the quality of reported methodological features among studies evaluating CBT-CP; (b) what is the mean effect size for CBT-CP versus viable, non-waitlist treatment alternatives; and (c) to what degree do participant and study characteristics moderate effect sizes based on reported data.

Method

We identified quantitative studies assessing the effectiveness of CBT-CP for decreasing the symptoms of chronic pain among veterans using a systematic search strategy. Data from eligible studies were coded and quantitatively synthesized using meta-analytic and narrative review procedures to depict an overall estimate of treatment effect.

Inclusion and Exclusion Criteria

Inclusion within the systematic review and meta-analysis was contingent upon the following criteria:

- Experimental or quasi-experimental designs were implemented
- Participants were veterans
- CBT for Chronic Pain was an identified as a primary treatment within levels of the independent variable
- Studies were intended to mitigate the symptoms of chronic pain
- Formal assessment procedures were implemented prior to treatment (pretest) and at termination (posttest)
- Descriptive statistics or statistical output was included that would facilitate computation of standardized mean difference effect size
- Participants were 18 years of age or older

- Study was published in English within peer-reviewed publications, dissertations/theses, or technical reports

Studies were excluded from our analysis if they included mixed samples of veterans and non-veterans, implemented single-case, pre-experimental, or correlational designs; did not include pretest data, did not include participant demographic information, or represented duplicate data published in previous studies. The decision to exclude these studies was made *a priori* as part of a broader strategy to control for study quality by controlling for confounding variables that may skew causal attributions of CBT-CP treatment effects.

Search Strategies

We implemented three search strategies to identify and include all eligible studies related to use of CBT-CP with veterans: (1) electronic database searches, (2) journal specific searches, and (3) review of reference lists. Two authors (second and third) independently searched the Academic Search Complete, PsycINFO, Medline, and Dissertations and Theses databases for the 20-year period from 1998 to 2017. Keywords that were used to identify the related intervention included: *Cognitive-Behavioral* and *CBT*; terms used to identify the intended outcome were: *Pain*, *Chronic Pain*, and *Pain Management*; terms used to identify the target participant population were: *Military*, *Veteran*, *Peacekeepers*, *Servicemen*, and *Soldiers*. Next, journal specific searches completed to identify any eligible studies included within relevant publication outlets included: *Journal of Military and Government Counseling, Military Psychology, Journal of Counseling and Development, Counseling Outcome Research and Evaluation, Journal of the American Medical Association, American Psychologist, Psychological Trauma: Theory, Research, Practice, and Policy; Counseling Psychologist, Journal of Consulting and Clinical Psychology.* All retrieved documents were screened by title and abstract review to yield potential studies for inclusion. Finally, reference lists within eligible articles identified in strategies 1 and 2 were reviewed to identify any additional documents for inclusion our sample of studies. Redundancies between references were eliminated and all candidate articles

selected for inclusion were saved in Portable Document Format (PDF) or Hyper Text Markup Language (HTML) formats.

Data Extraction and Coding

Data (bibliographic information, outcome data, participant characteristics, and methodological features) from eligible studies were extracted and coded according to procedures proposed by Erford, Savin-Murphy, and Butler (2010) and Lenz (2017). The second and third author completed independent coding of articles based on a coding guide developed by the first author. Both coders were doctoral students in a Council for Accreditation of Counseling and Related Educational Programs (CACREP) Counselor Education Program, were Licensed Professional Counselors, and had completed coursework in research methods, statistics, and assessment. Both coders received an orientation to evidence-based practices, systematic review procedures, and training for article coding using a manual developed by the first author. The first author verified accuracy and resolved any inconsistencies in the overall data set once coding was completed.

Data Analyses

Methodological quality. Methodological quality was estimated using the protocol depicted by Piet and Hougaard (2011) which reflects 10 criteria receiving dichotomous (yes/no) responses to the presence of a methodological feature. Responses receiving "yes" received 1 point whereas those receiving a "no" determination received no point. These ratings were summed to yield a score ranging from 0-10 with higher scores representing a greater degree of methodological quality for each unique study. Findings from this analysis were referenced as an indicator of the robustness of CBT-CP effectiveness estimates.

Effect size data. We computed the standardized mean difference between CBT-CP and alternative treatments using *Comprehensive Meta-Analysis, Version 3* (Biostat, 2015) across outcome variables (pain and

depression) based on descriptive statistics or relevant test statistics reported within primary studies. The Hedge's *g* metric was selected due to the presence of a statistical correction factor that controls for influence of small sample sizes and sampling error and results in a more even-handed approximation of effect size (Watson, Lenz, Schmit, & Schmit, 2016). Unique effect sizes were synthesized using random effects modeling with weighted variance to control for the influence of small studies within the mean effect size. Individual and mean effect size values were conceptualized in terms of standard deviation units of difference between groups, referenced in relation to 95% confidence intervals, interpreted using conventions suggested by Lipsey and Wilson (1993) for small (.30), medium (.50), and large (.67) effects, and situated into therapeutic context.

Heterogeneity analyses. The heterogeneity among effect sizes was evaluated using the Cochran's *Q* statistic and inconsistency index (I^2). The *Q* statistic tests the hypothesis that all studies share a common effect size. When *Q* is greater than degrees of freedom and statistically significant ($p < .05$) the null hypothesis related to a common effect size among studies can be rejected. The I^2 statistic reveals the proportion of observed variance that is due to true error among effect sizes versus sampling error. When *Q* is greater than degrees of freedom and I^2 is greater than 50, moderator variables should be evaluated (Borenstein, Hedges, Higgins, & Rothstein, 2009).

Exploration of variables that moderate treatment effect. We implemented two statistically-based strategies for exploring relationships between one sample variable (*mean participant age*) and five study variables (*study quality, delivery format* [face-to-face versus telephone-based], *delivery modality* [individual versus group], *number of sessions*, *comparison type*) and effect sizes estimates. Stepwise meta-regression modeling was used to depict proportions of variance explained by continuous variables (mean participant age, study quality, and number of sessions) and an analysis of variance analogue (*Q* test) was used to inspect differences between categorical subgroups (delivery format, delivery modality). We completed meta-regression analyses using individual

predictor-criterion combinations and method of moments estimator that converted z-scores to *F* values within the *t* distribution using the Knapp-Hartung (2003) modification procedure. Subgroup analyses featured a mixed effects analysis and interpreted at the .05 level of statistical significance.

Estimation of publication bias. We assessed the potential for our sample to trend toward the biased inclusion of studies reporting desirable effects of CBT-CP by inspecting three putative indicators. First, we created funnel plots situating study effect sizes on the horizontal axis and related standard errors on the vertical axis. When distributions of effect sizes and standard errors plots are symmetrical, less potential for publication bias within a sample of studies can be inferred. By contrast, asymmetrical plots are indicative of potential publication bias. Second, trim and fill procedures were completed to estimate the influence of any detected asymmetry by imputing hypothesized missing studies, including them within the analysis, and recomputing the mean effect size. Lastly, we inspected the classic fail-safe *N* (N_f) value to estimate the number of effects sizes reported in unpublished studies reporting null results that would be needed to render our findings non-significant. When N_f is strikingly low, the mean effect size may not be indicative of actual treatment effectiveness (Borenstein et al., 2009).

Results

The search resulted in 68 candidate articles and 5 dissertations that qualified for further scrutiny. After applying the inclusion/exclusion criteria to each candidate document, 7 were selected (6 peer-reviewed publications, 1 dissertation) for inclusion in our analyses (see Figure 1). There were 1,718 participants across the selected studies with 882 having received CBT-CP as their primary intervention and 856 having received an alternative treatment. Among studies that reported gender and age, participants were men (n = 1,480; 87%) and women (n = 219; 13%) with a mean age ranging from 36 to 69 years. Among studies that reported ethnic identity of participants, samples were predominately Caucasian (n = 945;

56%) and African American (n = 384; 23%), but also included reporting for participants identified as Hispanic (n = 222; 13%) and Other (n = 145; 8%). All studies implemented manualized CBT protocols specifically designed to address the symptoms of chronic pain in association with Veterans Affairs clinics (See Table 1).

Methodological quality. The mean score representing methodological quality of our sample of studies was 6.85 (SD = 1.95), indicative of modest study quality (See Table 1). Within the sample of studies, two featured all (Carmody et al., 2013) or nearly all (Donta et al., 2003) indicators of methodological reporting quality. However, the majority of studies (Arb, 2004; Cosio, 2016; Ilhan et al., 2016; Otis et al., 2013) reported about half of those features that promote transparency and critical discussion of findings. The most commonly reported methodological features across studies were details related to participant attrition (j = 7, 100%); randomization practices, group similarities at baseline, and statistical power (j = 6, 85%). By contrast, only a minority of studies reported methodological features related to blinded treatment allocation (j = 3, 42%), intent to treat analyses (j = 3, 42%), and reliability estimates for measures used with samples (j = 2, 28%).

Decreasing symptoms of chronic pain among veterans. The 10 effect sizes included in the analysis of CBT-CP versus alternative treatments for reducing chronic pain symptoms among veterans (N = 1,718) yielded a mean effect size of -.19 (CI95 = -.370, -.004), τ^2 = .06, p = .04, indicative of a small effect size and suggesting that the null hypothesis related to therapeutic superiority of CBT-CP can be rejected (See Figure 2). This finding suggests that within the universe of studies included herein, participants receiving CBT-CP tended to report a decrease in symptoms about 19% of one standard deviation less than those who received an alternative treatment, particularly treatment-as-usual (TAU). Inspection of the prediction interval indicates that the range of possible effect sizes that can be expected from studies of CBT-CP compared to TAU falls between -.79 and .41. Thus, future studies conducted with similar sample/setting

features could be predicted to yield favorable effect sizes as large as 79% of a standard deviation or null outcomes supportive of alternative treatments of about 41% of a standard deviation. The effect size distribution within the sample of studies was heterogeneous $Q(9) = 44.11$, $p < .01$ and $I^2 = 79.59$, indicating that about 79% of the observed variance reflects actual differences in effect sizes; thus, exploration of moderating variables was warranted.

Moderator analyses. The meta-regression analyses resulted in an initial predictive model that was statistically significant, $Q(3) = 8.93$, $p = .03$, $R^2 = .43$. Once removing non-significant model contributions of participant age ($b < .01$ [CI95 = -.02, .02], $p = .36$) and number of sessions ($b = .03$ [CI95 = -.06, .13], $p = .25$), study quality emerged as the single statistically significant predictor of effect size within the model, (Q[1] = 8.96, $p < .01$, $b = .14$ [CI95 = .05, .23], $R^2 = .54$), indicative of a large effect size wherein 54% of the variance among study effects can be accounted for by the number of quality features reported by study authors. Inspection of scatterplot and regression line suggested that studies with higher quality ratings tended to yield smaller effect sizes within our sample of studies.

Subgroup analysis of differences between CBT-CP comparison types and resulting effect size resulted in a statistically significant model, $Q(3) = 28.83$, $p < .01$. Inspection of effect sizes by comparison type revealed the most favorable effects noted when CBT-CP was compared to psychoeducation ($g = -.55$), with more equitable effects noted with TAU ($g = -.27$) and acceptance and commitment therapy ($g = -.05$) comparisons. By contrast, effect sizes associated with exercise-based interventions revealed a trend toward slightly outperforming CBT-CP ($g = .17$). Subgroup analyses of differences between CBT-CP delivery modality and format resulted in visually apparent, but not statistically significant, differences. The three effect sizes associated with individual intervention were associated with larger treatment effects ($g = -.37$) when compared to seven in group format ($g = -.13$), yet were not statistically significant, $Q(1) = .98$, $p = .32$. Similarly, the two effect sizes related to telephone-based interventions resulted in larger effect sizes ($g = -.30$) than the eight associated with face

to face intervention (g = -.06), but were also not statistically significant, $Q(1)$ = .08, p = .77.

Publication bias. Inspection of the funnel plot of effect size-standard error combinations depicted a slightly asymmetrical pattern of outlier influence surrounding the mean effect wherein six effect sizes were situated to the left (therapeutic) side of the mean effect and four were situated to the right (non-therapeutic). Among these effect sizes, one (Otis et al., 2013) yielded the largest effect size within the sample yet featured a relatively small sample size (N = 19) which may have contributed to inclusion of some minor degree of sampling error when computing the mean effect. Trim and fill procedures revealed two effect sizes would need to be imputed into the right (non-therapeutic) side of the distribution parameters to generate hypothetical symmetry. If these two effect sizes existed and were included within the sample of studies, the mean effect would be decreased slightly, g = -.12 (-.30, .05), p > .05. This sample yielded a N_f of 42 indicating that 42 unpublished studies with an effect size of zero would need to be included in the sample of effect sizes for the combined p-value to exceed .05. Hence, we would need to locate 4.2 missing effect sizes for every one observed in our sample for the mean effect to be nullified.

Discussion

The results of our systematic search, methodological quality review, and meta-analyses have provided an overview of the available CBT-CP treatment literature, its methodological characteristics, and related effectiveness. Our results depicted the evidentiary support for CBT-CP with veterans as characterized by limited number of studies for review based on our time period (j = 7), mixed methodological quality, and treatment effects that were slightly more impactful than other included modalities with the exception of exercise-based interventions. Thus, a picture has emerged wherein all of the included treatment types, formats, and modalities included within our review appear helpful to veterans in some degree, yet none has been identified as unequivocally superior, including CBT-CP.

This is concerning given Nahlin's (2017) findings that nearly two-thirds of veterans experience some degree of persistent pain, with roughly 1 in 10 describing that pain as severe.

The number of eligible studies (j = 7) and related effect sizes (k = 10) returned from our search was surprisingly low. Admittedly, the date range within our search was narrow and our trim and fill analysis indicated a statistical probability that two effect sizes may have been missing within a normal parametric distribution. However, hand searches of reference lists within training manuals and included articles were not fruitful for identifying additional studies featuring between-groups comparisons. This lack of studies is concerning because it appears that the publicly available corpus of studies available for consumption, critique, and consideration when making decisions about treatment choices for veterans is minimal. Further, outside of a few studies (Carmody et al., 2003; Donta et al., 2013), methodological features across studies were not particularly rigorous. This is potentially problematic given that studies with lower quality ratings were not only associated with larger effect sizes, but also more error when compared to studies with higher ratings. These considerations are concerning when contemplating the implications for veteran quality of life (Crosby et al., 2006), harm risk (Blakey et al., 2018), and taxpayer funded healthcare costs (Gatchel et al., 2014). Thus, we submit that as more studies emerge, increased rigor and consistency with journal article report standards such as those presented by Appelbaum et al. (2018) will promote greater trustworthiness and transparency of findings.

CBT-CP emerged as slightly more effective treatment option when compared to other viable interventions. Inspection of confidence intervals for our mean effect indicated that the true mean effect size for sample of studies could be as great as 37% of a standard deviation unit (still a small effect) or as small as zero (null finding). Further, evidence from moderator analyses indicated that observed treatment effect may have been largely a function of type of intervention being contrasted with CBT-CP. These finding was not entirely surprising given that chronic pain is a persistent ailment of which many participants may have experienced for quite some time. Thus, our results provide some support of Murphy et al.'s (2014)

proposition that the greatest impacts of CBT-CP may be observed when used as a complimentary, adjunctive, or adjuvant intervention rather than a standalone one. We propose that as innovations and revisions to the standard CBT-CP protocol are made over time, a more comprehensive depiction of observed and predictable treatments effect may follow.

Implications for Counselors Who Work with Veterans

Based on the convergence of our findings and practical experiences, a number of implications related to the treatment of chronic pain among veterans are worth mentioning. First, intervention options may be limited if working in the VA, but greater if working in a related clinic or other settings. Counselors working with the veteran population who continue to utilize CBT-CP may also consider utilizing additional services. The best approach to treatment for chronic pain may be a holistic one that enhances the impacts of CBT-CP. Therefore, counselors working in an integrated setting such as the VA should work closely with other providers including primary care physicians, physical therapists, dietitians, chiropractors, and even acupuncturists. In these instances, counselors may act as advocates for their patients with chronic pain to help connect them with appropriate referral during the counseling process.

