

## Article 78

### **Bridging the Gap Between Veterans and Civilian Clinicians**

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#### **Abstract**

This article's purpose is threefold: to articulate a portrait unique to the new generation of veterans; to identify existential/transpersonal, animal-assisted, and play therapy approaches with veterans and military families; and to advocate the use of trauma informed practices by counselors. Culturally competent civilian counselors best serve veterans and military families when their practice includes collaborative approaches, individual and family focused processes, community coordinated efforts, strength based and meaning reconstructive ideas, and polytraumatic care needs.

In an interview on National Public Radio this past year, General Martin E. Dempsey, Chairman of the Joint Chiefs of Staff stated, "We face a deficit that's larger than our budget, and that is a deficit of understanding between those of us who serve in uniform and our fellow citizens" (Bowman, 2014). He was referring to the capabilities of

the United States military in places like Iraq, Afghanistan, and Syria. However, his statement points even further than misunderstanding the physical capabilities of our servicemen and women. Not only is there a gap in understanding of what the military can and cannot accomplish physically and politically, but also a gap of understanding of the post-combat needs of military men and women and their families. In response to this gap of understanding, the purpose of this article is threefold: to articulate a portrait unique to the new generation of veterans; to identify several alternative interventions that address the issues of veterans and their families; and to conceptualize a healing connection between returning veterans and their communities.

The service member is more richly understood in a holistic manner before, during, and after returning from a combat deployment. The skills seen as an asset in a war zone are often a liability in a peacetime environment. Successful navigation of the transition between combat and home requires not only effort from the veteran to integrate combat experiences, but also support and understanding from family, community, and country. Service members need a safe, nonjudgmental space where their experiences can be shared and processed without shock or sympathy. They need a space to recall and reconcile memories that most people would consider unthinkable. Much has been written about interventions like trauma focused cognitive behavioral therapy (CBT), prolonged exposure therapy (PE), cognitive processing therapy (CPT), and acceptance commitment therapy (ACT; Collins & Kennedy, 2008; Hall, 2008). However, there are alternative interventions that are proving successful in helping veterans address their issues with reintegration and posttraumatic stress disorder (PTSD) such as narrative therapy, psychological first aid, animal-assisted psychotherapy, mindfulness, existential/transpersonal therapy, and play therapy with families and children of veterans (Beck et al., 2012; Corbett & Milton, 2011; Portela & Culbreth, 2014; Whiting & Moody, 2009). This article will focus on three of these alternatives for clinicians to consider when working with veterans: existential/transpersonal therapy; animal-assisted psychotherapy; and play therapy.

### **The Portrait of Veteran Culture, Values, and Cycles of Deployment**

Over 2 million servicemen and women have deployed over 3 million times since 9/11 in support of the Global War on Terror (Department of Defense [DoD], 2012). These troops have included Active Duty, Reserve, and National Guard personnel, with Reserve and National Guard personnel being utilized as a part of the operational force structure after 9/11. More women, single parents, and dual-military parents have deployed than at any other time in history. Due to the increased operational tempo and wars on multiple fronts, deployments were lengthened, dwell time, or time at home, was shortened, and troops deployed multiple times (North Carolina Institute of Medicine [NCIOM], 2011). These veterans and their families are now dispersed throughout the country. While Active Duty personnel return from deployments to their military base, Reserve and National Guard troops disperse back into the community and often do not have access to the resources on and around military installations (Hoge et al., 2004). Additionally, with the current downsizing, there will be an increasing number of servicemen and women exiting the military. Given these circumstances and the current struggles of the Department of Veterans Affairs (VA), civilian mental health clinicians

must become culturally competent in military culture and the challenges facing veterans and their families.