Second, we suggest critical consideration and flexible use of the CBT-CP manual in ethical, culturally sensitive ways that may increase intervention impact. Counselors using the CBT-CP protocol may include adding additional sessions by prolonging specific topics. Topics including, but not limited to, relaxation skills and cognitive restructuring may be extended to multiple weeks if necessary. Counselors may also invite other professions in various disciplines to present on alternative treatments available. Some veterans may be unaware of treatment modalities other than medication, counselors can help to expand awareness through psychoeducation.

Third, some chronic pain may be attributed to traumatic events wherein the psychological effects of trauma can manifest in physical pain. Counselors using CBT-CP should consider a veteran's history of traumatic events and the degree that pain is related to a traumatic event, such as

exposure to an IED blast which killed a comrade. In such cases, counselors may consider treating the trauma first or concurrently, or referring to another clinician because unresolved trauma may hinder any potential improvement of chronic pain.

Finally, much of the evidence related to CBT-CP effectiveness has been garnered through VA and university collaborations. Although these partnerships have yielded some valuable evidence for consideration by clinicians, administrators, and policy makers, there is a considerable amount of practice-based evidence portraying intervention effects at local clinics throughout the United States which is not represented in the literature. Therefore, scientist-practitioners and quality improvement specialists associated with veterans' care facilities may represent a practical source of invaluable information for increasing the CBT-CP literature base.

Limitations and Recommendations for Future Research

Although our findings have provided some depictions of the CBT-CP literature and effectiveness, several caveats warrant discussion. Table 1 depicts not only a small number of between-groups studies, but also some key features such as mean age, participant characteristics, and source of pain that were unreported. Although these studies implemented experimental controls to promote precision and experimental validity, the absence of this reporting provides a barrier for generalization to the larger veteran population. Until a considerable amount of future studies are added to the literature, findings such as ours may be regarded as providing more guidance than primary studies alone, yet not wholly representative of intervention effects. Thus, without the completion of well-designed primary studies of CBT-CP, more convincing depictions of treatment effectiveness and related moderators will not be possible. Although treatment as usual comparisons are helpful, studies evaluating CBT-CP to other manualized therapies or exercise-based protocols with large and diverse samples of veterans will support meta-analysts in providing the type of information can support clinical, administrative, and legislative decision making.

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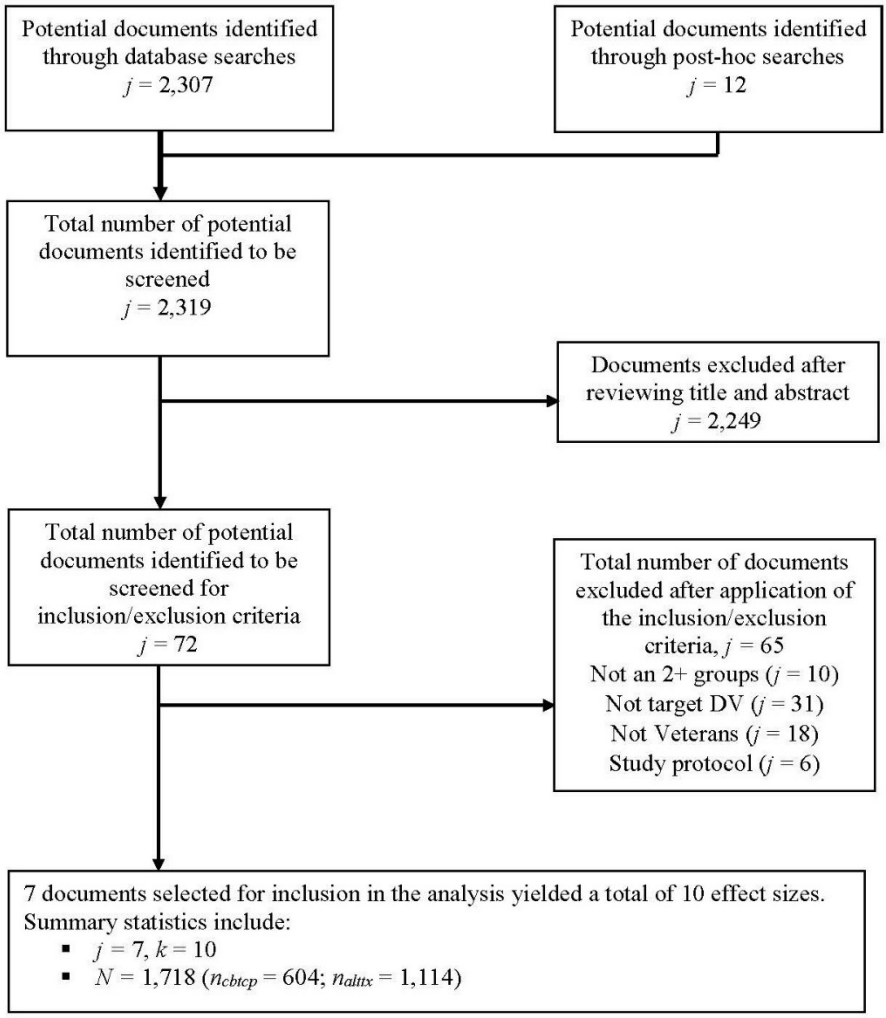


Figure 1
Depiction of Search Strategy, Yielded Studies, and Final Sample of Studies.

Table 1.
Characteristics of Studies Included in Meta-Analyses and Narrative Review

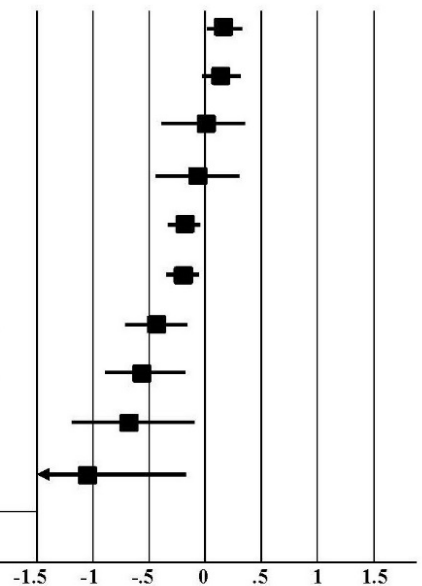
Study	CBT Treatment Length & Format	*N*	Mean Age	Sample Characteristics	Source of Chronic Pain	Relevant Outcome Variables	Study Quality
Donta et al. (2003)	12, 60 to 90-minute sessions delivered weekly in face-to-face group format	1,092	40	Men (n = 930) and women (n = 162) who were reported as Caucasian (n = 575), African American (n = 266), Hispanic (n = 214), and Other (n = 37).	Mixed idiopathic chronic pain conditions	Typical Level of Pain	9
Arb (2004)	6, 60-minute sessions delivered weekly in face-to-face group format	43	49	Men (n = 41) and women (n = 2) who were reported as Caucasian (n = 27), African American (n = 12), Hispanic (n = 2), and Other (n = 2).	Mixed idiopathic chronic pain conditions	Average Pain	5
Otis et al. (2013)	11, 60-minute sessions delivered in face-to-face individual format	19	**	**	Diabetes mellitus type II	Pain Severity Depression	6
Carmody et al. (2013)	12 sessions delivered in telephone-based individual format	98	66	Men (n = 95) and women (n = 3) who were reported as Caucasian (n = 67), and Other (n = 31).	**	Pain Intensity Depression	10
Cosio (2015)	12, 60-minute sessions delivered weekly in face-to-face group format	96	**	Men (n = 86) and women (n = 10) who were reported as African American (n = 75), Caucasian (n = 15), and Hispanic (n = 6).	Mixed idiopathic chronic pain conditions	Pain Severity	6
Bair et al. (2015)	6, 45-minute sessions delivered bi-weekly telephone-based individual format	241	36	Men (n = 213) and women (n = 28) who were reported as Caucasian (n = 185), African American (n = 31), and Other (n = 22).	Mixed idiopathic chronic pain conditions	Pain Severity	7
Ilgen et al. (2016)	10, 60-minute sessions delivered weekly in face-to-face group format	129	51	Men (n = 115) and women (n = 14) who were reported as Caucasian (n = 76) and Other (n = 53).	**	Pain Intensity	5

Note. ** = information not reported in source document.

Figure 2

Sample Sizes, Comparison Types, Effect Sizes, 95% Confidence Intervals, and p-Values for Studies Evaluating CBT-CP for Decreasing Symptoms of Chronic Pain based on Alternative Treatment Comparisons

Study	*N*	Comparison	Effect Size with 95% CI	*p*
Donta et al. (2003)	535	Exercise	.18 [.01, .35]	.03
Donta et al. (2003)	555	Exercise	.16 [-.01, .32]	.06
Carmody et al. (2013)	98	TAU	.00 [-.39, .39]	1
Cosio (2015)	96	ACT	-.05 [-.45, .34]	.79
Donta et al. (2003)	557	TAU	-.18 [-.35, -.01]	.03
Donta et al. (2003)	537	TAU	-.20 [-.37, -.02]	.02
Bair et al. (2015)	241	TAU	-.42 [-.68, -.17]	< .01
Ilgen et al. (2016)	129	EDU	-.55 [-.90, -.20]	< .01
Arb (2004)	43	TAU	-.64 [-1.18, -.09]	.02
Otis et al. (2013)	19	TAU	-1.02 [-1.88, -.16]	.02
		Mean Effect Size	-.19 [-.37, .00]	.04



Note. Negative effect size values indicate that treatment outcomes favor CBT-CP; positive effect size values indicate that treatment outcomes favor alternative treatments. TAU = treatment as usual; ACT = acceptance and commitment therapy; EDU = educational intervention.

Evidence-Based Treatment for Women Veterans Who Have Experienced Military Sexual Trauma: What Civilian Counselors Need to Know

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The U.S. Department of Veteran Affairs (VA) currently endorses cognitive processing therapy (CPT) as a primary treatment of military sexual trauma (MST) for veterans. However not all veterans, particularly women, seek counseling services through the VA. The authors of this article provide an overview of military culture, effective practices including cognitive behavioral therapy (CBT) and CPT for treatment of MST, and clinical implications and competencies for civilian counselors in their work with women veterans that have experienced MST.

Keywords: women veterans, military sexual trauma, cognitive processing therapy

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Clinical research on veterans and their experiences with combat, trauma, and posttraumatic stress disorder (PTSD) has focused on males, largely for two reasons: 1) male veterans outnumber women veterans, and 2) historically, male troops are more often exposed to combat than female troops (Mattocks et al., 2012). Although military sexual trauma (MST) has been a long-standing issue within the military, it has often been

overshadowed in research by other combat-related traumas (Kintzle et al., 2015). However, MST in veterans has emerged as a focus in trauma research, along with a burgeoning effort to study best practices for treating symptoms of this specific trauma (Mattocks et al., 2012). There is evidence that women veterans select civilian counselors rather than treatment through the Veterans Health Administration (VHA) system due to stigma and concern of negative repercussions within the military (Coll, Weiss, & Yarvis, 2011; Koo & Maguen, 2014). Further, Karlin and Cross (2014) reported that women veterans preferred civilian counselors due to the veterans' limited knowledge of available services within the VHA system and their disinterest in attending treatment within an overall male-dominated institution. Although referrals to the VHA's mental health services are available, women veterans who have experienced MST may feel more comfortable engaging in treatment within civilian communities.

The Veterans Affairs (VA; U.S. Department of Veterans Affairs, [USDVA], 2019b) defined MST as "experiences of sexual assault or repeated, threatening sexual harassment that a veteran experienced during his or her military service" (para. 1). This definition includes explicit and unwanted sexual contact or touching, threats of negative consequences if a service member does not engage in a sexual act, verbal remarks of a sexual nature, and inability to consent to a sexual act (USDVA, 2019b). In other words, MST encompasses both sexual assault and sexual harassment (Barth et al., 2016).

In 2018, Prosek and colleagues presented a detailed list of seven core competencies for civilian counselors as many of them provide services to veterans and military families: 1) military culture; 2) identity development (i.e., military and civilian identities); 3) family systems; 4) assessment of presenting concerns; 5) best practices in treatment approaches; 6) ethics and self-awareness; and 7) advocacy. The current article serves to extend Prosek et al.'s (2018) competencies for civilian practitioners when working specifically with women veterans who served in Operations Enduring Freedom and Iraqi Freedom (OEF/OIF). The following key competences for community-based counselors will be examined: an introductory guide to MST, military culture within the

context of women serving in the military, effective evidence-based treatments for MST, and implications when counseling women veterans. Although MST affects both men and women veterans, MST in OEF/OIF women veterans is the focus of this manuscript as this subpopulation is underrepresented in current literature due to their numerical minority status within the military. Additionally, women veterans are less likely than their male counterparts to have experienced combat and combat-related stress and trauma (Lloyd-Hazlett, 2016; Mattocks et al., 2012). Despite the limited exposure to combat and its related negative consequences for women veterans, the impact of combat-related trauma should not to be minimized.

Military Sexual Trauma and Women Veterans

Approximately two million veterans are women, with the average rate of women veterans expected to increase by 18,000 per year over the next decade (National Center for Veterans Analysis and Statistics, 2017). Of those two million women, the VA reports that 1 out of 5 women veterans have disclosed experiences of MST to their VHA healthcare providers (USDVA, 2017). This estimate may be lower than actual total cases due to women veterans' decision to refrain from receiving VHA healthcare services; for example, only 57.4% of OEF/OIF women veterans have reported seeing a VHA healthcare provider at least one time (USDVA, 2017), which indicates that nearly 43% of women veterans are not included in the VA's report on the frequency of MST (i.e., USDVA, 2017). Further, statistical analysis of survey responses from 4,352 OEF/OIF (deployed and non-deployed) women veterans revealed that 41.5% reported experiencing MST (Barth et al., 2016), an estimate that is more than double that reported by the VA (USDVA, 2017). MST is increasingly prevalent among OEF/OIF women veterans, indicating that a response of effective clinical mental health treatment is necessary.

Risk factors for the occurrence of MST in women veterans includes joining the military at a younger age, being recruited into an enlisted rank rather than as an officer, prior experience(s) of childhood sexual trauma, and lacking a college degree (Surís & Lind, 2008). Women who have

experienced MST are at an increased risk of developing depression, anxiety, PTSD, eating disorders, alcohol and substance abuse (Bell & Reardon, 2011; Mattocks et al., 2012; Surís & Lind, 2008), as well as physical ailments such as pelvic and back pain, menstrual issues, headaches, gastrointestinal problems, and chronic fatigue (Godfrey et al., 2015; Surís & Lind, 2008). The most common mental health diagnoses associated with MST include PTSD, mood disorders, and substance abuse (USDVA, 2012). Additionally, the severity of both physical and depressive symptoms among women veterans with MST is generally higher than those who have not experienced MST (Schuyler, Kintzle, Lucas, Moore, & Castro, 2016). It is important for counselors to be cognizant of these factors during their assessments of women veterans, especially those who report MST.

The U.S. Department of Veterans Affairs' Response to MST

The VA has developed a comprehensive response to the pervasiveness of MST for all veterans, which includes free physical and mental health services to those who self-report MST (USDVA, 2012). Furthermore, a veteran does not need to be enrolled in the VA healthcare system and does not need to have a VA disability claim or any proof of the occurrence of MST to access health services related to this specific trauma through the VA (Bell & Reardon, 2011). In addition to every VA medical center and facility having a designated MST Coordinator, community-based Vet Centers provide out-patient readjustment and PTSD counseling for veterans, including those who self-report experiences of MST (USDVA, 2012). In-patient treatment programs are available through VA healthcare medical centers at no cost to veterans. For preventative measures, the Sexual Assault Prevention and Response Office (SAPRO, n.d.) oversees the U.S. Department of Defense's prevention policies, trainings, and reports of sexual assaults. Through SAPRO's (n.d.) sexual assault initiatives, over one million service members and sexual assault program officials have received sexual assault prevention and response training.

Currently, the VA endorses trauma-focused therapy and counseling for PTSD, including cognitive behavioral therapy (CBT) and cognitive

processing therapy (CPT; USDVA, 2019a). CBT and CPT are effective evidence-based practices for the treatment of PTSD as well as MST in veterans (Monson et al., 2006; Surís, Link-Malcolm, Chard, Ahn, & North, 2013). Despite the VA's delivery of free mental health services to veterans, some women veterans opt for community mental health providers. Possible reasons for women veterans selecting civilian practitioners include reported dissatisfaction with VA services which include difficulty accessing and ease of using women's healthcare services as well as dissatisfaction with doctors' and other staff members' characteristics (Burgin, Prosek, & Atkins, 2017; Kelly et al., 2008). Despite the extensive amount of VA resources to address trauma-focused issues, Kelly et al. (2008) reported that MST is positively related to increased use of VHA services, but also with *increased dissatisfaction* (emphasis added). Additionally, the stigma and portrayal of weakness, as well as the fear of commanding officers discovering the service person's engagement in mental health services, can serve as deterrents for many veterans to seek mental health treatment within the VHA system (Coll et al., 2011).

The Impact of Military Culture for Women Veterans

The U.S. military is comprised of five service branches: Army, Navy, Air Force, Marines, and Coast Guard. While each branch retains its own subculture, there is an overarching military culture that engenders loyalty, self-restraint, obedience, teamwork, and integrity (Coll et al., 2011). The universality of these virtues results in acceptable, predictable thought patterns and behavioral responses in service members (Coll et al., 2011). For many veterans, military cultural values remain in both personal and professional functioning (Prosek et al., 2018).

While virtues and morals are a cornerstone of military culture, qualitative interviews of women veterans have reported experiences of their male counterparts engaging in sexually forthcoming behaviors and recounted such behavior as not only widely accepted, but also anticipated (Mattocks et al., 2012; Weitz, 2015). In fact, the term "command rape" refers to a higher ranking official demanding sex from a lower ranking service member, despite the clear abuse of power and authority (Bell &

Reardon, 2011, p. 37). Weitz (2015) described this acceptance of inappropriate behavior as part of a "masculinist institution [that is] dominated both by men and by cultural attitudes traditionally inculcated into men, such as a rejection of any signs of weakness" (p. 165). At the same time, military experience and training could possibly serve to assist in reducing feelings of vulnerability and fear of sexual assault through preparedness to defend and protect oneself. Weitz (2005) proposed that this concept challenges the notion of women being "responsible" for the occurrence of rape, and in fact, that military training serves to build a sense of camaraderie, solidarity, and trust with male troops. Within this male dominant institution, women veterans face the challenge of assimilating into, and eventually transitioning out of, a military subculture that does not necessarily value, protect, or serve them.

Despite free mental health services available to veterans through the VHA, a stigma remains when seeking mental health services (Prosek et al., 2018). Coll et al. (2011) suggested that many veterans are concerned that engagement with a counselor will result in negative repercussions within the military, and that help-seeking behaviors will be viewed as a sign of weakness within a culture that promotes strength. Furthermore, veterans who experienced MST are likely to struggle with conflicting identity development as both a strong service member and as a vulnerable victim of sexual assault (Bell & Reardon, 2011). In a quantitative study of 53 Post-9/11 women veterans who experienced MST, only 18% of the participants indicated seeking acute mental health and sexual abuse services (Kintzle et al., 2015); however, 76% of the participants reported seeking mental health services within a year of the incident. The researchers (Kintzle et al., 2015) highlighted the difficulty that women veterans face in reporting and seeking services for MST while still actively serving.

The military environment is generally closed-off from the civilian world, and functions independently, which can also make avoiding or escaping repeated sexual offenses difficult (Surís et al., 2013). While military culture promotes unity within, once discharged from active duty service, veterans can experience feelings of isolation and ostracization from the civilian world (Coll et al., 2011). Such difficulties in readjustment to

civilian life can be exacerbated by prior exposure to military combat, violence, destruction, and/or MST (Coll et al., 2011). Although family and social support at times are a protective factor, relationships may be a source of stress for veterans experiencing interpersonal isolation (Prosek et al., 2018). For example, the veteran and her partner may experience a divergence in value systems between military and civilian culture and customs, leading to dissonance in decision making and heightened relationship stress. With many survivors of sexual assault and rape expressing hesitancy in disclosing their experiences to loved ones due to fear of negative reaction (Street, Bell, & Ready, 2011), withholding this information may cause a strain on family and/or partner relationships.

For women veterans, the avoidance of seeking mental health services through the VHA system involves a cultural belief amongst male and female troops that promotion of women within the military is linked to engagement in sexual favors (Koo & Maguen, 2014; Mattocks et al., 2012). Hence, a woman veteran may fear her reports of being sexually assaulted or raped would be dismissed by others as an attempt for professional gain. For women veterans, there is also the fear of negative repercussions in reporting the occurrence of MST, particularly if the perpetrator was a superior (Koo & Maguen, 2014). As a result, women veterans might avoid mental health services offered through the VHA system in efforts to escape a male-dominated institution (Karlin & Cross, 2014), or due to being wholly unaware of the VHA's mental health services (Karlin & Cross, 2014; Washington, Yano, Simon, & Sun, 2006) despite the VHA's efforts of outreach to veterans in need or in crisis. For example, in their survey of 2,174 women veterans, Washington et al. (2006) found that 48.8% of respondents reported that they had none or almost none of the information they needed regarding VA healthcare, and 42.7% held the false belief that the only veterans who are eligible for VA healthcare are those with a military-related injury or illness. It should be noted that although all veterans do not qualify for free healthcare and mental health services through the VHA, an exception is made when MST is self-reported; however, this action inherently requires an individual to report the sexual

abuse directly to the VA, which is information that women veterans may not choose to disclose (Koo & Maguen, 2014).

Development and Historical Context of CBT

Cognitive behavioral therapy (CBT) has roots in both cognitive and behavioral psychology, as well as influences from Freud's psychoanalytic framework (Beck & Weishaar, 2014). In its infancy, cognitive counseling primarily treated depression whereas behavioral therapy was designed exclusively to alter maladaptive behaviors. Today, CBT is accepted as an evidence-based practice used to treat a variety of mental health symptoms and disorders, including anxiety, depression, schizophrenia, and PTSD resulting from sexual trauma (Antony, 2014; Beck & Weishaar, 2014; Brown et al., 2016). Major contributors to the foundation of modern cognitive therapies and CBT include Aaron Beck, Albert Ellis, Joseph Wolpe, and Richard Lazarus.

Automatic thoughts are a cornerstone of CBT, which Beck and Clark (1997) described as responses to stimuli that are involuntary, difficult to regulate, and generally require low levels of cognitive processing and analysis. Conversely, controlled or systematic thought processing is intentional, requires effort and conscious awareness, is easier to regulate, and can result in conscious analysis of new information and stimuli (Beck & Clark, 1997). These two concepts established the foundation of modern CBT. According to contemporaries of CBT, cognitive distortions occur at various levels within a hierarchy of thoughts: "voluntary thoughts, continuous or automatic thoughts, underlying assumptions, and core beliefs" (Beck & Weishaar, 2014, p. 245). Hence, distorted thoughts are accessible and amenable to change.

Contemporary therapists implement CBT with the goal of altering cognitive distortions that influence maladaptive and dysfunctional thoughts, behaviors, and emotions (Beck & Weishaar, 2014). For those who have experienced trauma and PTSD, cognitive distortions are defined in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013) as "persistent and exaggerated negative beliefs or expectations about oneself, others, or the world" (p. 272)

that can lead to self-blame for the traumatic event. Trauma-related cognitive distortions occur when the traumatic event confirms preexisting negative beliefs about the world, or replaces previously-held beliefs with new, extreme thoughts. In the latter case, new thoughts are overgeneralized, which changes one's perception of the world as safe into a world characterized as dangerous and unforgiving (Dondanville et al., 2016).

CBT has faced criticism as being too standardized and mechanical, requiring additional training and skills to administer, and being rigid in techniques and delivery (Karlin & Cross, 2014). Regarding effectiveness of evidence-based treatments, such as CBT, it is generally assumed that training and supervision are sufficient to provide uniform and effective implementation of treatment, while ignoring factors relating to the individuality of therapists: interpersonal style, treatment delivery, and extent to which they challenge clients (Laska, Smith, Wislocki, Minami, & Wampold, 2013). As a result of these limitations, professional counselors may not select CBT in their practice despite its status as an evidence-based treatment (Karlin & Cross, 2014).

CBT and the Treatment of Trauma

From a CBT framework, PTSD is a result of a fear circuitry response to trauma. Specifically, hyperarousal and intrusive thoughts lead to avoidant and isolating behaviors. Such trauma-induced reactions are then challenged in counseling through exposure to fear-inducing stimuli and memories to weaken the conditioned response (Brown et al., 2016). Although past traumatic events can be addressed in therapy, the focus remains on the client's current thoughts, behaviors, and emotions (Beck & Weishaar, 2014). The therapeutic relationship between the counselor and veteran client is considered an integral aspect of effectively implemented CBT. Hence, a strong relationship serves to encourage vulnerable clients (such as MST survivors) to be more readily able to engage in therapy, which in turn could motivate clients to complete treatment (Karlin & Cross, 2014).

While CBT is largely endorsed as an evidence-based treatment for PTSD, Gerger et al.'s (2014) meta-analysis found that CBT was not superior to other evidence-based practices, which suggests other factors (e.g., client preference, accessibility of treatment) might influence treatment effectiveness. Additional criticism of CBT includes Brown et al.'s (2016) reported limitations regarding the concept of fear circuitry. These authors (Brown et al., 2016) challenged the assumption of all PTSD cases being a result of fear conditioning and proposed that adults with PTSD have already developed the ability to self-regulate emotions and cognitions. As a result, systematic cognitive process techniques that focus on fear are not sufficient to alleviate symptoms related to high arousal states (e.g., anger, disgust; Brown et al., 2016). Nevertheless, CBT remains an evidence-based treatment for combat trauma and PTSD, and a treatment that the VHA endorses to address trauma-related cognitive distortions (Dondanville et al., 2016; Karlin & Cross, 2014; USDVA, 2019a).

Development of CPT for Sexual Assault Victims

Drs. Patricia Resick, Candice Monson, and Kathleen Chard developed cognitive processing therapy (CPT) in response to the need for effective cognitive treatment of PTSD in victims of rape and sexual assault (CPTWeb, n.d.; Resick, Nishith, Weaver, Astin, & Feuer, 2002; Resick & Schnicke, 1992). This form of counseling is an information-emotional processing technique that consists of exposure (e.g., writing a narrative of the rape, induced imagery) and cognitive therapy (Resick et al., 2002). Written trauma narratives, as part of trauma-focused narrative therapy, have been incorporated with CPT in civilians diagnosed with PTSD (Mott, Galovski, Walsh, & Elwood, 2015). The founders of CPT posited that the experience of rape or sexual assault creates a new schema, or way of thinking, that contradicts previously held beliefs, which results in the expression of symptoms related to PTSD such as avoidance, intrusive thoughts, and hypervigilance (Resick & Schnicke, 1992).

Although grounded in Dr. Aaron Beck's CBT work, CPT includes unique characteristics regarding conceptualization and treatment. CBT counselors conceptualize PTSD psychopathology as a result of life events

(e.g., trauma) triggering previously held cognitive distortions into client's awareness (e.g., PTSD). On the other hand, CPT counselors suggest that life events cause a dissonance between previously held beliefs and new information, resulting in symptomology (Resicke & Schnicke, 1992). Hence, from a CPT perspective, a woman veteran can experience dissonance between her identity as a member of a cohesive unit in the military (i.e., previously held belief) and her new belief as identifying as an "outsider" as a result of experiencing MST (i.e., new information). With this scenario, the CBT counselor might focus on challenging distorted thought patterns (e.g., "If I tell others about being raped, they will think it was my fault") whereas the CPT counselor would identify and challenge specific conflicting beliefs between preexisting cognitions (e.g., self-worth, belonging) and new information from the experience of sexual assault (e.g., self-blame, insecurity; Resick & Schnicke, 1992).

In response to PTSD-related symptoms resulting from trauma, CBT counselors focus on the role of fear as well as cognitive and emotional fear reduction (Brown et al., 2016). However, according to a central tenet of CPT, PTSD evokes additional emotional reactions beyond fear (Resick & Schnicke, 1992). Therefore, instead of changing a fear response, CPT counselors focus on identifying conflicts between prior schemata (i.e., worldview, beliefs) and new information (i.e., the rape; Resick & Schnicke, 1992). Another distinction between the two approaches lies within the exploration of emotions. Unlike CBT, CPT focuses on the expression of emotion as a means for clients to identify their irrational beliefs (Brown et al., 2016; Rescick & Schnicke, 1992). It is important for counselors to keep in mind, that despite fundamental differences between CBT and CPT, CPT remains closely linked with the CBT framework from which it is derived.

Effective Treatment of MST in Women Veterans

CPT has been found to be an effective evidence-based treatment for combat-related PTSD symptoms in both men and women veterans (Monson et al., 2006), as well as for treatment of MST in women veterans (Surís et al., 2013; USDVA, 2019a). In a study consisting of 43 female and 9 male veterans who experienced MST, participants self-reported lower levels of

PTSD over the course of six months of CPT treatment; however, 35% of participants dropped out of treatment prior to completion (Surís et al., 2013). Although the authors (Surís et al., 2013) did not indicate participants who terminated prematurely by gender, they noted that participants who dropped out did not differ in baseline measures for PTSD and depression from those who completed CPT treatment.

In another study that included 351 male and female veterans receiving VA clinical services that included prolonged exposure (PE) therapy or CPT, 38.5% dropped out of counseling services prior to completion of treatment (Kehle-Forbes, Meis, Spoont, & Polusny, 2016). The authors of this study reported those participants assigned PE therapy were more likely to drop out than those who received CPT (Kehle-Forbes et al., 2016). This outcome suggests the role of client preference in treatment modality to overall treatment effectiveness (Gerger et al., 2014). As evidenced by the aforementioned studies, high dropout rates of veterans with MST (in addition to the lack of self-referrals for counseling services) remain a barrier to effective treatment (Kehle-Forbes et al., 2016; Surís et al., 2013).

Most MST research studies tend to focus on the effects of the trauma and the symptomology of PTSD rather than on treatment effectiveness (Voelkel, Pukay-Martin, Walter, & Chard, 2015). Steenkamp and Litz (2014) further contended that when researchers study the effectiveness of the VA's endorsed treatments of PTSD in veterans (including CPT), those researchers concluded these treatments work, but not necessarily that they "work well" (p. 706). For example, in one randomized clinical trial of veterans with MST, only "preliminary evidence" (Surís et al., 2013, p. 8) of the effectiveness of CPT was reported. However, researchers reported that CPT was more effective than person-centered therapy in the treatment of PTSD resulting from MST (Surís et al., 2013). In another study, CPT was not found to be effective in improving quality of life perceptions, such as relationships, daily activities, and health, in both men and women veterans with MST (Holliday, Williams, Bird, Mullen, & Surís, 2015).

Minimal research has examined the effectiveness of CBT and CPT treatment and variances in race, ethnicity, and sexual orientation (Holliday et al., 2015). These limited studies highlight the importance for researchers to conduct future studies on subpopulations of OEF/OIF women veterans rather than inferring that treatment shown to be effective for civilian women (Brown et al., 2016; Resick & Schnicke, 1992) who experienced sexual assault outside of military culture will be effective for women veterans.

Implications for Professional Counselors

Despite the availability of free mental health services through the VHA, veterans may choose to seek services from mental health providers within their civilian communities (Bell & Reardon, 2011), marking the importance for all professional counselors to familiarize themselves with military culture, related trauma, and effective treatments. Counselors should be aware that veterans may not readily disclose their experiences of MST, and therefore it is recommended that counselors include questions regarding experiences of sexual assault in their screenings (Bell & Reardon, 2011). To normalize the screening process for sexual assault with all clients, Street et al. (2011) recommended clinicians to include a statement such as, "Experiences like these are unfortunately so common that I ask these questions of all my patients" (p. 329). Street et al. (2011) also suggested that clinicians avoid using the terms "rape" and "assault" during an initial screening as such language may evoke strong emotional reactions; instead, asking "Has anyone ever touched you in a sexual way against your will?" (Street et al., 2011, p. 330) relies on simple behavioral language. Additionally, clinicians should always immediately validate a client who discloses any experiences of sexual trauma (Street et al., 2011). Conard, Young, Hogan, and Armstrong (2014) reported that women veterans may even be reluctant to disclose their veteran status, and recommended civilian-based service providers to ask all women clients "Have you ever served in the military?" (p. 281). Rather than asking for veterans to self-identify, the aforementioned question includes both peace and wartime duties.