The U. S. military, composed of five branches including Army, Navy, Air Force, Marines, and Coast Guard, has a unique culture with its own language, values, traditions, and ways of viewing the world. Additionally, each branch has its own cultural distinctions, and differences exist between Active Duty, Reserve, and National Guard components (Osran, Smee, Sreenivasan, & Weinberger, 2010). A clinician working with veterans needs to become familiar with the branch and component within which his/her client served and seek to learn the language and nuances of the client's experiences. Military culture and values become ingrained in the service member's identity so much so that by the completion of initial training, service members can readily quote the creeds and values of their branch. Military identity is thus deeply infused, demanded, and adopted for combat survival. Civilian clinicians must familiarize themselves with the particulars of the identity of the veteran being served in quite a similar way to acting with cultural competence in contemporary diverse society. As espoused by narrative therapists, identity is central to the story of self, others, and the world of which we are a part (Bragin, 2010).

For example, in the U.S. Army, soldiers in basic training learn the Soldier's Creed and the seven Army values of Leadership, Duty, Respect, Selfless Service, Honor, Integrity, and Personal Courage (LDRSHIP). The Soldier's Creed begins with "I am an American Soldier, a warrior and a member of a team. I will serve the people of the United States and live the Army values." It goes on to state the Warrior Ethos, "I will always place the mission first. I will never accept defeat. I will never quit. I will never leave a fallen comrade" (U.S. Army, 2015). Throughout basic training, soldiers must be able to recite these words whenever ordered to do so. This lifestyle becomes second nature and in a combat zone, this level of commitment and attention to detail is vital to survival. A service member's comrades, also known as battle buddies or wingmen, become one's family. Upon returning home, a veteran must make the transition from depending on his/her buddies to relying on previously defined family and friends. This transition is often difficult. During reintegration briefings, service members and their families are told that for every day the service member is deployed, it takes two days for the family to reintegrate. Given deployments can last anywhere from three months to one year, the family reintegration time may be quite longer than understood by civilian counselors.

Military deployment cycles allow for preparation, employment, and reconstitution of personnel and equipment. Since September 11th, the timeframe for this cycle decreased as the operational tempo and "boots on ground" or time in the war zone increased. Furthermore, the families of servicemen and women are experiencing a parallel cycle of emotions and adjustments (Yellow Ribbon Reintegration Program, 2015). Table 1 outlines these cycles in a parallel format to show the progression.

As outlined here, military competent civilian counselors should be aware of the simultaneous impact of deployment cycles on both the service member and her/his family. In essence, civilian counselors better serve veterans when family processes are a conscious part of counseling intervention. Behind work with any individual veteran is a unit experiencing parallel stressors that interplay when reintegration after combat occurs.

Table 1

*Deployment Cycle of Military Personnel and Their Families*

<b>Military Cycle</b>	<b>Family's Emotions</b>	<b>Family Cycle</b>
	Equilibrium	<i>Stabilization</i>
Trainup/ Preparation	Denial, shock, & anger Beginning of detachment	<i>Anticipation of Separation</i>
Mobilization	Loneliness & depression Confusion & irritability	<i>Emotional Disorganization</i>
Deployment	Increased responsibilities Changes can be overwhelming	
Employment	Equilibrium is found Acceptance of being alone Confidence in responsibilities Worries about safety	<i>Stabilization of Separation</i>
Redeployment	Hope & excitement Expectations rise Apprehensive of change Renegotiate responsibilities of family members Reintegrate service member back into family life	<i>Anticipation of Return</i>
Post deployment	Guilt mixed with relief Disappointment when expectations are not met Establish new equilibrium for the family	<i>Emotional Readjustment</i>
Reconstitution	Adjust to the changes in service member Adjust to the changes in family members at home Equilibrium	<i>Stabilization</i>

## **Post-9/11 Veterans**

While veterans share common experiences across specific war situations, a civilian counselor should be knowledgeable about the particulars and uniqueness of post-9/11 military personnel. The ensuing conflicts after 9/11 have created a new generation of veterans who served in the longest war in United States history fought with an all-volunteer force (DoD, 2012). Additionally, technological advances have increased survival rates from combat injuries and connected the home front and the battlefield more closely than ever before. In the past, information flow from the battlefield took weeks or months to get back to the United States. With the use of contemporary technology, military personnel deployed in a combat zone can often return from a mission and Skype with their family at home. A service member could potentially go from engaging the enemy to talking with a spouse within a few hours on the same day. Counselors working with present day veterans will confront the losses and adjustments inherent in polytraumatic physical and psychological survival and in the transition to more immediate communication during familial separation.

Since 9/11, suicide rates, alcohol abuse, prescription drug abuse, and divorce rates have increased among service men and women (DoD, 2012; Iraq & Afghanistan Veterans Association [IAVA], 2014a; National Institutes of Health [NIH], 2013). At least 22 veterans commit suicide daily and the suicide rate among young male veterans has increased 44% in the past several years (IAVA, 2014a).

The Iraq and Afghanistan Veterans Association (IAVA) reports unemployment as one of the leading challenges facing post-9/11 veterans. The unemployment rate for this generation of veterans is higher than the rate for veterans as a whole (IAVA, 2015). With budgets decreasing and military downsizing, these numbers are increasing. In July 2014, the post-9/11 veteran unemployment rate rose to 9.2%, while the overall unemployment rate remained steady at 6.2%. As many as 25% of these veterans are long term unemployed (IAVA, 2014b). The operational tempo of the past decade has kept these personnel gainfully employed until military deployment declines or stops and post-war jobs are scarce. This problem is multiplied for National Guard and Reserve forces. These traditionally part-time military personnel have been able to maintain full-time military employment through combat deployments and support missions to enable the force to fight a war on two fronts (IAVA, 2015).

## **Contemporary Military Families**

The effects of wartime service ripple outward through families and communities. There are 3 million military family members in the United States, with over 2 million of these dependents being children. These children have had one or both parents deployed at least once and probably multiple times over the past decade (DoD, 2012). This transition of family structure shifts the balance of power within the family system. Attachment issues, children taking on responsibilities at younger ages, role and routine changes, and potential secondary trauma effects are all potential hazards for military families (Chawla & Solinas-Saunders, 2011; Collins & Kennedy, 2008; Hall, 2008; NCIOM, 2011). Concerns about safety and security arise and the family structure is destabilized (White, de Burgh, Fear, & Iverson, 2011). Additionally, reintegration of the service member back

into the family structure after a deployment offers a whole new set of challenges (Portela & Culbreth, 2014). When the service member comes home with less visible or invisible injuries, like posttraumatic stress disorder (PTSD), this reintegration becomes even more challenging (Tanielian et al., 2008). At least 15% of Operation Iraqi Freedom veterans and Operation Enduring Freedom veterans are known to have PTSD (Shiner, 2011).

Studies of Vietnam veteran couples over the decades since the end of the war show that it is important to address specific couple and family system issues when intervening with individual veterans. For example, often the spouse and/or other family members play a codependent role in the veteran's PTSD symptoms. This codependence enables the veteran to remain distant and detached from family and friends thus distant from the healing potential of the primary relationships within which post-combat recovery might occur (Lantz & Gregoire, 2000).

Veterans and their families face reintegration into the wider community also. There are lessons to be learned from the ways cultures throughout history have reintegrated their warriors into society after combat. Jonathan Shay (2002) in *Odysseus in America* used Homer's *Odyssey* to address what it means to come home from war. As Shay describes, while returning veterans may be treated sympathetically by society, this still leaves them disconnected from the fabric of their communities. Shay (2002) proposes that veterans not be treated as having a disorder, being broken, or in need of being fixed. The adjustment from combat to peacetime is not addressed in the society's cliché of when will the veteran "return to normal." Servicemen and women who have experienced combat cannot become the people they were prior to deployment and this would not be an appropriate goal of reintegration (Bragin, 2010; Shay, 2002; Whiting & Moody, 2009). They and their families must find a revised normal, one with rebalance of equilibrium, redefinition, and reconstruction of meaning. The stories of their injuries and recovery can contribute to the healing of the wider community by teaching us strength, coping, and resilience.