It is important for civilian-based mental health counselors to have an awareness of basic military culture, issues women OEF/OIF veterans who have experienced MST continue to face, and effective evidence-based practices (Koo & Maguen, 2014). Professional counselors who have worked with male veterans should be mindful that women veterans' experiences within the military may be vastly different, hence a gender-sensitive lens is suggested for conceptualization purposes (Lloyd-Hazlett, 2016). For example, Lloyd-Hazlett (2016) suggested that counselors assist women veterans in understanding their experiences, mental health symptoms, and other social challenges within the contexts of military culture, civilian society, in addition to social constructions and expectations of gender. In this socially-just approach, counselors can empower clients as well as use their role as the mental health practitioner to serve as change agents within oppressive systems. Additionally, counselors are encouraged to conceptualize gender not as a descriptive category (i.e., differences between male and female veterans) but rather as an analytical category (i.e., understanding gender and gender norms as related to and influencing experiences in the military and in civilian life; Eichler, 2016).

The VHA endorses the use of CBT and CPT as effective evidence-based practices for the treatment of MST (USDVA, 2019a). Furthermore, research on VA counselors receiving training in CBT to treat depression supported that these counselors had increased evidence-based competencies as well as confidence to perform CBT (Karlin et al., 2012). Unfortunately, this type of widespread training within an organization is uncommon, and civilian-based mental health counselors, such as those in private practice, may find it challenging to acquire the financial means to obtain these evidence-based practices when working with women veterans. Further, some counselors have challenged the rigidity of cognitive therapies regarding effective implementation (Karlin & Cross, 2014; Volungis, 2019) and have found the additional training too cumbersome (Karlin & Cross, 2014). Additionally, Rodriguez-Quintana and Lewis (2018) conducted a systematic review of 81 peer-reviewed studies that evaluated CBT and treatment fidelity, and found inconsistency among authors' reports on how

CBT training was conducted (e.g., in-person, video, manuals), with training duration described in just one out of 81 studies.

Despite reported inconsistencies to the CBT training process, as well as possible financial limitations and personal biases towards CBT, the VHA's best practice guidelines can be implemented with veteran clients at the community-based level. For example, clients can play an instrumental role in the treatment development process to promote engagement and motivation throughout counseling. To implement this technique, Karlin and Cross (2014) suggested clients to co-construct their treatment goals and determine how counseling will assist them in achieving those goals. Clients can also collaborate with civilian counselors in examining their symptoms and the consequences of them, as well as discussing potential obstacles they foresee to impede their treatment goals (Karlin & Cross, 2014). OEF/OIF women veterans with MST may experience difficulty with authority or being in a position in which there is a perceived or real power differential, which can include the counselor-client relationship (Bell & Reardon, 2011). Therefore, it behooves counselors to ask for client feedback regarding their perceptions of the relationship throughout treatment and to minimize the power differential whenever possible (Karlin & Cross, 2014).

While the VA endorses CBT and CPT as effective practices for the treatment of MST and PTSD (USDVA, 2017), additional research is needed to further understand effective treatment for OEF/OIF women veterans who have experienced MST. Most research on CPT has focused on the civilian population (e.g., Brown et al., 2016; Resick & Schnicke, 1992). A challenge of implementing CBT techniques among culturally diverse clients is incorporating strategies that are or may be inconsistent with clients' core beliefs, values, or expectations (Antony, 2014). Additional research is needed in examining OEF/OIF women veterans that highlight cultural identities and how such identities intersect (e.g., race, ethnicity, sexual orientation, gender and transgender identification) as influencing factors in effective treatment of MST. Holliday, Holder, Williamson, and Surís (2017) reported that CPT is an effective treatment for both White and Black veterans, yet more research is needed to explore

cultural responsiveness of CPT across and within cultures and across intersecting cultural identities. It is important for clinicians to be mindful that veteran status (Coll et al., 2011) as well as additional cultural identities (e.g., race, ethnicity, religious affiliation) can serve as deterrents for seeking out mental health services and/or disclosing sexual trauma (Street et al., 2011).

Conclusion

This article was intended to serve as an introduction for civilian mental health counselors to military culture and its role in treating women veteran clients, MST, and evidence-based practices for the treatment of MST in OEF/OIF women veterans. While many women veterans seek both physical and mental health services through the VHA, some may pursue treatment through civilian, community-based practices. For example, some women veterans may be deterred from seeking services offered within the VA, a historically male-dominated institution (Karlin & Cross, 2014) or may be unaware of the VA's increased mental health services and whether or not they are eligible to engage in them (Karlin & Cross, 2014; Washington et al., 2006). Thus, it is important for civilian counselors to be cognizant of basic military culture and best practices for working with women veterans who have experienced MST. Furthermore, it is important for professional counselors to develop an understanding of the roles and experiences of women within the military and military culture, including the conflicting identity development as both a strong service member and as a vulnerable victim of sexual assault for those women who have experienced MST (Bell & Reardon, 2011).

Overall, our intent was to build upon Prosek et al.'s (2018) competencies for professional counselors who are working with military populations with an intentional focus on OEF/OIF women veterans who have experienced MST. We have demonstrated the importance of professional counselors working with this particular population to have an awareness of competencies related to both military culture and evidence-based practices for MST, including CBT and CPT. Future research and clinical implications should include an examination of culturally and

racially inclusive counseling techniques that highlight how a variety of a woman veteran's identities (e.g., race, ethnicity, sexual orientation, gender and transgender identification) intersect.

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Wellness-Focused Supervision for Counselors Working with Military Service Members and Veterans

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Providing counseling to military service members and veterans presents a unique constellation of considerations for providers. The context of the military, exposure to traumatic events, and other service-related experiences can impact counselors working with this population. To ensure the wellness of providers, utilizing Wellness-focused supervision as a mechanism of support can prevent and remediate deleterious outcomes associated with clinical contact with this population. Utilizing Wellness principles informed by an understanding of the unique experiences of counselors assisting military service members and veterans creates a responsive supervisory environment fostering positive counselor growth and development. This article discusses the mental health landscape of service members and veterans, the context of the military, and the implementation of Wellness-focused supervision for counselors serving this population. A case study is discussed to further illustrate the application of this model.

Keywords: counseling military, clinical supervision, Wellness-focused supervision

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Military service members and veterans often experience unique circumstances associated with their service. Members of this population encounter specific experiences differentiated from a civilian existence such as engagement in combat; transitioning from military to civilian life; and career development considerations. There are indications that military service members and veterans of recent military conflicts are at an elevated risk of mental health challenges related to their service (Hom, Stanley, Schneider, & Joiner, 2017). Counselors who work with this population are exposed to clinical content that can unearth personal and professional concerns for those providing services. Clinical supervision provides a modality of support that can assist counselors struggling with issues associated with counseling military service members and veterans.

Given the nature of the combat-related service, mental health concerns such as Posttraumatic Stress Disorder (PTSD, American Psychiatric Association, 2013), depression, suicide, and transitional stress exist within military populations. There are indications of a high prevalence of Major Depressive Episodes and Generalized Anxiety among service members (Kessler et al., 2014; Rosellini et al., 2015; Stein et al., 2015). In addition, those who serve are at an increased risk of suicide (LeardMann et al. 2013; Shen, Cunha, & Williams, 2016) and suicidal behaviors (Nock et al., 2014) associated with major depression. Military service members experience unique stressors specific to pre-deployment, deployment, and post-deployment phases of deployment (Esposito-Smythers et al., 2011). In terms of PTSD, there are differences in the estimated rates of this condition across eras of combat such as Operations Iraqi Freedom (OIF) and Enduring Freedom (OEF) (11-20%), the Gulf War (Desert Storm) (12%), and the Vietnam War (30%). Regardless of the era of combat, rates of PTSD are higher than the estimated 7-8% in the general population (National Center for PTSD, n.d.).

By extension, counselors working with military service members and veterans will likely encounter clients experiencing PTSD and other mental health concerns. Continual exposure to trauma in clinical work increases the likelihood of negative well-being on the part of providers (Brady, Guy, Poelstra, & Brokaw, 1997; Chrestman, 1995; Cunningham,

1999; Kassan-Adams, 1995; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995). Counselors can be significantly impacted to the point of developing vicarious traumatization (VT) described as disruptions to a therapist's imagery system of memory, yielding painful experiences of images and emotions associated with clients' traumatic memories (Pearlman & Saakvitne, 1995). Though one experience with a client's traumatic issue can negatively affect the counselor, VT often manifests after repeated exposure to clients' traumatic narratives (Moulden & Firestone, 2007; Pearlman & Mac Ian, 1995). There is also the potential for first and second-hand exposure to traumatic events for counselors embedded in areas of conflict (Finklestein, Stein, Greene, Bronstein, & Solomon, 2015).

Given these considerations, it is essential to develop modalities of support to augment this effect. Clinical supervision provides a context of support in which to address deleterious concerns on the part of counselors assisting military service members and veterans. Counseling supervision is a mechanism in which to prepare, teach, and monitor the quality of counseling provided by supervisees (Evans, Wright, Murphy, & Maki, 2016). In summarizing empirical findings of several studies, Watkins, Budge, and Callahan (2015) found supervision contributed to favorable supervisee outcomes such as enhanced self-awareness, increased sense of practitioner self-efficacy, enhanced skill acquisition, enhanced treatment knowledge, and utilization, and strengthening of the supervisee-client relationship. Johnson, Johnson, and Landsinger (2018) discussed the use of trauma-informed supervision as a means to support counselors in deployed military settings to ensure well-being on the part of those who provide services in this context. We propose the use of a Wellness-focused model of supervision to assist counselors who provide services to military service members and veterans regardless of the context in which counseling occurs. To better understand the experience of counselors providing services to this population, it is important to know the mental health landscape of those who serve.

Mental Health Concerns of Military Service Members and Veterans

Service members often experience little to no substantial ill effects related to their service, however there are those who are negatively impacted by their experiences in the military. When struggles arise, counselors may come in contact with these problematic issues via the therapeutic engagement. By extension, those providing supervision to these counselors are exposed to the traumatic experiences of clients. The following is a brief description of various concerns experienced by this population.

PTSD

PTSD can be experienced by anyone who suffers a particularly traumatic event. Military service members may develop PTSD in ways that are distinct from civilian populations. For example, soldiers in combat may experience trauma as a sustained event or series of events as opposed to a one-time occurrence, such as a severe car accident or sexual assault, which would be more typical in the civilian population. In response to combat conditions, hyper-arousal over time can further exacerbate the development of PTSD symptoms. Prolonged arousal of the sympathetic nervous system can lead to physical problems that further hinder emotional healing (Fragedakis & Toriello, 2014).

It is difficult to pinpoint the prevalence of PTSD among veterans due to issues of under-reporting and cultural stigma. Huang and Kashubeck-West (2015) found that, across all branches, military veterans' exposure to combat was positively correlated (r = .67) with developing PTSD. Fragedakis and Toriello (2014) report that between 12-30% of Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) veterans reported combat-related PTSD. Diagnosis of PTSD may be further complicated as some service members and veterans do not meet the full criteria for diagnosis, yet bear the burden of debilitating symptoms. In addition, there exists a high rate of co-morbidity between PTSD and other adjustment difficulties (Huang & Kashubeck-West). Of particular concern for counselors, elevated risks of developing major depressive disorder co-

exist with PTSD, increasing the risk of suicidal intention (Fragedakis & Toriello). PTSD can be complicated by the severity and duration of the initiating traumatic event, the resulting course of development (e.g., sustained vs. distinct), and barriers to treatment following the event. Counselors must assess for these various factors in order to make the most effective treatment decisions (Fragedakis & Toriello). In sum, approximately 77.3% of active-duty service members hospitalized with PTSD had co-morbid diagnoses, including mental health and substance abuse issues (APA, 2015).

MTBI

Mild traumatic brain injury (MTBI) occurs when there is a form of impact to the head. These injuries frequently occur during violent, life-threatening experiences, and may be referred to as “shell shock” or “getting your bell rung” by soldiers in the field. Around 20% of soldiers who served in Afghanistan and Iraq experienced MTBI (APA, 2015; Jones, Young, & Leppma, 2010). Because a traumatic event within the context of combat such as an explosion causes MTBI, PTSD is a frequent co-occurrence, with co-morbidity rates ranging from 13%-84% (Jones et al.). MTBI does not cause the same degree of behavioral or cognitive dysfunction as more severe TBI. Because these injuries often go undetected during deployment, soldiers may seek treatment for symptoms weeks or months after the injury (Jones et al.).

Suicide

The rate of suicide among service members and veterans has been a particular focus of public concern over the past decade. Nock et al. (2014) indicated that in the past, military service members and veterans demonstrated lower rates of suicide than the civilian populations. However, in recent years, the Army suicide rate has risen dramatically while the civilian rate remains stable. For example, suicide rates among active-duty military personnel began rising in 2005 from 10 to 11 persons per 100,000 to 18 per 100,000. These rates leveled off in 2009. The highest rates of

suicide were among Army and Marine Corps service members (LeardMann et al., 2013). US Military suicides account for 20% of military deaths. Self-inflicted wounds accounted for 23% (2nd highest) of U.S. Active Duty Military deaths from 2006 - 2018 (Congressional Research Service, 2018)

There are many factors counselors and supervisors must be aware of when assessing for and treating suicidal ideation in service members or veterans. The strongest predictors for suicide are the appearance of mental health disorders including self-injurious behavior, major depression, and substance use disorders (Shen et al., 2016). PTSD is of particular concern, as veterans with this diagnosis are four times more likely to report suicidal ideation than those without a PTSD diagnosis (APA, 2015).

Time since deployment or separation from the military also seems to play an important role in the development of suicidal ideation. Shen et al. (2016) reported that suicide rates rose post-deployment and within one year of separation from the military. The risk of suicide nearly tripled in the first year after separation from military service and remained elevated six years after separation. The risk of suicide for those who served only a short time (six months or less) may be as much as 12 times higher than for those who served longer durations. The exact reasons for this disparity are unknown (Shen et al., 2016).

Factors prior to enlistment and deployment can also impact the development of suicidal ideation. Nock et al. (2014) found that the majority of those surveyed disclosed suicidal ideation prior to enlistment (58.3% of men and 57.6% of women). A history of law violations prior to enlistment also appears to correlate with elevated suicidal intention (Shen et al., 2016).

Sexual Violence

The Department of Defense (2017) military sexual assault report demonstrates positive trends as there was a 10% increase in reporting from the previous year, while the prevalence of assaults decreased by 45% since 2012. These numbers imply that stigma around reporting is decreasing, as is the frequency of the assaults themselves. Nevertheless, sexual assault remains a significant issue in military culture. During screening with a Veterans Administration (VA) provider, one in four women reported sexual

trauma, compared to one in 100 men. Women with a history of military sexual trauma (MST) are nine times more likely to develop PTSD than women without a history of MST (APA, 2015).

Violence

Perhaps the greatest risk of vicarious trauma (VT) for counselors lies in service members' descriptions of violent acts both witnessed and perpetrated. VT occurs when counselors experience a cognitive processing shift as their beliefs, attitudes, and perceptions about safety, trust, and control change as a result of repeatedly treating clients with significant trauma (Newell & MacNeil, 2010). In counseling military clients, counselors may be overwhelmed and under-prepared for the intensity of the narrative histories of these clients. Death, violence, and atrocities may surface. Grossman (2009) describes the inherent human resistance to taking life, and the desensitization that occurs during combat training to assist military service members in overcoming that resistance. Still, service members who witness or perpetuate violence or killing, particularly at close range, and particularly when personal honor has been compromised (such as killing civilians) often carry guilt, shame, and trauma (Grossman, 2009). If trust and rapport are built with a counselor, the session may involve recall of traumatic events that are shocking or disturbing to the counselor who has not been exposed to military-level violence before.

Other Concerns. On the whole, about one third of OIF/OEF veterans report mental health concerns (APA, 2015). In active-duty military, mental disorders are the second leading cause of role impairment (including days out and visits to health care providers) after physical injuries. Among active-duty military, the 30-day prevalence for mental health disorders was 25.1%, compared to 11.6% among civilians. Nearly half (49.6%) of active-duty military surveyed had at least one disorder prior to enlistment (Kessler et al. 2015).

Utilization of Mental Health Services

A recent meta-analysis indicates that 60% of military personal who struggle with mental health concerns do not seek treatment (Sharp et al., 2015). Stigma remains a significant barrier to mental health treatment for many active duty service members and veterans. Psychosocial barriers to treatment include cultural stigma (i.e. mental health issues seen as weakness), self-esteem issues (guilt or shame about needing help), concern about future advancement in the military if they ask for help, concerns about confidentiality, and concerns about weapons restrictions if they express thoughts of suicide or homicide (Fragedakis & Toriello, 2014).

In addition, a 2013 study demonstrated a lack of sufficient services to meet the mental health needs of active-duty service members and veterans, and insufficient training for providers in evidence-based practices (APA, 2015). Service members or veterans who feel their mental health counselors lack sufficient training or knowledge of military culture or trauma-specific treatment modalities may see counselors as untrustworthy, incompetent, or ineffective (Currier, McDermott, & McCormick, 2017). These perceptions, either real or imagined, are a significant issue that must be addressed in order to better meet the needs of military populations. Given this constellation of concerns, mental health counselors serving this population are in need of supportive mechanisms which equip them to encounter these concerns. Informed clinical supervisors are an essential tool for supporting military-affiliated counselors as they encounter these concerns and barriers to services. Apart from the mental health service concerns and other obstacles to care, the military environment presents a unique set of considerations worthy of attention.

Context of the Military

Apart from clinical concerns, the context of the military is a unique culture which infiltrates both counseling and supervision domains. This context has been indicated as a distinct culture by counselor educators (Hayden, Robertson, & Kennelly, 2018). The military melds a diverse array of cultural elements (e.g., race, gender, socio-economic class), and also

possesses unique and distinct cultural elements of its own. Military service members live and work in "The Fortress", a unique cultural structure where theses defenders of democracy do not function within a democratic system. Authoritarianism, hierarchy, and conformity are stressed (Hall, 2011). Counselors who have never served in the military or who have limited experience with military service members or veterans may be unfamiliar or uncomfortable with cultural aspects of the military. When working with military-affiliated clients, the counselor may be perceived as the authority (i.e., higher rank, officer) and thus building trust and rapport may prove challenging in establishing an egalitarian relationship with clients (Hall, 2011).

Military service members inherently possess or are indoctrinated into a set of self-expectations including the warrior ethos: Strength, emotional control, self-sacrifice, pride in accomplishing tasks without help, and fear of appearing weak (Cole, 2014). In the warrior ethos, honor is to be maintained at all costs. This commitment means that service members may struggle with guilt or shame about what they have seen or done and may be reluctant to share their actions with people outside of the military (Hall, 2011). In addition, frequent deployments may further distance active-duty military from family members and friends, straining those bonds and creating a sense of isolation once the service person returns home (Hall).

Though liabilities may result from military culture, beneficial characteristics exist that can assist the client in overcoming challenges and inform intervention. Once rapport is built with a counselor, military clients can engage qualities of strength, integrity, and honor to make real progress toward a healthier life. Learning the unique jargon, ethics, standards, and beliefs within military culture informs both counselor and supervisor of important aspects of this context that may influence the helping relationship. In relation to specific counseling strategies, incorporating strengths-based approaches or cognitive techniques that appeal to the progress orientation in the military leverages the context to the benefit of the counselor. Finally, focusing on short-term, evidence-based practices that bring concrete, rapid change (as long-term counseling might not be

possible for service members on the move) accounts for the reality of unanticipated termination due to deployment or reassignment (Hall, 2011).

Examination of Personal and Cultural Biases

Whether counselors are pro-military advocates, fierce pacifists, or somewhere in between, coming to terms with personal biases and stereotypes is an essential process in developing cultural understanding and awareness. The Multicultural and Social Justice Counseling Competencies developed by the Association for Multicultural Counseling and Development (Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2015) encourages counselors to examine their beliefs and attitudes, knowledge, and skills across three dimensions: counselor awareness of own cultural values and biases, counselor awareness of client's worldview, and culturally appropriate intervention strategies.

Supervisors can encourage counselors to self-reflect and enhance knowledge and skills in a variety of ways. Supervisors might perform a needs assessment to determine supervisees' perceptions of, and experience with, the military, uncovering any potential stereotypes or biases as well as areas for knowledge development (Strom et al., 2012). Opportunities for ongoing training to increase knowledge of military culture might include assigned readings, lectures, case study discussions, and field trips to area military organizations (Cole, 2014; Strom et al., 2012). Experiential knowledge might be gained through an immersive experience in the culture, e.g., volunteering on a military base or with a veteran organization. Though specific strategies are useful, adopting a theoretically-based approach when supervising counselors working with military service members and veterans provides a broader framework to inform supervisory interventions

Wellness-focused Clinical Supervision of Military-associated Counselors

Given the significant concerns inherent in military service members and veterans which will affect those who provide services, a Wellness-focused approach accounts for the impact of this work on counselors.

Models of wellness offer a holistic perspective by addressing physical, mental, social, emotional, and spiritual, as well as other aspects of individuals' lives (Ardell, 1988; Hettler, 1984; Myers & Sweeney, 2004; Myers, Sweeney, & Witmer, 2000). Wellness has been defined as a way of life focused toward optimal health and well-being. The body, mind and spirit are integrated, resulting in a life lived more fully within the human and natural community. This state of wellness exists on a continuum as opposed to an end state (Myers et al., 2000; Roscoe, 2009).

The Indivisible Self Model of Wellness (IS-Wel; Myers & Sweeney, 2004) is an evidence-based model of wellness (Hattie, Myers, & Sweeney, 2004; Myers & Sweeney, 2008) that can be applied to help supervisees address the conscious and unconscious effects of their counseling work as it relates to: (1) Coping Self (e.g., stress and burnout); (2) Essential Self (e.g., identity and self-care); (3) Creative Self (e.g., professional/work well-being and emotions); (4) Physical Self (e.g., physical health and eating habits); and (5) Social Self (e.g., interpersonal relationships and expressions of love). The IS-Wel model (Myers & Sweeney, 2004) is a holistic and interconnected nature of the model incorporating the opportunity for formal assessment of the five factors described above using the Five Factor Wellness Inventory (5F-Wel; Myers & Sweeney, 2005). A collaborative relationship that focuses on the strengths of supervisees also is a cornerstone to the wellness approach (Myers & Sweeney, 2008). An IS-Wel approach to supervision is structured to provide opportunities for supervisees to reflect on their emotional and cognitive resources to deal with the effects of their work.

Lenz and Smith (2010) introduced the Wellness Model of Supervision (WELMS) noting that when wellness is an essential part of the supervision process, the deleterious effects of trauma can be augmented or prevented. Educating supervisees about wellness, assessing supervisees' level of wellness, evaluating wellness throughout the supervisory relationship, and developing strategies to address supervisees' personal wellness are process elements of this approach. Investigation of the WELMS approach found that supervisees were better able to articulate their personal definition of wellness in comparison to other approaches as a

result of exposure to this framework (Lenz, Sangganjanavanich, Balkin, Oliver, & Smith, 2012). In addition, Wellness-focused supervision enhanced mental health counseling students' level of wellness (Meany-Walen, Davis-Gage, & Lindo, 2016).

The potential for vicarious traumatization and other associated effects warrant a holistic and wellness approach to the supervision of counselors assisting military service members and veterans. Hayden, Williams, Canto, and Finklea (2015) specifically described the manner in which a wellness approach can be utilized to address VT. To assist in understanding the dimensions of a wellness approach to supervision, specifically focused on counselors working with military service members and veterans, the following case study is provided to inform the manner in which to facilitate this process.

Case Study

To better understand the application of a Wellness-focused approach to supervising military-affiliated counselors, the following case study of a fictionalized clinical scenario is provided. The proposed application of this supervision approach is but one way to integrate concepts of wellness into counseling supervision.

Brian was a novice counselor working in private practice in a community within close proximity to a large military installation. He had extended family members and friends who served, but was not directly connected to anyone affiliated with the military. Recently, other members of the practice were primarily seeing military service members, veterans, and their family members who chose to seek services outside of military mental health to avoid potential concerns about stigmatization in seeking services. He had begun to serve military-affiliated clients due to need of the practice and his indicated interest in serving this population.

Brian's clinical supervisor, Tia, served in this role while he had been accruing hours toward counseling licensure in his state. Tia had served as a clinical supervisor for several of his clients and was confident in her capability to assist Brian. She operated from a wellness perspective both in her counseling work and in her supervision of other counselors. Focusing

on both prevention and remediation of supervisee concerns connected to their clinical work, indicating her own definition of wellness to supervisees, continually assessing supervisee's wellness, and providing support when issues of wellness are identified, characterized her work as a supervisor (Lenz, et al., 2012). They had been meeting weekly to process Brian's work.

In a supervision meeting, Tia noticed that Brian seemed less prepared for their meetings, with him not examining counseling notes beforehand and being somewhat withdrawn, evidenced by providing brief responses to questions as opposed to his usual manner of sharing expansive perceptions of his work. This occurred for a few sessions and Tia informally checked in with Brian about how he's doing and received minimal responses of "I'm okay" or "I'm a little tired, but doing alright." As Tia was concerned about his overall-wellbeing, she decided to formally evaluate Brian using the 5F-Wel assessment (Myers & Sweeney, 2014) to obtain a specific picture of his overall wellness. High scores on overall wellness along with specific dimensions indicate a greater degree of wellness.

Assessment

To obtain a comprehensive assessment of Brian's well-being across multiple domains, the 5F-Wel (Myers & Sweeney, 2005) was administered. Brian completed the 91-item measure rating the extent of his participation in wellness behaviors (e.g., exercise) or perceived wellness in different areas (e.g., self-esteem or social support) on a four-point Likert-type scale. He received scores on a 25–100 scale (with higher scores indicating higher wellness) for overall wellness, the five second-order factors, and the 17 third-order factors which provided specific information for Tia to inform her Wellness-focused supervision interventions.

The assessment data indicated Brian's well-being in relation to the IS-Wel model (Myers & Sweeney, 2004). Brian's overall wellness score was low, creating concern from Tia for his overall wellness. Results also indicated that Brian's Physical Wellness (i.e., exercise and nutrition) score was high. His Coping Self (i.e., leisure, stress management, self-worth, and

realistic beliefs) and Social Self (i.e., friendship and love) scores were low. His profile indicated high scores in the domains of Essential Self (i.e., spirituality and gender identity) and Creative Self (i.e., thinking, emotions, positive humor, work, and control). Tia shared the results of the assessment with Brian and he concurred that assessment results aligned with his perception of his current lived experience.

Wellness Plan

This information was used to guide specific interventions to support Brian. They collaborated to develop a Wellness plan to address his Coping and Social wellness. The plan was designed to inform both Brian and Tia of ways to support him in his overall wellness. While aspects of the plan focused on Brian, Tia also agreed to engage in certain actions to better support Brian's wellness. Tia indicated she would more consistently monitor the number of military-affiliated clients Brian was serving as it appeared aspects of this population's experience (such as exposure to trauma and significant stressors associated with the military experience) elicited a strong empathic reaction and detrimentally affected his well-being. Brian did not want to totally divest himself from working with military-associated clients, so he agreed that limiting the number and diversifying his caseload with civilian clients might improve his wellness in the domain of Coping Self.

Given the specific concerns of this population, Tia also provided Brian with information and resources on the culture of the military and the specific concerns service members and veterans encounter, such as PTSD and suicide. Given that Brian did not have first-hand knowledge of serving in the military, enhancing his awareness of their unique experience was beneficial as it contextualized these concerns and enhanced his competence in addressing these concerns.

Brian and Tia explored other strategies to address his areas of need indicated by the assessment. Brian indicated he would benefit from spending more time engaging in leisure activities, such as reading non-counseling related books and re-engaging with a running club to which he once belonged, as he valued exercising while also interacting with friends

with a shared interest. This would enhance his Coping, Physical, and Social Self wellness.

In addition, Brian shared that he had not spent time with several close friends as seeing clients on weekday nights and weekends to ensure he accrued necessary hours towards licensure did not align with their schedules. Brian and Tia discussed scheduling more daytime counseling appointments by participating in a school-based mental health counseling program that had recently been initiated in the practice. These strategies were targeted to improve Brian's wellness in the domains of his Coping and Social Self.

Case Study Outcome

Tia consistently checked in with Brian at subsequent supervision meetings to determine the effectiveness of the Wellness Plan. Brian was able to reconnect with the running group which was feasible for his work schedule and helpful with his Physical and Social wellness. His working more days as a mental health counselor in schools allowed more time to connect with friends which he reported enhanced his Social Self wellness.

Brian indicated he had not had as much time to read as he would like, but is aware of it and hopes to more fully enact this aspect of his plan. Tia encouraged Brian to do so, but would not be critical as she desired to support him in his wellness and affirmed that he had made significant progress.

In relation to Brian's work with military-affiliated clients, Tia was intentional in monitoring Brian's affective and cognitive reaction to his clinical engagement with members of this population. Brian became more willing to discuss these reactions as it became apparent this was an important aspect of his development as a professional counselor in relation to his overall wellness.

Continual monitoring occurred in future supervision sessions with Brian demonstrating steady improvement in his ability to deal with the stress of his work while living a fulfilling life. Though more growth was needed, his wellness improved making him better able to address the needs

of military service members and veterans while living a more balanced personal and professional life.

Conclusion

Providing services to military service members and veterans presents a specific set of considerations for counselors. To ensure quality services and counselor wellness, mechanisms of support such as clinical supervision are needed. A specific structure to supervision - such as a Wellness-focused approach - enables the supervisor to be intentional in the prevention, assessment, and remediation of threats to counselor-wellness stemming from contact with military-connected clients. Given the needs of that population and need for competent counselors to serve them, ongoing support is necessary for enhancing wellness both for those providing and receiving services.

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From the Barracks: A Multi-Dimensional Model of Student Veteran's Cultural Transition

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Using constructivist grounded theory, the authors present a multi-dimensional model of cultural transition between military and civilian culture based on individual and focus group interviews with 31 student veterans. Our grounded theory portrays 3 multidimensional strategies of acculturation during military-civilian transitions: (a) maintenance of military culture and identity, (b) acquisition of civilian culture, and (c) chameleonic adaptation in civilian cultural context. This new model provides a deeper, more precise conceptualization of how student veterans reintegrate into civilian society and higher education, while negotiating military and civilian identities. This model also supports veterans' heterogeneity by taking into account the degree to which participants affiliated to military culture and showing important differences between modest and strong military identity. Theoretical and practical relevance for counselors and counselor educators is discussed.

Keywords: student veterans, cultural transition, higher education

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A student veteran is defined as "a student who is a current or former member of the Active Duty Military, the National Guard, or Reserves regardless of deployment status, combat experience, or legal status as a Veteran" (Vacchi, 2012, p. 17). In 2009, the Post-9/11 Veterans' Educational Assistance Act, colloquially known as the Post-9/11 GI Bill, dramatically increased veterans' educational benefits (U.S. Department of Veterans Affairs, 2015), which facilitated the largest and most diverse influx of student veterans into higher education. The most recent data reports over one million veterans enrolled in colleges and universities across the nation (U.S. Department of Veterans Affairs, 2018).