### **Alternative Interventions With Veterans**

While evidence-based practices for the treatment of PTSD such as prolonged exposure therapy (PE), cognitive processing therapy (CPT), and dialectical behavior therapy (DBT) have proven effectiveness, studies have shown that interventions need to be broadened (Heinssen, 2008; Milliken, Auchteronie, & Hope, 2007). Newer interventions include acceptance commitment therapy (ACT) and eye movement desensitization and reprocessing (EMDR; Shiner, 2011). Indigenous cultures, like Native American and African cultures, addressed the return of warriors through symbolic ceremonies that assisted in the transition from war back into the community. Freud researched these cultures in *Totem and Taboo* (Freud, 1913). These reintegration rituals helped the veterans and civilians integrate the wartime experiences, rather than promoting the splitting off of these memories as inappropriate or too extreme for the peacetime world (Bragin, 2010). In the words of Abraham Joshua Heschel (1963) in regard to the cruelties committed in the name of a free society, "some are guilty, but all are responsible" (para. 48).

This article addresses three alternate approaches for counselors to consider: existential/transpersonal; animal-assisted psychotherapy; and play therapy.

### **Existential/Transpersonal Therapy**

Viktor Frankl (1992) approached traumatic stress as a triangle of guilt, suffering, and death. He developed logotherapy on the idea that the key to sustaining life in the midst of extreme suffering is finding meaning and purpose. Martin Heidegger (1962) endorsed the same concept that too much death or trauma at too young an age often produces a severe reaction of avoidance, detachment, and aggressive tendencies in an effort to protect one's self from vulnerabilities. In recent years, existential therapy has resurfaced as an alternative to the more symptom-focused cognitive behavioral interventions. Employing existential theories offers a wider array of therapeutic approaches and widens the scope of clients that can be helped (Corbett & Milton, 2011).

Existential therapy takes a more holistic view of the client including physical, social, psychological, and spiritual dimensions (Corbett & Milton, 2011). Irvin Yalom (1980) described the existential approach to therapy as resolving the issues of existence by addressing concepts like isolation, freedom, and identity. In contrast to manualized therapies that take a directive and prescriptive approach, existential therapy is more person-centered and focused on meeting an individual's needs, moving the individual toward posttraumatic growth (Corbett & Milton, 2011). Additionally, Yalom described existentialism as an overlay that can be applied to many therapeutic approaches from other theories.

Osran et al. (2010) developed a transpersonal approach to therapy with veterans built on the values inherent to military service and utilizing an existential approach to processing traumatic experiences. When applied to combat experiences, the transpersonal approach offers veterans an opportunity to process experiences and find the meaning necessary to move toward posttraumatic growth. This approach helps the veteran use his/her own values and belief system to underscore strengths and see value and meaning in his/her experiences. The Army's Warrior Ethos and parallel concepts in the other branches give this theory a ready-made foundation with military personnel. Utilizing a strengths-based approach, combat stress is viewed as a natural reaction to war and not as a failure on the part of the warrior. Capitalizing on the human's freedom of will, this transpersonal approach to PTSD empowers the veteran to employ his/her own strengths and military training. Military service is built on the desire to serve a purpose bigger than oneself. This approach to treatment of PTSD ties into this desire in the veteran (Osran et al., 2010).

Similar approaches have been used with veterans from other wars. Jim Lantz used the model of *hold, tell, master, and honor* to help Vietnam veterans and their spouses address combat trauma and reintegration (Lantz & Gregoire, 2000). The first step in Lantz's approach is the therapist's ability to be empathically available and create or hold a safe space for the pain and trauma of war to be processed. The client can then tell his/her story bringing the internal dialogue into the open where it can be processed in a meaningful way. Mastering and honoring entail helping the client find meaning and purpose that are consistent with their individuality, values, and worldview and that lead to posttraumatic growth (Lantz & Gregoire, 2000). While these authors are not comfortable with the connotation given by the phrase "mastering the trauma," Lantz's model of bringing the trauma story to a safe space and developing meaning and purpose that leads to healing has shown positive results.