One of the most significant challenges many student veterans experience upon entering college is the difference between military and civilian cultures (Lim, Interiano, Nowell, Tkacik, & Dahlberg, 2018; Rumann & Hamrick, 2010). They experience the push and pull of two cultural identities; one as a veteran with unique dispositions and values different than the traditional student, and the other as a student trying to integrate and adapt to civilian college life (Borsari, Yurasek, Miller, Murphy, McDevitt-Murphy, Martens et al., 2017). Rumann and Hamrick (2010) reported that by experiencing both military and academic contexts, student veterans inevitably engaged in identity negotiation as they adjusted to college culture. Considering the inexorable cultural tension between the two well-established social institutions, this study seeks to provide a deeper, more accurate conceptualization of student veterans' negotiation between military and civilian identities.

Military-Civilian Cultural Contrast

The existence of long-standing institutions can be attributed to the establishment of commonly accepted values, traditions, and missions, which Clifford Geertz defines as "culture" (1973, p.89). Given the benefits of the GI Bill, veterans encounter two of America's oldest social institutions: the military and higher education, each with their own set of established values, norms, customs, and traditions which prescribe them both as cultures following Geertz' description (Fennel, 2008; Moffat, 1991). However, stark cultural differences between the military and

institutions of higher education impact veteran's transitions between them (Ackerman, DiRamio, & Mitchell, 2009; Arminio, Grabosky, & Lang, 2015; Green, Dawson-Fend, Hayden, Crews, & Painter, 2016).

The military has a shared set of belief systems that informs service members' thought processes and behaviors (Arminio et al., 2015). Service members are required to learn the "military way" comprised of values such as collective identity, minimized individual expression, and indisputable respect for authority (Lim et al., 2018). Socialization begins with an intensive training colloquially known as "boot camp", (DiRamio & Jarvis, 2011) that typically occurs between the ages of 18-20, a critical period of identity formation. Throughout their training and service, military members learn to abide by the mission of the Department of Defense, "to deter war and protect the security" of the country (U.S. Department of Defense, 2018, para. 9). Therefore, many service members create a long-standing military identity that remains true even after they transition to civilian life.

Institutions of higher education foster a set of values and habits of mind that do not always translate well into military ideology (Moffat, 1991). Student veterans, like other underrepresented student populations, face additional hurdles as they navigate a culture that values independence, personal achievement, and individualism (Arminio et al., 2015; Lim et al., 2018; Vacchi, 2012). Military veterans also leave a highly structured and respected professional environment and enter a microcosm bound by syllabi, books, and traditional student life (Ackerman et al., 2009). They lived by principles of camaraderie to achieve a shared goal during their service (DiRamio & Jarvis, 2011). In higher education, the college student is focused almost entirely on personal goals and is not bound to the educational experience of his or her peers. Given the military-civilian cultural contrast, re-entering civilian life and becoming a student can be a significant cultural adjustment for many veterans (Ackerman et al., 2009; DiRamio & Jarvis, 2011, Lim et al., 2018).

Theoretical Framework on Student Veterans' Cultural Transition

Theoretical frameworks such as Schlossberg's (1984) adult transitional framework, Bronfenbrenner's (1989) ecological systems theory,

Bell's (1992) critical race theory, and Berry's (1997) acculturation model were previously used to comprehend service members' post-military transitions. Schlossberg's transition theory (1984) has paved the way for research on student veterans and is the most frequently used theory to date (Boettcher, Marten, Salmon, Smith, & Taylor, 2017; Rumann & Hamrick, 2010; Schiavone & Gentry, 2014). This model helped elucidate how for veterans, as adult students, the situation, self, support systems, and strategies can determine their transition to higher education. However, this model focuses primarily on a student's individual transition to higher education rather than approaching the transition from a cultural lens. This individual-level focus occludes the intricate cultural interplay between the military and civilian society (Arminio et al., 2015; Vacchi & Berger, 2014). Many student veterans must reconceptualize not only what they do professionally, but also how they behave, what values they believe in, and who they are as civilians.

Theoretical frameworks taking on a more cultural perspective highlight the cultural disparities between military and civilian identities and how these may impact student veterans' transitions. Arminio and her colleagues (2015) adopted Berry's (1997) model of acculturation in their recent study on student veteran transition. Berry defined acculturation as the intrapsychic changes that occur when dissimilar cultural groups encounter each other first-hand. According to this model, members of cultural minority groups vary across four possible resolutions to address cultural dissonance: (a) *assimilation* (dismissal of prior cultural identity and acceptance of new culture), (b) *rejection* (cultural retention of non-dominant culture and rejection of any new cultural beliefs, values, or practices), (c) *marginalization* (rejection of both cultures), and (d) *integration* (successful balance of cultural maintenance and participation between minority and dominant cultures) (Berry, 1997).

Arminio and colleagues (2015) provided a new, culturally informed perspective and challenged scholars to reconsider the role of cultural contexts, an important step in the right direction for research on student veterans' transition experiences. However, Berry's model holds a universalistic stance where "acculturation", as an umbrella terminology,

covers a larger body of cultural constructs (Schwartz, Unger, Zamboanga, Córdova, Mason, Huang, et al., 2015; Schwartz, Unger, Zamboanga, & Szapocznik, 2010). According to this model, veterans would reject military culture entirely, embrace civilian culture as whole, or integrate both cultures in every aspect of who they are. Since this model contains four acculturation categories that provide only four acculturative strategies, all veterans, regardless of their military affiliation, time, or experiences in the military, and adjustment to civilian society, would fall into one of those four categories. Conceptualizing acculturation as a monolithic construct ignores the different parts of the complex human experience during cultural transition (Schwartz et al., 2010).

Multidimensional Model of Acculturation

Schwartz and colleagues (2010) reconceptualized Berry's (1997) acculturation model by creating a framework that independently measures cultural changes across three domains. The first domain, *behavioral acculturation*, focused on cultural practices, such as language use and dress code (Schwartz et al., 2010). The second domain, *value acculturation*, referred to beliefs and values. The third domain, *identity acculturation*, evaluated solidarity and commitment with one's ethnic group (Schwartz et al., 2010). According to this model, acculturative changes at each domain do not occur at the same rate or in the same direction. Each domain operates independently from the others, meaning that acculturation is not a singular process occurring at a fixed pace. Instead, individuals can acquire receiving-society practices but completely reject a receiving-society identity, all while integrating values from both cultures (Schwartz et al., 2015).

Our study draws from theoretical frameworks previously described, yet presents a new conceptual model of student veterans' cultural transition based on grounded theory research with 31 student veterans to highlight the dialogical and multi-layered nature of their acculturation process. More specifically, the purpose of this study is to illuminate the middle space so many student veterans occupy—the gray area that constitutes integration of both military and civilian culture. A theoretical model expanding how we

conceptualize student veterans' cultural transition aligns with the Competencies for Counseling Military Populations (Burgin, Atkins, Weherman, Fenell, & Carter, 2018) by recognizing that counselors must comprehend the intricate cultural interplay between military and civilian culture to better support this population.

Methods

Reflecting on the primary purpose of our inquiry—to develop a model that more accurately explains student veterans' cultural integration of civilian and military identities—our study adopted a constructivist grounded theory approach (Charmaz, 2014). Constructivist grounded theory acknowledges the natural and formative influence of existing theories in the development of a grounded theory while preserving the inductive nature of the inquiry that highlights the authenticity and robust empirical evidence from the field (Charmaz, 2014). Grounded theory methods were used to fill in the void in existing scholarship lacking empirically-based, precise theoretical conceptualizations of student veterans' acculturation between military and civilian culture.

Context and Participants

This research was conducted in a large public university located in a rapidly-growing metropolitan area in the Southeast. After IRB approval, over 600 student veterans were contacted by the research team through direct emails provided by two administrative offices on campus. This research project was part of a formative evaluation funded by an external grant agency supporting student veterans in engineering programs. Thus, the first 20 student participants were recruited within the College of Engineering. To ensure diversity in race, gender, and program of choice, the second round of student recruitment invited non-engineering and racial/gender minority veterans as a theoretical sampling procedure (Charmaz, 2014). The total sample consisted of 31 student veterans, both at an undergraduate and graduate level. Table 1 provides further demographic information about the participants.

Data Collection and Analysis Procedures

The research team collected data through semi- structured individual (n=26) and focus group interviews (n=3) with 2-3 student veterans. Five student veterans volunteered to participate in both individual and group interviews. The interviews typically lasted from 60 to 90 minutes and were later transcribed verbatim. Transcribed interviews were also sent to each participant for verification and further insights, of which over half of our participants verified with no additional comments besides grammatical corrections to military verbiage.

The collaborative data analysis was an inherently reflective process during which we continuously reexamined and challenged our personal opinions on the subject; restraining our pre-understanding of the research phenomenon and remaining as open as possible to the voices of participants. The entire research team, consisting of five members with diverse professional and cultural backgrounds, contributed to data analysis. Following the general procedure of grounded theory analysis (Charmaz, 2014; Glaser & Strauss, 1967), the lead faculty investigator and two research assistants carefully read all interview transcripts and developed inductively-drawn open codes in order to identify key points and/or important aspects of the student veterans' transition experiences. We used constant comparative method, an analytic technique of grounded theory research, to compare similarities and variations across multiple participants (Glaser & Strauss, 1967). In order to make the coding process systematic and transparent, we used a qualitative data analysis software, *ATLAS.ti*, which enabled us to collaboratively revise and refine the codebook and efficiently build consensus on emerging codes and their applications to multiple transcripts. The initial codebook included over 150 open codes, later saturated into 101 codes under six main categories that structured our final three themes.

The data analysis took over 18 months as the team decided to go through theoretical sampling procedures and recruit additional student veterans from various disciplines. Throughout this period, three members had a weekly project meeting to discuss new insights and counter-evidence

until all three members agreed on the empirical ground for each major synthesis. The other two research members, an engineering faculty member and another Ph. D student veteran, served as a sounding board providing feedback on emerging themes and tentative interpretations proposed by the data analysis team. In the later stage of data analysis, the research team found that student veterans' successful transition did not require a uniform acculturation pattern, but rather exhibited significantly different levels of acculturation in varied domains (e.g., behaviors, values, and identity). As our inductive analysis supported the relevance of Schwartz et al.'s (2010) theory, we constructed our grounded theory by interpolating Schwartz et al.'s three dimensions of acculturation to highlight the uneven, yet successful transition outcomes as evidenced in our empirical data. Therefore, our study reflects the characteristics of constructivist grounded theory (Charmaz, 2014), which acknowledges the role of researchers' prior knowledge in—and its contribution to—data sensitization and theory development. The diverse research team's long-term, multi-disciplinary collaboration was also a fertile ground for authentic feedback from student veterans and critical self-reflection by the researchers, which are essential components in constructivist grounded theory (Charmaz, 2014).

Findings

As student veterans transitioned out of service into civilian society, all participants recognized their affiliation to cultural practices, values, and identities grounded in military culture. Nevertheless, participants displayed a continuum of military affiliation impacted by factors such as age at enlistment, years of military service, rank, gender, race, and overall attitude toward the military before enlistment. Student veterans engaged in three different acculturation strategies during reintegration: (a) maintenance of military culture and identity, (b) acquisition of civilian culture, and (c) chameleonic adaptation in civilian cultural context.

Maintenance of Military Culture and Identity

During the initial stage of transition, all student veterans attempted to retain practices and values of military culture acknowledged as helpful dispositions for success, while rejecting traditional practices and norms of higher education viewed as irresponsible and disrespectful. Their degree of military connection proved to be a significant determinant of how they experienced maintenance of military culture and identity.

Student veterans with low to modest military identity. For student veterans with a low to modest military socialization, maintenance of a military identity appeared to be less important than for those service members with a stronger affiliation. These findings applied to only eight participants who stood out on the low end of the continuum. Participants who reflected this type of military identity had either served for a limited time (=<4), lacked a military family background, had not experienced combat, and/or had entered the military with other professional goals in mind. As one student veteran stated, "the military was a means to an end." Their long-term professional goals never included the military and therefore their service was a necessary step rather than professional development.

Despite a low to modest military identity, these participants were still likely to embrace military cultural behaviors and values during and after their service. For example, military behaviors such as "always arriving 15 minutes early," "waking up early," and working "until the job was done" were viewed by all student veterans as desirable professional conduct. These students also continued to uphold and respect certain values of the military such as collectivism, perseverance, and respect for authority and leadership. They accounted these military behaviors and values as determining factors in their academic success. However, acquisition of military behaviors and values did not lead to a strong military identity across the eight participants for two main reasons. For some, pre-conceived perceptions of the military prevented a deeper socialization as evident in Saul's statement, "I never drank the Kool-Aid about being in the military. I never quite fit into that mold." For others, their military service simply didn't significantly impact their core identity. "My military service is a big

part of my life, but it was only four years of my life and I don't really define myself by it. It changed me, but I don't really like to define myself by it," explained Ryan, an Army student veteran.

Student veterans with strong military identity. Most student veterans felt a stronger connection to their military experience based on motivations to enlist (i.e. military family background, a calling to fight for their country, professional interest), combat experience, and longer service time (4+ years). For many, military culture had become a significant portion of their core identity. "I'll always be proud of my service and I'll always be a proud to be a Sailor. It's just part of my identity." expressed Peter, a Navy student veteran. The sense of camaraderie, social and professional purpose, and roles (i.e., leader, service member) they had acquired in the military was deep-seated into their self-concept, as detailed by Stafford,

> I spent nine months being in Kosovo and it definitely changed who I am. It's gonna sound a little cliché, but it kind of makes you realize who you actually are as a person. Everything is in your rucksack and you find out how you think, how you act, and how you interact with people.

However, student veterans with a strong military identity quickly realized that many military practices, such as blunt speech, were not well taken in the context of higher education. "It was hard. What worked in the military for me didn't work out here," stated Allan, a Marine student veteran. Some military values, such as collectivism, were not the cultural norm in both civilian society and higher education. All participants noticed that individualism was the prevailing cultural norm which caused emotional turmoil for many student veterans. Wayne explained that the individualistic-collectivistic pull developed "resentment." Surrounded by civilians whose cultural values were so different from theirs, student veterans experienced a deep sense of isolation, frustration, anxiety, confusion, loneliness, and even psychological distress such as depression. Service members with a strong military identity yearned for the world and

connections they had left behind and resented the new culture that required them to change. Thomas, another student veteran, explained how this difference in mindset impacted his ability to connect with others,

> I think it is a different standpoint. If you were to walk into a group of Soldiers in a classroom, it would be about an hour before you knew everybody's name and you knew what unit they were with, and everything. But there's just not the same level of connection here as you would expect in the military.

Acquisition of Civilian Culture

After the initial period of military-culture retention, some student veterans went through the process of assimilation into civilian culture. Participants described this process as "blending in" which involved (a) discarding military norms (e.g., proper attire, appearance, speech) and adopting civilian conventions; (b) accepting and acquiring values of higher education (i.e. independent thinking); and (c) proactively embracing their civilian identity (i.e. student, civilian, professional). However, this acculturative strategy played out differently based on the student veterans' military identification.

Student veterans with low to modest military identity. The acculturative strategy of "blending in" proved to be a smooth transition for student veterans with a relatively low military identity. "For me the transition wasn't hard. I just want to be treated like everybody else. I kind of swept my veteran-ness under the rug and moved on," explained Anton. Some student veterans admitted that their line of work in the military prevented a strong connection, proving an easier transition into civilian culture and identity. Roger explained,

> I feel more as if I worked for the government than the idea that I was a Marine. I worked on planes. So, I think it was easier for me to disconnect because I wasn't out patrolling. I never watched anybody get shot. So, I didn't have to keep up with that mentality.

In addition, a civilian identity also granted student veterans, who did not aspire to a military profession, the freedom to enjoy their adult life and explore a civilian career. “I think the whole being back was good for me. I had free time and all the freedoms…I wanted to just plan my career out from there on my own”, explained Mitchell. However, the acculturative strategy of complete civilian assimilation was only possible for three of the eight student veterans who expressed a low to modest military affiliation.

Student veterans with strong military identity. Many participants echoed that complete adoption of a civilian identity (i.e. “blending in”) meant redefining themselves as a civilian. “You don’t learn how to reestablish your own sense of identity in the civilian world. When you get out you have to reestablish who you are as a person outside of the military. Am I really the person that I thought or who am I?” explained Nicholas. Most participants also grieved aspects of their military identity that were lost during their transition to civilian culture. Patrick, an Air Force veteran explained this sentiment,

> You are in uniform one week and the following week you’re in civilian clothes going through the Transition Assistance Program. I mean it’s almost like grief. It was almost like having a loved one pass on and then being expected to handle all the legal paperwork during that time.

All participants recognized that higher education presented specific cultural values and behaviors that were significantly different from those of the military culture. Yet, most agreed that the acquisition of civilian cultural values and expectations was necessary to succeed. Maintenance of military culture prevented many of them from connecting with non-veteran peers. “If you identify yourself differently than 85% of the population, it's going to isolate you. It's going to keep you from reaching out for help and it's going to become a barrier,” explained Thomas. However, for those who had spent their formative years in the military and deeply immersed in this unique cultural environment “blending in” was extremely difficult, and for some, even impossible. “I've been through everything you can think of,”

stated Charles, a Marine student veteran. “But, that doesn't mean I will forget or get rid of everything I’ve become. I don't want to be 100% civilian because being in the military makes me unique.”

Chameleonic Adaptation in Civilian Cultural Contexts

Although the initial stage of military culture maintenance prevented smooth reintegration, complete assimilation to civilian culture was not the desired goal for most participants (n=27) either. Military identity closely aligned to most student veterans’ strong sense of purpose and pride as service members; they did not want to discard what they viewed as important behaviors, values, and expressions of their core identity. “You’ve become a different person. You’re operating with a different set of values and behaviors. Identity is deep and maybe it doesn’t change for everybody, but it does for most,” explained Wayne. Consequently, most student veterans believed and encouraged other student veterans to embrace a multi-dimensional self-concept that included aspects from both cultures, resembling a chameleonic adaptation. “I would tell other student veterans to move on to a civilian life, while holding on to aspects of that veteran life. Don’t be afraid to have one foot in the military and one foot in the civilian world,” explained Benjamin, a Navy student veteran. Participants voiced that they consciously chose which behaviors, values, and aspects of their identity would remain intact or be adapted by “turning it off and on,” as termed by several participants.

However, this process occurred in three different domains s (e.g. behavioral, value, and identity) on a continuum between military and civilian cultural contexts. Each domain acted independently from one another and movement towards a context on one domain did not necessarily influence the other two (see Figure 1). Wayne’s account described the complexity of this process. He acknowledged that behavioral changes were necessary to succeed in higher education.

> If reintegration is key, how do you integrate somebody? Well there are some things that I had to leave behind. Some things transfer, like leadership and discipline, but I can’t go into a corporate office and be the way I was in

> the military and expect it to be well received. It's not going to be.

Nevertheless, accepting values embraced in higher education were more emotionally taxing for him,

> The collectivism versus the individualism builds resentment. You don't want to be a part of that culture because you see that as selfish. All that stuff you were preaching about America being a team, protect your buddies. You'll take sacrifices. You'll give up food. You'll work through the night to do things for other people and then you come home to your awesome country and no one's like that.

Wayne also stated that although student veterans recognized a military-civilian cultural gap, American civilian culture was not a new or foreign concept to them. Most participants, except for two, were born and raised in the United States. However, their experiences in the military had changed them and trying to reconcile an American and military identity was difficult. Wayne explains his experience,

> Some veterans identify as Americans, for sure, because you put a flag on your shoulder for every single day of your life for years. [Then] you come to America and you don't feel like you're identifying with that place. That's the part that confuses me the most.

Discussion

This study illuminates the complex process of student veterans' reintegration into civilian society through higher education. Once again, we see the critical role played by the military-civilian cultural gap echoed in previous literature (Ackerman et al., 2009; Arminio et al., 2015). Findings from this study show that most student veterans felt pressured to adopt cultural norms embedded in the context of higher education, while attempting to hold on to a military identity. As a result, most participants adopted the most visible parts of civilian cultural norms and expectations (e.g., physical appearance and behaviors), yet kept less visible and deeper

cultural dimensions (e.g., strong sense of camaraderie among veterans, veteran identity) intact. As a result, a chameleonic adaptation to civilian contexts was identified as the most common and effective acculturative strategy. By consciously choosing how they integrated both cultures, they reduced cultural conflicts and any emotional turmoil present during their transition. However, our findings also highlighted the heterogeneity of this population (Vacchi, 2012). Participants displayed a continuum of military affiliation that proved to be a significant determinant of how they experienced military culture retention and civilian culture acquisition.

Findings from this study move beyond bi-dimensional models of cultural transition that ignore individuals' ability to negotiate different aspects of their identity construction in a specific cultural context. Student veterans reported a multi-dimensional process of cultural transition; they selectively retained elements of their military identity while purposefully deciding which civilian cultural norms to accept, reject, and/or negotiate. Participants' narratives demonstrated that different acculturation strategies across each dimension occurred simultaneously, yet independently. For example, participants with a low to modest military affiliation retained some behaviors and norms of their military service, while identifying to a great extent with their civilian identity. For participants with a strong military connection, acquiring behaviors and norms of civilian culture were necessary to succeed in higher education, but this change did not necessarily alter their core military identity. These findings showed that changes at the behavioral, value, or identity level did not occur at the same rate or in the same direction; a finding more in line with the multidimensional model of acculturation (Schwartz et al., 2010).

Based on a critical review of existing theories and evidence from our participants, our study introduces a new conceptual model. As a whole, our grounded theory model, a multidimensional model of student veterans' cultural transition, incorporates Schwarz and colleagues' (2010) domains into the military-civilian cultural gap that shapes so many student veterans' reintegration into American society. It also incorporates the significant role that higher education institutions play in this process (Ackerman et al., 2009; Arminio et al., 2015). Our participants felt that institutions of higher

education were a microcosm of the larger culture, an aspect that they both rejected and appreciated as they adjusted back into American life. The model also illuminates the heterogeneity of this population. Although most of our participants integrated both cultures, each student veteran disclosed a unique combination, with changes at each domain acting independently from one another. This model presents a framework for student veterans' cultural transition, while respecting each participant's subjective military affiliation and experiences in higher education.

Implications

Our study offers several important practical implications for helping professionals serving this population. Re-conceptualizing student veterans' cultural transition encourages cultural competence and understanding of military culture, its impact on service members, and unique with-in group cultural differences (Burgin et al., 2018). Using this theoretical framework as a guide can help students acknowledge military and civilian influence on their behaviors, values, and sense of identity without having to completely reject or assimilate to one culture. Lessening the pull between both worlds may help reduce feelings of isolation, anger, resentment, and sadness. It is important for counselors to understand that veterans are entering a culture that may be their own but that does not always connect to the person that they became after serving. This multidimensional model highlights the cultural aspect of this transition easily overlooked with a population whose members are typically stereotyped as the dominant group in American society. Finally, initiatives for diversity training that highlight veterans' experiences in higher education are encouraged to understand their complex identity development (Burgin et al., 2018; Lim et al., 2018). Therefore, as part of becoming "veteran friendly" counselors should encourage staff and faculty in institutions of higher education, counselor educators, other mental health providers, and any other person working with this population to incorporate this multidimensional model of cultural transition into their training. This new theoretical lens is an effective conceptual tool that moves beyond the existing deficit perspective that has limited student veterans' acculturation strategies to a *one size fits all*. This study aims to encourage a

more flexible and complex understanding of student veterans' civilian transition and identity reconfiguration through higher education.

Limitations and Future Research

Like all other research studies, our study is not without limitations; several recommendations were drawn based on the limitations of this study. A geographically diverse sample would provide a deeper and more complex understanding of student veteran reintegration and identity negotiation. Our sample consisted primarily of student veterans enrolled in an engineering department from one institution. Despite our efforts to increase gender and racial diversity, and invite non-engineering student veterans, our sample primarily consisted of Caucasian males in engineering. In addition, this study was conducted only with veterans enrolled in higher education after their service, excluding military populations on Active Duty, Reserve Component, and officers. The subsequent step is to increase gender representation, racial diversity, and understand how these with-in group differences, and the intersectionality of these traits with military status, impacts reintegration into civilian society. Finally, although this study engaged in an ongoing discussion with some participants over an extended period of time (2 years), multiple interviews with all participants at different stages of their transition would provide a longitudinal representation of their cultural transition.

Conclusion

We developed this study to better understand student veterans' cultural transition into higher education. Our grounded theory approach presents a multi-dimensional model of cultural transition that provides a deeper, more accurate conceptualization of how student veterans reintegrate into civilian society and higher education at three different levels. This model also elucidates veterans' heterogeneity by taking into account the degree to which participants affiliated to military culture, showing important differences between modest and strong military identity. Findings

from this study inform counselors of veterans' cultural transition while respecting individual differences between members of this population.

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Table 1
Participant Demographic Information

Pseudonym	Gender, Ethnicity	Military Branch (Years of Service)	Type of Interview
Saul	Male, Caucasian	Army (4)	Individual
Mitchell	Male, Caucasian	Army (4)	Individual
Steven	Male, Caucasian	Army (4)	Individual
Derek	Male, Caucasian	Air Force (20)	Individual
David	Male, Caucasian	Air Force (4)	Individual
Paul	Male, Caucasian	Navy (10)	Individual
Nicholas	Male, Caucasian	Army (5)	Individual, Group
Robert	Male, Indian	Navy (4)	Group
Allan	Male, Caucasian	Marine Corps (4)	Group
Justin	Male, Caucasian	Marine Corps (4)	Individual, Group
Seth	Male, Caucasian	Marine Corps (4)	Group
Maxwell	Male, Caucasian	Marine Corps (5)	Individual, Group
Anton	Male, Caucasian	Air Force (6)	Individual, Group
Jacob	Male, Caucasian	National Guard (5)	Group
Dayton	Male, Caucasian	Navy (4)	Individual
Dean	Male, Caucasian	Army (21)	Individual
Shaun	Male, Caucasian	Marine Corps (3)	Individual
Peter	Male, Caucasian	Navy (6)	Individual
Dalton	Male, Caucasian	Navy (5)	Individual
Jason	Male, Caucasian	Army (20)	Individual, Group
Brittany	Female, African-American	Navy (6)	Individual
Matthew	Male, African American	Marine Corps (5)	Individual
Wayne	Male, Hispanic	Army (6)	Individual
Patrick	Male, African-American	Air Force, (8)	Individual
Benjamin	Male, Biracial	Navy (3)	Individual
Thomas	Male, Caucasian	Army (4)	Individual
Charles	Male, Caucasian	Marine Corps (9)	Individual
Ryan	Male, Caucasian	Army (4)	Individual
Roger	Male, Caucasian	Marine Corps (4)	Individual
Stafford	Male, Caucasian	National Guard (6)	Individual
Tiffany	Female, African-American	Marine (8)	Individual

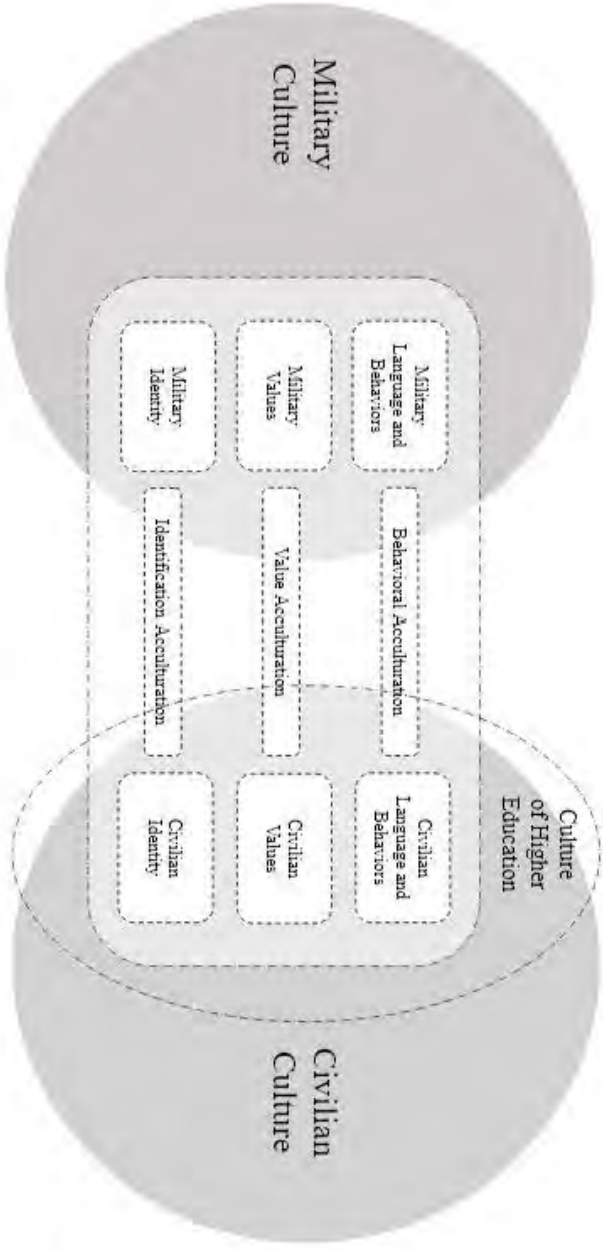

Figure 1. Multidimensional Model of Student Veterans' Cultural Transition

Cadets' Attitudes Toward Help-Seeking: The Effects of Language and Labels

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Reserve Officer Training Corps (ROTC) cadets (N = 179) completed a measure of attitudes toward seeking professional help for mental health concerns. Participants completed one of three versions of the same instrument, with the only difference being the term ("licensed clinician," "mental health counselor," or "psychologist") used to describe the professional. Cadets receiving the version with the term "licensed clinician" had the most positive attitudes toward seeking professional psychological care, significantly higher than those who received the version that used the term "psychologist." Implications for counselors, such as identifying barriers to cadets' help-seeking, are discussed.

Keywords: military, language, attitudes

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Professional counselors understand that words have power. Words influence identity, shape reality, and create shared understandings. Language shapes perceptions of the world and linguistic relativity (known as the Sapir-Whorf hypothesis) holds that language can influence cognitive processes and behaviors as well (Wolff & Holmes, 2011). From this perspective, language is a powerful tool that could be used intentionally to help lessen the stigma attached to mental health help-seeking. Strategies to lessen mental health stigma may be particularly important among populations that have traditionally been reluctant to access mental health

care, such as military-involved college students. Understanding how specific word choices can lessen stigma among this population could lead to increased mental health care utilization along with the associated benefits.

There is evidence that mental health help-seeking is influenced by language. A large-scale study of 207 people with untreated mental illness found that label-avoidance, or the reluctance to label oneself as having a mental illness, was the single largest barrier to help-seeking (Stolzenburg et al., 2017). Several other studies found that self-labeling as 'mentally ill,' with the cognitive appraisal of mental illness stigma as a stressor, led to more negative attitudes toward medication and psychotherapy among individuals at risk for psychosis, both at initial diagnosis, and at one-year follow-up (Rüsch et al., 2013; Ziyan et al, 2016). Another study found that the words that individuals used to describe their mental illness had a direct effect on treatment-seeking attitudes and behaviors. In this qualitative study of veterans with depression, a consistent response emerged to questions about help-seeking. Although very few participants used the word stigma, most veterans in the study used stigmatizing words or descriptions, such as "craziness, weakness, and inferiority" (Rodrigues et al., 2014, p. 137) to convey their negative experiences with depression. A further theme from this study was that depression was an unwanted label that participants did not want to adopt, and they expressed fear of appearing "'psycho' or 'crazy' to others, including family and friends" (p. 137). What was clear from the veterans in this study was that the language used to describe their mental illness had a clear effect on their help-seeking attitudes.