The existential approach may be utilized with narrative-oriented therapy that helps veterans reconnect their stories back into their communities (Bragin, 2010). The clinician serves as a bridge between society that withdraws from the horrors of war and the veteran who feels isolated with stories too terrible to share. The clinician works with the veteran to co-create a narrative that draws together life before, during, and after war, linking the veteran back to his/her community, and helping the veteran find meaning and purpose (Bragin, 2010; Whiting & Moody, 2009).

### **Animal-Assisted Psychotherapy**

Another approach that is gaining ground in effectiveness is animal-assisted psychotherapy. In studies with trauma survivors as a whole and with veterans in particular, animal-assisted psychotherapy has shown promising results (Beck et al., 2012; Chitic, Rusu, & Szamoskozi, 2012; Geist, 2011; Winston & Chassman, 2013; Zilcha-Mano, Mikulincer, & Shaver, 2011). Animals, like horses and dogs, serve as a bridge to help veterans reconnect with the peacetime environment. Both dogs and horses naturally sense emotions and read human nonverbal language, while also providing a calming and relaxing presence (Winston & Chassman, 2013). The U.S. Army has even experimented with therapy dogs embedded with Combat Operational Stress Teams in Iraq and Afghanistan using animal-assisted activities to help service members cope with stress (Fike, Najera, & Dougherty, 2012). Research in this field is very new and initial findings are positive. Sample sizes in these studies have been small, making it hard to draw definitive conclusions (Beck et al., 2012; Chitic et al., 2012). However, initial results point to positive benefits from animal-assisted interventions (Carminati, Leotkay, Martin, & Carminati, 2013).

It is important to distinguish the terminology used here as the term “animal-assisted therapy” has been used in a wide variety of situations. When talking about animal-assisted therapy or psychotherapy in this article, the term refers to utilizing animals as partners in the therapeutic process. This act is distinctly different from therapy animals who visit schools, hospitals, and other locations. In animal-assisted psychotherapy, the animal is integral to the therapeutic process and the work of therapy involves interaction between the client, the animal, and the therapist (Carminati et al., 2013).

Animals contribute to the therapeutic process in numerous ways. Animals meet the criteria for an attachment bond including proximity, seeking, safe haven, secure base, and separation distress, and relationships with animals tend to be more predictable, consistent, and simpler than human relationships (Zilcha-Mano et al., 2011). Given that many veterans returning from combat often struggle with attachment, intimate relationships, and connection with family and friends, an animal in the therapeutic process can become a bridge for the veteran to begin initial steps in relating.

Additionally, research has shown that the simple presence of an animal can reduce physiological reactions to stress and anxiety, thereby improving a client’s ability to focus and process difficult topics (Geist, 2011). In a study on animal-assisted therapy with persons with substance abuse disorders, findings showed animals, when used in therapy, increased the therapeutic bond and provided a method for therapeutic touch (Westlund, 2014). While touching between a therapist and client can represent boundary issues, touch with an animal can provide comfort and support in a way that the therapist

cannot (Wesley, Minatrea, & Watson, 2009). With the numerous veterans that present with alcohol and drug dependence disorders, animal-assisted therapy presents another method for intervening with these clients who have difficulty forming connections.

### **Play Therapy With Military Families**

No discussion of interventions with veterans would be complete without addressing the needs of their families as well. Portela and Culbreth (2014) discussed practical suggestions for how to implement play therapy with military families. The recommendations are based upon the research findings stating that deployments not only result in issues associated with attachment and separation to the service parent, but also to adjustments with the at-home parent/caregiver who has increased stress given deployment (Chawla & Solinas-Saunders, 2011).

Play therapy techniques can foster what is termed as *emotional presence* to help bridge the relationship with a deployed parent. Family therapists can assist military families in pre-deployment sessions that encourage emotional presence with the absent parent through the use of such things as pictures, linking objects, and technology that connects the deployed and her/his family (Chawla & Solinas-Saunders, 2011). Child-centered play methodologies can be taught to at-home parents and caregivers who might need practical skills to help children manage their emotions associated with the absent parent. These skills include tracking, reflections of feeling, limit setting, and encouragement and are based upon the premise that children will adjust better if they feel acknowledged, understood, and responded to holistically, not simply around their negative behavior (Portela & Culbreth, 2014).