What is less clear from the research is the effect that the words or labels used to describe the helpers might have on help-seeking attitudes. Research demonstrates that when words are used to label others, the choice of the word used can have significant effects on attitudes and perceptions (Granello, 2019; Granello & Gibbs, 2016; Zyromski, Hudson, Baker, & Granello, 2019). When words are used as labels to define professions and professionals, the title of the profession itself becomes a symbol that implies a certain knowledge, skill set, power, and set of responsibilities associated with that profession (Martinez, Dana Laird, Martin, & Ferris,

2008). As early as 1962, research found that titles alone impact society's perception of an occupation, a finding that continues to hold true across various fields and professions (Caldwell, 2002; Hoque & Noon, 2001; Osipow, 1962; Pinto, Patanakul, & Pinto, 2016). Although research is limited about the effect that titles of mental health professionals might have on help-seeking, a 2009 study found that undergraduates were more likely to have negative perceptions about a helping professional labeled a 'shrink' than a 'psychologist,' to rate the professional labeled a 'shrink' lower on measures of expertise and intelligence, and to perceive the shrink as less caring, less helpful, and less humble than the psychologist (Gadon & Johnson, 2009). The results of this study support the overall premise that labels of professionals might have an impact on help-seeking. However, the Gadon and Johnson study cannot provide much specific assistance in determining which labels might lower stigma, as clearly no mental health professional would advertise their services as those of a 'shrink.' Thus, the current study seeks to understand, from a research perspective, what labels attached to mental health professionals might encourage help-seeking attitudes among a group of military-involved college students, such as Reserve Officer Training Corps (ROTC) cadets.

Language in the Military

As powerful as language is within all populations, language has a special importance to understanding military culture. Military culture is distinct, where military members, such as Soldiers, Sailors, Airmen, Guardsmen, and ROTC cadets, develop norms, formal structure, and unique identities that encompass a cultural group for military-connected individuals (Atuel & Castro, 2018). Communication styles (e.g., acronyms, jargon) and military language and terminology are unique to military culture that civilians may not readily understand (Atuel & Castro, 2018). In fact, the Department of Defense (2018a) created a 386-page document titled *DOD Dictionary of Military and Associated Terms* describing the way the military uses language. Not only is this dictionary useful for civilians to understand military language, this reference includes different terminology used based on branch. For instance, terms used in the Air Force (e.g., Air

Force special operations forces) or Army (e.g., Army air-ground system) may not be as useful to other branches, suggesting communication and language differs from within the military as well. Military members use language to indicate their ranks (e.g., officer, sergeant, lieutenant) as well as show respect for others (e.g., frequent use of "sir" or "ma'am") that may not be as highly valued by civilians. It is within this context that counselors must consider the language that they use when interacting with members of the military, from the moment that counselors reach out to help military-involved individuals connect to mental health services. Counselors must understand that language is an important aspect of military culture in order to effectively engage with military-connected individuals, such as ROTC cadets.

ROTC Cadets and Mental Health

The ROTC is a college program that prepares trainees (cadets) to become officers in the United States military (Department of Defense, n.d.). Over 1,700 colleges and universities across the country offer ROTC programs. ROTC cadets commit to serve in the military post-graduation and have their tuition paid in exchange. The branches of the ROTC are Army ROTC, Navy and Marine Corps ROTC, and Air Force ROTC. These different ROTC programs include academic study as well as military training to ensure the future officers are prepared for a successful military career. Throughout their training, ROTC cadets learn skills in leadership and technical training, as well as other trainings specific to their branch of the military. Upon graduation, cadets receive officer status in their branch of the military and are officially enlisted into the military. ROTC programs ensure that cadets are prepared to serve as officers in the U.S. military upon graduation.

The experiences that cadets have with stress and mental health while attending university has yet to be understood from a research perspective. Only recently have researchers given attention to understanding the mental health needs of college students who are veterans (Borsari et al., 2017), and this research may inform the experiences of cadets, due to some overlap by the nature of their status as military-

connected students. Nearly a third (28%) of veteran college students report difficulty adjusting to college life (Schonfeld et al., 2015). A few of the more commonly cited difficulties include attitudes about civilians and other students, social adjustment, and emotional problems. For instance, veteran students have reported that they perceive civilian students to be "liberal" and "anti-military" (p. 254), which can cause difficulty connecting with peers on campus (Osborne, 2014). It is possible that ROTC cadets may share some of these challenges with student veterans; however, there is a dearth of research that clarifies the unique mental health challenges of student-cadets while attending college.

Military Members and Help-Seeking

ROTC cadets operate within a military system where mental health and help-seeking continues to be heavily stigmatized (Bein, Grau, Saunders, deRoon-Cassini, 2019). The Department of Defense (2018b) has listed disqualifying conditions for appointment, enlistment, or induction into the military, which include a variety of mental health conditions. For instance, the military disqualifies anyone who has symptoms of, or received treatment for, depression and/or anxiety in the previous 36 months (Department of Defense, 2018b). Further, any suicidality (e.g., ideation, plan) is considered a disqualifying condition. Disqualifying conditions additionally include any history of eating disorders, post-traumatic stress disorder, obsessive-compulsive disorder, and others (Department of Defense, 2018b). Cadets who are aware of these disqualifying conditions may be hesitant to consider seeking help for their past and present mental health conditions. For those military members who do wish to seek treatment, there are many barriers, including institutional barriers, personal barriers, and stigma (Maung, Nilsson, Berkel, & Kelly, 2017). Research has yet to address how cadets perceive and experience these barriers.

We recognized a lack of research addressing the attitudes that ROTC cadets have toward seeking professional mental health care while they are university students. This dearth in the literature does not allow researchers, mental health professionals, or military members to understand cadets' perspectives on help-seeking for mental health concerns, which

limits knowledge of effective ways to serve the needs of this population. For example, research could identify how potential barriers (e.g., stigma associated with mental health in the military, disqualifying conditions) might affect cadets' decision to seek help. We chose to better understand how the use of language could positively impact cadets' attitudes toward help-seeking. Thus, this study examined the influence of language on ROTC cadets' attitudes toward seeking professional mental health care. We hypothesized that different terms for a mental health professional (e.g., "licensed clinician," "mental health counselor," "psychologist") would have a significant impact on cadets' attitudes toward seeking professional mental health care.

Method

Participants and Data Collection

A sample of 186 cadets at a large mid-western university was given the instrument in several ROTC courses. This university's ROTC includes training programs for the Army, Air Force, and Navy and Marine Corps. The primary investigator was invited by ROTC course instructors to the beginning of various ROTC courses to administer the survey for data collection. The ROTC courses consisted of cadets ranging from first-year students to senior students, as well as involvement in different military branches (Air Force, Navy and Marine Corps). Cadets were given an informed consent form, which was reviewed verbally by the primary investigator. Interested cadets then completed the questionnaire in-class. Participants completed the questionnaire in no longer than 20 minutes. The primary investigator collected the completed questionnaires in a box to maintain anonymity of responses.

The majority of participants were male (72.6%, $n = 135$) and white/Caucasian (81.7%, $n = 152$), with 5.9% ($n = 11$) identifying as Hispanic/Latinx, 4.8% ($n = 9$) as Asian/Asian American, 3.2% ($n = 6$) as Black/African American, 1.1% ($n = 2$) as multiracial, 0.5% ($n = 1$) as Indian, 0.5% ($n = 1$) as Pacific Islander, and 2.2% ($n = 4$) did not respond. Participants had an average age of 20.09 years ($SD = 2.20$, range = 18–30).

These demographics are comparable to the population of officers nationally (Office of the Under Secretary of Defense, Personnel, and Readiness, 2017). The sample was randomly divided into thirds, with 63 participants completing Version A ("psychologist"), 59 participants completing Version B ("mental health counselor"), and 57 participants completing Version C ("licensed clinician"). Seven surveys had missing data, and although analysis suggested the data were missing completely at random, they were nevertheless removed from the analysis (Little's MCAR test = 35.94, p = .801), resulting in a final sample of 179 cadets.

Instrument

Participants received a single instrument, the revised Attitudes Toward Seeking Professional Psychological Help–Short Form (ATSPPH–SF; Picco et al., 2016). This instrument was revised from the original ATSPPH–SF (Fischer & Farina, 1995). As paper-copy versions of the surveys were distributed, they were alternated between the three different versions that included different terms for the helping professional; one–third received Version A "psychologist" to describe the professional, one–third received Version B "mental health counselor" to describe the professional, and one–third received Version C "licensed clinician" to describe the professional.

The ATSPPH–SF is a 10–item self–report instrument designed to measure people's attitudes toward seeking professional care for mental health concerns. Respondents indicate the degree to which they agree with an item using a 4–point Likert scale ranging from 1 (*disagree*) to 4 (*agree*). Half of the items are reverse scored to minimize the possibility of response set bias. All reliability and validity information for the ATSPPH–SF is based on the revised version of the instrument, which uses language to describe the helping professional such as "psychologist," "professional help," "psychological help," and "psychological counseling" (Picco et al., 2016).

Participants were asked to respond to questions regarding their attitudes toward seeking professional care for mental health concerns. The instrument remained constant for each participant except for the language

used to describe the professional. Participants responded to items such as "I might want to seek a ____ in the future" and "The idea of talking about problems with a ____ strikes me as a poor way to get rid of emotional conflicts," where the language used to describe the helping professional was either Version A "psychologist," Version B "mental health counselor," or Version C "licensed clinician." A mean score was calculated for each participant. Participants with more positive attitudes toward seeking professional psychological care would be expected to have higher scores on the ATSPPH–SF. Total scores range from 1 (lowest agreement) to 4 (highest agreement).

The internal consistency for the ATSPPH–SF was 0.84 in a sample of undergraduate students (Picco et al., 2016), which is comparable to the original ATSPPH–SF scale (α = 0.87; Fischer & Farina, 1995). In the current sample, internal consistency was α = 0.78. To determine whether changing the language of the survey affected its reliability, the researchers calculated the Cronbach's alphas for the three different versions of the ATSPPH–SF. Cronbach's alphas for Versions A = 0.79; Version B = .069; and Version C = .081.

Data Analysis

A univariate analysis of variance (ANOVA) was run to test the hypothesis. The independent variable was the survey received, which consisted of three levels (Version A; Version B; Version C). The dependent variable was the total score on the ATSPPH–SF.

Results

Assumptions for running an ANOVA were met (independence, homogeneity of variance, normality). The omnibus test suggested a significant effect of survey received on ATSPPH-SF, $F(2,176) = 3.43$, $p = .035$, partial $\eta^2 = 0.04$. Bonferroni post–hoc tests revealed significant differences between two versions of the ATSPPH–SF (see Table 1). ROTC cadets who received Version C of the ATSPPH–SF ("licensed clinician", $M = 2.71$, $SD = 0.55$) had significantly more positive attitudes toward seeking

professional care for mental health concerns than their peers who received Version A of the ATSPPH–SF ("psychologist", $M = 2.47$, $SD = 0.51$), $p = .035$. There were no statistically significant differences between Version B ("mental health counselor", $M = 2.63$, $SD = 0.47$) and Versions A or C of the ATSPPH–SF. An independent samples *t*-test was used to determine the magnitude of the effect size of this significant difference, Cohen's $d = 0.45$, post-hoc power ($1–\beta$ err prob) = 0.79, which represents a medium effect size (Cohen, 1988). Cadets who saw the term "licensed clinician" had significantly more positive attitudes toward help-seeking compared to cadets who saw the term "psychologist" with an effect size approximately one-half a standard deviation.

Discussion

For the participants in this study, language had a significant effect on attitudes toward seeking professional care for mental health concerns. ROTC cadets in this sample who saw the term "psychologist" reacted differently than those who saw the term "licensed clinician." Cadets were significantly more likely to have more positive attitudes toward seeking professional care when the term for the helping professional was "licensed clinician" when compared to "psychologist." Language alone resulted in significantly different attitudes toward seeking a counselor when in need. Importantly, cadets are considering not only their own mental health needs, but will be setting the tone for the military members that they lead. They will eventually become leaders in the U.S. military. Therefore, they will be an important resource and model for many military members throughout their time of service. Cadets, or future officers, must be able to give Soldiers, fellow officers, as well as themselves appropriate referral for mental health concerns, and changing language around mental health early in cadets' training may influence these attitudes, thus supporting a myriad of Soldiers and fellow officers in the future.

It is unclear why results for mental health counselor emerged in the middle range of the scores. Importantly, results indicated that internal consistency for Version B ("mental health counselor") was lowest

compared to other instrument versions, $\alpha = 0.69$. Cadets who saw the term "mental health counselor" did not have significantly different attitudes toward help-seeking compared to those who saw "licensed clinician" or "psychologist." This suggests that cadets had more ambivalence about this term when it comes to attitudes toward help-seeking. The researchers believe this may be due to more ambiguity around the term "mental health counselor" as opposed to more set views when seeing the term "licensed clinician" or "psychologist," but this is a researcher hypothesis that will require more investigation in the future. Future studies may consider using the term "mental health counselor" when researching with cadets to further identify what is causing this ambiguity and may consider qualitative interviews to better understand what cadets perceive when they hear this term.

Future research can address cadets' unique mental health experiences as well as attitudes toward help-seeking. Many mental health experiences are disqualifying conditions (Department of Defense, 2018b), which may discourage cadets from sharing their history and current mental health concerns. Future research can identify how this barrier may directly impact cadets' attitudes toward help-seeking. Additionally, identifying institutional barriers to mental health help-seeking for cadets at universities is an important consideration for future research. Researchers and counselors can encourage increased attitudes toward help-seeking by addressing the barriers that exist for cadets to receive the mental health care they need.

Implications for Counselors

The findings from the present study have significant implications for counselors. Counselors can use language that increases cadets' attitudes toward mental health help-seeking by referring to themselves and colleagues as licensed clinicians when speaking with ROTC programs and cadets. In doing so, counselors can communicate with ROTC programs and cadets that they understand the importance of language in the military as well as increase the likelihood that cadets will have more positive attitudes

toward help-seeking. Additionally, counselors can reduce stigma around help-seeking in the ROTC community through effective language.

Identifying barriers that exist at a counselor's place of employment are important to increase cadets' help-seeking attitudes. The military's disqualifying conditions are a significant barrier that already exists. Additional to disqualifying conditions, individuals interested in enlisting in the military must authorize the Department of Defense to request medical or behavioral health data holders to release complete transcripts of health data for the processing of their application for military service (Department of Defense, 2018b). If enlistees do not disclose prior mental health disorders, they are subject to fines, penalties, imprisonments, or discharge from the military with the risk of receiving a less than honorable discharge (Department of Defense, 2018b). Cadets with this knowledge may be hesitant to seek university counseling services or recommend such services to their ROTC peers. Counselors can combat this barrier by decreasing institutional barriers and critically assessing their counseling centers for barriers that may be impacting cadets' attitudes and help-seeking behaviors. Counselors can communicate how confidentiality is unique to counselors compared to officers, which may decrease cadets' concerns about enlistment into the military after their officer training by discussing prior or current mental health concerns.

Limitations

There are limitations to the current study to consider. Not all branches of the university's ROTC were recruited for participation in the current study. We recruited participants from Air Force ROTC and Navy and Marine Corps ROTC and did not have participants from Army ROTC, which could have potential unknown implications on the results. Additionally, making broad generalizations about how attitudes are affected by language within the larger population of undergraduate students or military members (e.g., veterans) should not be considered from the present study. Although this study provides strong initial evidence of the effects of language on cadets' attitudes, more research could further the understanding of this phenomenon, including within the military. It would

be interesting to understand if similar effects may occur within a sample of veterans who have served in the military prior to taking the instrument, as well as understanding the potential similarities and differences between cadets and veterans regarding attitudes toward seeking professional help.

In addition, counselors use a variety of terms to describe themselves, depending on multiple factors. This study used three terms, although more terms exist that could be included in future studies (e.g., "therapist"). Future research can address this limitation by including multiple terms to describe a mental health professional.

Conclusion

This initial study on the effect of language on attitudes toward seeking professional psychological help in a sample of ROTC cadets offers the possibility that the use of different terms may be influential in various ways. Using effective language to refer to a mental health professional, specifically using "licensed clinician," may positively influence a cadet's attitudes toward seeking mental health care, which may impact the likelihood that the Soldiers and officers seek a mental health professional in the future. It is important to consider future research that addresses the unique experiences of stress and mental health conditions that ROTC cadets may encounter throughout their training. Additionally, research considering the impact of language on attitudes toward seeking care for mental health should be examined in a variety of military communities, including veterans, National Guard, reserve Soldiers, and more. Importantly, counselors can foster help-seeking attitudes in cadets by addressing a variety of institutional barriers and using effective language, continuing to serve as advocates for ROTC cadets across the country.

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