Expressive arts techniques provide a creative outlet for emotional facilitation for not only the child, but also for the at-home family (Foa, Keane, Friedman, & Cohen, 2008). A play therapist can assist the family by observing important interactions and strengths as the activity unfolds and can make these conscious to the family unit (Lowenfield, 1993). Additionally, Lowenfield (1993) described how sandtray may be used to gain access to preverbal content of experience not usually otherwise accessible. Counselors using this approach would need to be mindful of using “figures that represent the culture where the military parent is headed and the jobs she or he will do” (Portela & Culbreth, 2014, p. 21). Puppets have also been used to mediate stress faced by children who are confronting experiences like deployment that prompt fear, loneliness, and anxiety (Steele & Malchiodi, 2012).

Play therapy not only addresses the needs of children within families, but empowers parents to improve their understanding of and interaction with their child(ren). Deployments interrupt the structure of the family system, as well as the parent-child attachment process. While much focus has been given to the deployed parent-child relationship, less research has addressed the impact of deployments on the at-home parent-child relationship (White et al., 2011). Separation, physically and emotionally, from the deployed parent affects parent-child attachment. However, the additional stress on the at-home parent can make that parent less available for the child as well (Chawla & Solinas-Saunders, 2011).

There are strategies that therapists can teach parents to assist with maintaining the parent-child bond through a deployment. The deployed parent can maintain an emotional presence in the child’s life through recorded bedtime stories, online text or video chat,

and/or a transitional object like a stuffed animal or ID tag that both the deployed parent and the child keep with them (Portela & Culbreth, 2014). At home parents or caregivers can be taught child-centered play therapy techniques like tracking, encouragement, reflection of feeling, and limit setting. These tools can enable a parent to focus more fully on the child and empower the child to express themselves more clearly. Creative interventions within art therapy are also effective techniques for military families and their children. A simple idea like a family coloring a mandala together can help the family work on communication skills and allow the therapist to see the family's interaction patterns (Portela & Culbreth, 2014).

### **Trauma-Informed Care**

Trauma-informed care should guide our interventions with military families (Steele & Malchiodi, 2012). The alternative therapeutic approaches presented here are examples of the premise and promise of trauma-informed practice with veterans. The principles of this approach include the following aspects: an emphasis on safety, empowerment and self-regulation; an application of trauma-informed assessment; the use of interventions targeted toward the brain's right hemisphere; the development of trauma-informed relationships with counselors; the creation of trauma-informed environments that promote internal locus of control; the integration of meaning-making strategies; and the advancement of posttraumatic growth and resiliency (Steele & Malchiodi, 2012).

Finally, given the complex needs and numbers of veterans and military families who are experiencing integration difficulties, civilian clinicians must become culturally competent on the subculture of the military world and must expand interventions to include a multitude of trauma-informed practices. Most recommendations espouse interventions that include collaborative approaches, individual and family-focused processes, community coordinated efforts, strength-based and meaning reconstructive ideas, and polytraumatic care needs (Beck et al., 2012; Chitic et al., 2012; Hall, 2008; Heinssen, 2008; Milliken et al., 2007; Osran et al., 2010; Portela & Culbreth, 2014; Steele & Malchiodi, 2012; Whiting & Moody, 2009). Counselors can use military cultural meanings as the basis for a strength-based approach and can use military values as the tenets of coping, resilience, and post-deployment narrative reconstruction for veterans, military families, and the community to which they return and belong.

Counselors could give definition to resiliency as seeking meaning, revising attachment, reconstructing identity, accepting ambivalence, and finding hope. We can be providers of trauma-informed practice, counseling that is inherently strength-based and employs alternative, responsive, and creative methodologies for veterans and their families.

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